

Attachment I.C.19-2 Claims Process and Payment Procedures

Department: Medicaid Administration	Policy and Procedure No: Kentucky Medicaid	
Policy and Procedure Title: Claims Process and Payment Procedures Kentucky		
Process Cycle: Annually	Responsible Departments: RSO Claims	
Approved By: Gregg Schleusner- Policy / Lam Nguyen - Process	Issue Date: 1/13/2020	Revised:

CONTRACT REFERENCE:

29.0 PROVIDER PAYMENT PROVISIONS

29.1 Claims Payments

The Contractor shall accept only the uniform Claim forms submitted from providers that have been approved by the Department and completed according to Department guidelines. The Contractor shall accept Claims submitted directly to the Contractor by the Provider. The Contractor shall ensure that payments are made to the appropriate provider.

29.2 Prompt Payment of Claims

In accordance with 42 C.F.R. 447.46, the Contractor shall comply with the timely Claims payment requirements of 42 C.F.R. 447.45. The Contractor shall consider timely claims filing to be within three-hundred sixty five (365) Days of the date of service. The Contractor shall implement Claims payment procedures that ensure ninety percent (90%) of all Provider Claims, including to I/T/Us, for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) Days of the date of receipt of such Claims and that ninety-nine percent (99%) of all Claims are processed within ninety (90) Days of the date of receipt of such Claims. In addition, the Contractor shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and KRS 304.99-123, as may be amended. The Contractor shall provide to each Medicaid Provider the opportunity for an in-person meeting with a representative of the Contractor on any Clean Claim that remains unpaid in violation of KRS 304.17A-700 to 304.17A-730; and on any Claim that remains unpaid for forty-five (45) Days or more after the date on which the Claim is received by the Contractor and that individually, or in the aggregate, exceeds twenty five hundred dollars (\$2,500.00).

The Contractor shall reprocess claims that are incorrectly paid or denied in error, in compliance with KRS 304.17A-708. The Contractor shall not require a Medicaid Provider to rebill or resubmit such a claim in order to obtain correct payment, and no claim shall be denied for timely filing if the claim was timely submitted.

The date of receipt is the date the MCO receives the Claim, as indicated by its date stamp on the Claim or other notation as appropriate to the medium used to file a Claim and the date of payment is the date of the check or other form of payment.

The Contractor shall notify the requesting provider of any decision to deny a Claim or to authorize a service in an amount, duration, or scope that is less than requested. Notifications shall include reason for the Denial, and contact information for submission of Claims denied because a Subcontractor should have been billed. This information shall also be provided in the denying entity is a Subcontractor.

Any conflict between federal law and Commonwealth law will default to the federal law unless the Commonwealth requirements are stricter.

29.3 Payment to Out-of-Network Providers

The Contractor shall reimburse Out-of-Network Providers in accordance with Section 29.1 "Claims Payments" for the following Covered Services:

- A. Specialty care for which the Contractor has approved an authorization for the Enrollee to receive services from an Out-of-Network Provider;
- B. Emergency Care that could not be provided by the Contractor's Network Provider because the time to reach the Contractor's Network Provider would have resulted in risk of serious damage to the Enrollee's health;
- C. Services provided for family planning;
- D. Services for children in Foster Care, if applicable; and
- E. Pharmacy services.

The above listed Covered Services shall be reimbursed at no more than one hundred percent (100%) of the Medicaid fee schedule/rate - unless the Covered Service falls under the EPSDT benefit.

Out-of-Network Providers Policy for Medically Necessary Services

Preauthorized, medically necessary services rendered to Humana members by out-of-network providers will be reimbursed at 65% of the Kentucky Medicaid fee schedule unless otherwise noted.

- A. The following items will be reimbursed at 90% of the Kentucky Medicaid fee schedule:
 - 1. Emergency care (non-participating professional and facility services provided to members in an Emergency Room setting)
 - 2. Services provided for family planning
 - 3. Services for children in foster care

29.4 Payment to Providers for Serving Dual Eligible Enrollees

The Contractor shall coordinate benefits for Dual Eligible Enrollees by paying the lesser amount of:

- A. The Contractor's allowed amount minus the Medicare payment, or
- B. The Medicare co-insurance and deductible up to Contractor's allowed amount.

In the event that Medicaid does not have a price for codes included on a crossover Claim then the entire Medicare coinsurance and deductible shall be paid by the Contractor. The Contractor shall further assist Dual Eligible Enrollees in coordination of benefits required under Section 4.3 "Delegations of Authority."

29.5 Payment of Federally Qualified Health Centers ("FQHC") and Rural Health Clinics ("RHC")

The Contractor shall be responsible to reimburse, by making payments directly to FQHCs and RHCs no less than the amount established under Kentucky's prospective payment system (PPS) rate for the federally certified facilities.

The Contractor shall report to the Department within forty-five (45) Days of the end of each quarter the total amount paid to each FQHC and RHC per month. The report shall include the provider number, name, total number of paid Claims per month, total amount paid by Contractor, and any adjustments. If the Contractor fails to submit the information within the required timeframe, there shall be a penalty of five hundred dollars (\$500) per day until the information is received.

29.7 Payment of Teaching Hospitals

In establishing payments for teaching hospitals in the Contractor's Network, the Contractor shall recognize total costs for graduate medical education at state owned or operated teaching hospitals, including adjustments required by KRS 205.565

30.0 COVERED SERVICES

30.5 Billing Enrollees for Covered Services

The Contractor and its Providers and Subcontractors shall not bill an Enrollee for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this Contract. Any Provider who knowingly and willfully bills an Enrollee for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.

