Attachment C.19.b-1. KY Claims Processing Policies and Procedures

Pursuant to the guidance provided in the updated RFP and Q&A document on page 91 related to Sections 60.5.A.1-2, we are providing Attachment C.19.b-1 electronically, on thumb/flash drives in place of a hardcopy of these documents. The files are in a PDF format and do not include embedded documents, hyperlinks or hyperlinks to videos. As requested, we are providing a table of contents to clearly identify what information is included on the thumb/flash drive.

Attachment C.19.b-1 includes the following:

- Attachment C.19.b-1a. Inventory Management Policy & Procedure
- Attachment C.19.b-1b. KY Providers Claim Appeals Policy & Procedure

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Section (Primary Department) **Claims**	**SUBJECT (Document Title)** **Inventory Management - KY**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
January 1, 2014	December 22, 2019	December 22, 2019	December 22, 2019

Department Approval/Signature :

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid**	☐ Arkansas	☐ Indiana	☐ Minnesota	☐ Tennessee
☐ **Medicare**	☐ California	☐ Iowa	☐ Nevada	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Kansas	☐ New Jersey	☐ Virginia
	☐ District of Columbia	☒ Kentucky	☐ New York – Empire	☐ Washington
	☐ Florida	☐ Louisiana	☐ New York (WNY)	☐ Wisconsin
	☐ Georgia	☐ Maryland	☐ South Carolina	☐ West Virginia

POLICY:

The Plan is committed to achieving the highest level of timeliness in adjudicating claims through focused inventory and workflow management practices. This policy provides the guidelines on the management oversight of manual claims.

The Plan shall adjudicate any clean claims submitted for a substance use disorder service from an enrolled and credentialed behavioral health provider who provides substance use disorder services in accordance with KRS 304.17A-700 to 304.17A-730.

DEFINITIONS:

Adjudicated Claim: Claim(s) that have been processed for payment or denial of payment.

Clean Claim:
A properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the following applicable form:

(a) A clean claim from an institutional provider shall consist of:
1. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;
2. Entries stated as mandatory by the NUBC; and
3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.

Non-Clean Claim: Any claim not meeting the requirements set forth in the above-referenced KY statutes.

Pended Claim: Claim(s) awaiting review and/or instruction for adjudication.

Receipt Date: Date the claim is received.

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PROCEDURE:

The Claims Management Team reviews claims performance and the inventory daily and addresses outstanding concerns and/or trends as needed. The MACESS Report Manager Tool is used to manage and monitor the claim volumes and associates to achieve the timeliness requirement. We proactively realign associates to process the pended claims accordingly when high peak volumes are identified to maintain and sustain compliance.

All claim services are monitored accordingly:

- Claims < 15-days:
  - Work is distributed to the Claims associates based on the skill level and monitored using MACESS.

- Claim >15-days:
  - Work within the Claims Team control is assigned based on the associate skill level and monitored via MACESS.
  - A communication is sent to the Operational Areas to resolve the claims that are outside of the Claims Team.

- Claims 20-days and >:
  - Work is assigned to the Claims Operations expert to research, perform any necessary internal/external outreach to resolve the claim.
  - Document the reason and/or action needed to prevent the claim future occurrences of the claim aging.

- Claims > 26-days:
  - The Claims Operations expert and Claims Manager collaborate to review and resolve the claim(s).
  - Any claim that remains unpaid for forty-five (45) days or more after the date on which the claim is received and that individually, or in the aggregate, exceeds $2,500.00 has the opportunity for an in-person meeting.

The Claims Management team works with the Operational Areas to resolve the claim(s) outside of the Claims Team control.

