11 Claims Processing

General Information

All claims submitted to Health Choice Arizona are reviewed for completeness and accuracy. The process begins with a systematic check of the quality and completeness of the data entered on the claim.

If required fields are not completed or if any fields are completed incorrectly, an error code will be identified for the claim. For example, if the date is "December 10, 2016" it must be recorded as 12/10/2016 (MM/DD/YYYY format).

The system also confirms that a provider ID, recipient ID, date(s) of service, place of service code (CMS 1500), diagnosis code(s), procedure/revenue/NDC code(s) and billed charges are present on the claim. These data elements, as applicable, are required on all claims.

After editing for completeness and correctness of the data submitted, the system edits to ensure that data fields are valid and logical. The most important of these edits assure that:

- The provider ID number is shown on the claim
- The provider has the authority to provide this service
- The recipient is on file, eligible, and entitled to the service
- The service was covered by Health Choice Arizona on the date it was delivered
- Diagnosis and procedure codes were valid for the date of service
- Prior authorization is obtained if required
- The claim is reviewed by Health Choice Arizona medical staff before payment, if required
- The service is allowed for the recipient's age and gender
- The services were part considered included or mutually exclusive of another service performed
- The services billed exceeded maximum units
- The services were not considered as part of a Global days

The final step in the review of the claim is an audit process to assure that reimbursement for the service has not been previously paid or does not exceed service limitations. The claims system audits for duplications, checking the recipient, provider, date of service, and procedure/diagnosis are the same on a paid claim as the claim being reviewed.

EDITING PROCESS

The claims system attempts to apply all edits during a single processing cycle. This enables Health Choice Arizona to report all errors to the provider and avoid claims failing new edits after the provider has corrected and resubmitted the claim. However, if certain data are missing, incorrect, or invalid, completion of the entire processing cycle may not be possible.

When a claim fails an edit or an audit, an error record is created for that claim. All failed edits related to the claim denial are displayed on the Remittance Advice with an action code. A description of the action code is listed on the last page of the Remittance Advice, (see Chapter 13: Understanding the Remittance Advice), for more information.

If one or more edit(s) fail during the editing process, there are two possible outcomes:

- Pended Claim - claim may stop processing and "is pended" for internal review when the error detected concerns data or procedures that may be resolved by Health Choice Arizona staff.

  When a claim requires Medical Review, for example, it will be pended internally until Medical Review screens the services being billed. Internally pended claims are generally handled without input from the provider. The exception is when medical documentation is requested for a claim under review.

- Denied claim - If the data required for adjudication is complete but the service does not meet Health Choice Arizona policy requirements, the claim will deny without payment. For example, if a provider was not registered or if a recipient was not eligible on the date of service, the claim will deny without payment.

Health Choice Arizona's intention is to process all clean claims in a timely manner, normally within 30 days. A claim is considered "clean" on the date the following conditions are met:

- All required information has been received by Health Choice Arizona.
- The claim meets all Health Choice Arizona submission requirements.
- The claim is legible enough to permit electronic image scanning or manual input.
- Any errors in the data provided have been corrected.
- All medical documentation required for medical review has been provided.

A Claim Reference Number (CRN*)* is assigned to all claims on initial submission to Health Choice Arizona. The first five characters of the CRN represent the Julian date the claim was initially received by Health Choice Arizona. The remaining numbers make up the claim document number assigned by Health Choice Arizona.

When submitting documentation (e.g., Medicare EOB) subsequent to submission of a claim, the CRN of the initial submission of the claim should be provided to enable Health Choice Arizona to link the documentation to the claim. Providers also must provide the initial CRN when resubmitting, adjusting, or voiding a claim. If a claim is resubmitted without the CRN, the claim will be treated as a first-time submission and may not pass the 6-month initial claim filing deadline or the 12-month clean claim deadline. The claim also may be denied as a duplicate of an existing claim.

PRICING OF CLAIMS

When the editing process is completed and no errors are found on the claim, it will proceed to pricing and payment. Health Choice Arizona's pricing methodologies include, but are not limited to:

- DRG Pricing Formulas (See Chapter 19: Hospital Services)
- Tiered per Diem (See Chapter 19: Hospital Services)
- Ratios, such as inpatient and outpatient cost-to-charge ratios
- Out-Patient Fee Schedule (OPFS) Logic
- Percentages, such as a percentage of the fee for a service when performed by certain provider types, or when modifiers are used
- Set amounts, or capped fees, such as the unit price for ambulance mileage
- Negotiated rates

Health Choice Arizona had adopted a facility/non-facility rate differential similar to the Medicare format. The facility/non-facility rate structure assigns a reimbursement rate for a given Health Choice Arizona-covered procedure code based on the billed place of service (POS) code.

The system determines if a specific procedure has received prior authorization.

Once a claim is priced, applicable discounts, penalties, insurance payments, etc. are applied to the allowed amount to arrive at a final reimbursement amount.