REFERENCES:

KRS 304.17A-700 to 304.17A-730KRS 205.560(12)(d-e)
806 KAR 17:360

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RESPONSIBLE DEPARTMENTS:

Primary Department: Claims

Secondary Department(s): Provider Services –Health Plan

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
12/16/2013	• NEW
11/13/2014	• Definitions updated • Reference section updated
07/13/2015	• Updated policy section and reference section • Placed on correct MBU template
01/25/2016	• For Annual Review
02/03/2017	• For annual review
02/08/2018	• For annual review • No changes
01/24/2019	• For annual review • No changes
09/16/2019	• Off Cycle Edit • iPRO changes
12/22/2019	• Annual Review • Minor grammatical edits to definitions • Updated header

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Section (Primary Department)	**SUBJECT (Document Title)**
Claims	**Provider Claim Appeals - KY**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
January 1, 2014	September 16, 2019	September 16, 2019	September 23, 2019
Department Approval/Signature :			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid**	☐ Arkansas	☐ Indiana	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☐ California	☐ Iowa	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☒ Kentucky	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Louisiana	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Maryland	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Minnesota	☐ South Carolina	☐ West Virginia

POLICY:

The Plan is committed to achieving the highest level of timeliness in adjudicating claim appeals through focused inventory and workflow management practices. This policy provides the guidelines on the management of claim appeals.

The Plan will maintain a written record for tracking and resolving all provider appeals related to claims payment. This system will contain the date, nature of Appeal, identification of the individual filing the Appeal, identification of the individual recording the appeal, disposition of the Appeal, corrective action required and date resolved.

Within this process, the Plan will respond fully and completely too each provider's appeal.
The Plan's procedure is designed to afford providers access to a timely payment appeal process. The Plan has an appeal process for providers to dispute claim payment. If a provider is dissatisfied with the resolution of the appeal, the provider has the option to file an External independent third-party review.

Provider Payment Appeals are logged into a reportable database. Upon request, the Plan will provide the Department for Medicaid Services (DMS) with a report of information required by the contract; including received date, entity filing the appeal, person in taking the appeal, person dispositioning appeal, root cause, and date of determination. Upon request, the Plan will provide a case summary to DMS to include the Plan's position on specific provider appeals.

DEFINITIONS:

Clean claims:
A properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the following applicable form:

(a) A clean claim from an institutional provider shall consist of:

1. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;

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2. Entries stated as mandatory by the NUBC; and
3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.

Explanation of Payment (EOP): The Plan will send the provider a written or electronic remittance advice or other written or electronic notice confirming the claim was paid or partially/totally denied. Notification will specify all known reasons for the denial and any required information or documentation required for claim processing.

Pay: The Plan will either send the provider an EFT/check equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the Plan.

Provider Claim Appeal: A request from a health care provider to change a decision made by the Plan related to claim payment for services already provided. A provider payment appeal is **not** a member appeal (or a provider appeal on behalf of a member) of a denial or limited authorization as communicated to a member in a notice of action." No action is required of the member for provider payment disputes.
A member also has the right to appeal payment for services according to 907 KAR 17:010 (4)(3). The provider appeal is separate and does not count towards the member's appeal rights

PROCEDURE:

1) If a provider disagrees with a previously processed claim or adjustment, the provider may submit a verbal or written request for appeal to the Plan.

2) Due to the nature of appeals, some cannot be accepted verbally and therefore must be submitted in writing. The following guidance will be used in determining the appropriate submission method.

Issue Type	Verbal Allowed?
Denied for Timely Filing	• If Plan system error, then verbal • If provider needs to submit paper proof, then written
Denied for No Authorization	• If authorization on file and Plan system error, then verbal

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	• If provider needs to submit paper proof, then written
Authorization Issue	• If authorization is on file and clear Plan system error, then verbal • If provider needs to submit paper proof or requesting retro review, then written
Denied for needing additional medical records * **** Denials issued for this reason are considered non-clean claims and should not be logged as appeals. These will be treated as inquiries/correspondence***.	• If records have not been received prior to call, then written • If records received and on file, then verbal
Provider says not paid according to their contract, at appropriate DRG or per diem rate, fee schedule, Service Case Agreement or appropriate bed type, etc.	• Insurers cannot require a provider to appeal errors in payment if the insurer has not paid the claim according to the contracted rate. Miscalculations in payments must be corrected and paid within 30 calendar days upon receipt of documentation from the provider verifying the error. • An insurer is not required to correct a payment error if the provider's request is filed more than 24 months after the date the provider received payment.
Provider indicates member doesn't have OHI, but claim denied for OHI	• Verbal
Claim Check denial	• Written
Denied as duplicate	• Verbal
Claim denied related to provider data issue	• Verbal
Retro-eligibility issue	• Verbal
Experimental/Investigational procedure denial	• Written
Wrong provider or member selected	• Verbal
Claims data entry error	• Verbal

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External independent third-party review	• Written – verbal not accepted

This guidance will be provided in the provider manual.

3) After reviewing the provider manual for verbal versus written guidance, providers wishing to file a verbal appeal can call the Provider Service Unit (PSU) within the National Customer Care at 855-661-2028. Providers may also contact the Plan for guidance if their particular issue does not fall into these categories.

4) If the appeal must be submitted in writing or if the provider wishes to use the written process instead of the verbal process the appeal should be submitted to:

Anthem - Payment Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

5) The payment appeal, whether verbal or written, must be received at the Plan within ninety (90) calendar days of the Explanation of Payment (EOP) paid date or recoupment date.

6) When submitting the appeal verbally or in writing the provider shall provide:
   a) A listing of disputed claims;
   b) A detailed explanation of the reason for the appeal; and
   c) Supporting statements for verbal appeals and supporting documentation for written.

7) Verbal appeals received by the PSU are logged into the appeal database. Written payment appeals are received in Document Services and are date stamped upon receipt. They scan the appeal into the Plan's document management system (Macess), which stamps the image with the received date and the scan date. Once the dispute has been scanned it is logged into the appeal database by the Intake team.

8) Once the appeal is logged, it is routed in the database to the appropriate appeal unit. The appeal associates work appeals by demand drawing items based first-in, first-out criteria for routing appeals.

9) The appeal associate will:
   a) Review the appeal and determine the next steps needed for the payment appeal;
   b) Make a final determination if able based on the issue or will route to the appropriate functional area(s) for review and determination
   c) Ensure a determination is made within thirty (30) calendar days of the receipt of the payment appeal; and

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d) Contact the provider via their preferred method of communication and provide the payment information, if overturned or further appeal rights if upheld or partially upheld.

10) The thirty (30) calendar day response timeframe may be extended by fourteen (14) calendar days if deemed necessary to fully resolve the appeal. If an extension is required, the Plan shall request a fourteen (14) day extension from the Provider and will provide a new date for completion. If the provider requests an extension, it will be granted.

11) If a provider claim(s) remains denied, partially paid, or they continue to disagree, the provider may file an External independent third-party review in writing. External independent third-party review will not be accepted verbally. Beginning with the dates of service on or after December 1, 2016, if a provider disagrees with a previously processed appeal, the provider may submit a request for External independent third-party review to the Plan. The appeal for whether faxed, written or electronic, must be received by Anthem within 60 calendar days of receiving a final decision from the MCO internal appeal process. An additional three (3) days shall be added when the service is by mail.

12) Once the External Independent Third-Party Review is logged, it is routed in the database to the appropriate appeal unit (Health Plan IRU). The appeal associate works appeals by demand, drawing items based first-in, first-out criteria for routing appeals. If an appeal associate receives an External Independent Third-Party Review in error it must be routed to the Health Plan's IRU team.

13) Per contract section 28.9, Providers do not have the right to request state fair hearing.

14) Anthem will provide at no cost to the provider, all documents, records, and other information relevant to an adverse payment or coverage determination, the Contractor shall inform a Medicaid Provider of the determination with sufficient detail of the reason(s) therefore and the Provider's right to request and receive at no cost to the Provider, all documents, records, and other information related to the determination.

REFERENCES:

KRS 304.17A-700(3)907 KAR 17:010 (4)(3)
304.17A-708
Kentucky Medicaid Managed Care Contract §28.9

RESPONSIBLE DEPARTMENTS:

Primary Department: Claims

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Claims	**Provider Claim Appeals - KY**

REVISION HISTORY:

Review Date	Changes
12/16/2013	• New
1/13/2015	• Contract language updated • References updated
5/6/2016	• For annual review • Policy section updated • Reference section updated
7/7/2017	• For annual review
8/21/2018	• For annual review • Edits made to procedure with current contract language
9/16/2019	• Annual Review • Updates for iPRO audit