However, if an Enrollee agrees in advance in writing to pay for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Enrollee. The standard release form signed by the Enrollee at the time of services does not relieve the Contractor, Providers and Subcontractors from the prohibition against billing a Medicaid Enrollee in the absence of a knowing assumption of liability for a Non-Medicaid Covered Service. The form or other type of acknowledgement relevant to Medicaid Enrollee liability must specifically state the services or procedures that are not covered by Medicaid.

32.0 SPECIAL PROGRAM REQUIREMENTS

32.4 Out-of-Network Emergency Care

Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid Fee-For-Service rate as required by Section 6085 of the Deficit Reduction Act of 2005. For services provided by non-contracting hospitals, this amount must be less any payments for indirect costs of medical education and direct costs of graduate medical education that would have been included in Fee-For-Service payments.

36.0 PROGRAM INTEGRITY

36.2 Prepayment Review

The Contractor shall have written, policies, procedures and standards of conduct for a prepayment review process in accordance with the requirements of this contract, and should perform a review when there is a sustained or high level of payment error or data analysis identifies a problem area related to possible Fraud, Waste and Abuse. Any request for a prepayment review process outside of the scope of Fraud, Waste and Abuse as prescribed in this Section shall be submitted in writing to the Director of the Division of Program Quality Outcomes for approval with copy to the Director of the Division of Program Integrity.

The Contractor shall have discretion on when to utilize Prepayment Review, but should consider such review due to a high volume of services, high cost, dramatic change in frequency of use, high risk problem-prone area, complaints, or if the Department or any other federal or state agency has identified a certain vulnerability in a service area. The Contractor shall not use Prepayment Review to hold Claims for an indefinite period of time. The Contractor shall review the documentation submitted within a reasonable amount of time but not to exceed thirty (30) Days from the date of the request to determine whether the Claim should be paid. Claims under Prepayment Review are not subject to prompt payment or timely filing requirements.

- A. Specific reason for the review;
- B. Complete description of the specific documentation needed for the review and method of submission;
- C. Timeframe for returning the documentation, and information that the Claim will be denied if documentation is not returned timely;
- D. Length of time the Prepayment Review will be conducted if the Contractor has determined one at its discretion;
- E. Contact information if there are questions related to the Prepayment Review; and
- F. Information on how the provider may request removal of a Prepayment Review.

The Contractor shall ensure the documentation is readily available in the investigative progression from referral (external or internal) to closure and ensure the investigation meets Departmental requirements as well as the requirements of case tracking, case management and reporting.

The Provider shall be given forty-five (45) Days to submit documents in support of Claims under Prepayment Review. The Contractor shall deny Claims for which the requested documentation was not received by day forty-six (46). The Contractor shall deny a Claim when the submitted documentation lacks evidence to support the service or code. The Contractor shall follow Contract Provision 27.10 for any Appeals related to the prepayment process. The Contractor may extend the length of a Prepayment Review when it is determined necessary to prevent improper payments. If the provider has sustained a ninety percent (90%) error free Claims submission rate to the Contractor for forty-five (45) Days the Contractor must request express permission to continue Prepayment Review from the Director of Program Integrity (or designee) and the Director of Program Quality and Outcomes (or designee).

42.0 KENTUCKY HEALTH POLICIES AND PERFORMANCE REQUIREMENTS

41.5 Kentucky Health Cost Sharing

In imposing a copayment for an emergency room visit for a non-emergent service, the Contractor shall ensure compliance with 42 CFR §447.54 and Section 41.11 “Non-Emergency Use of the Emergency Room”. The Contractor shall consider an emergency room visit emergent, for purposes of waiving the copayment, if the Enrollee had a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the Enrollee (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

The Contractor shall not limit what constitutes a non-emergent visit, for purposes of imposition of the copayment, on the basis of lists of diagnoses or symptoms. Conditional Eligibility, Initial Invoicing, and Payment Processing

42.5.3 Copayments

The Contractor shall impose copayment requirements on all Copayment Plan Enrollees. The copayment schedule shall be the copayments approved by CMS in the Kentucky Medicaid State Plan. The Contractor shall update the copayment schedule in accordance with any future modifications made by the Department. The Department shall provide sixty (60) days advanced notice to the Contractor of any such modifications.

Additionally, the Contractor shall reduce the payment it makes to providers by the amount of the Enrollee’s copayment obligation, regardless of whether the provider has collected the payment. The Contractor shall ensure that copayments are not imposed on the following exempt services:

1. Emergency Services as defined at Section 1932(b)(2) of the Social Security Act and 42 CFR §438.114(a);
2. Family planning services and supplies described in Section 1905(a)(4)(C) of the Social Security Act, including contraceptives and pharmaceuticals for which the State can claim enhanced federal match under Section 1903(a)(5) of the Social Security Act;
3. Preventive Services, defined as (i) all the preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF); or (ii) all approved adult vaccines, including their administration, recommended by the Advisory Committee on Immunization Practices, as well as the influenza vaccine; or (iii) preventive care and screening recommended by the Health Resources and Services Administration Bright Future Program Project; or (iv) preventive services recommended by the Institute of Medicine;
4. Pregnancy-related services, which in accordance with 42 C.F.R. 447.56 shall include all services provided to pregnant Kentucky HEALTH Enrollees; and
5. Provider-preventable services as defined in 42 CFR §447.26(b)

41.11 Non-Emergency Use of the Emergency Room

To impose copayments and My Rewards Account deductions for non-emergency use of the emergency room, as described in Sections 41.5.3 “Copayments” and 41.15 “My Rewards Account,” the Contractor shall ensure that any hospital in its network providing non-emergency care in its emergency room to a Kentucky HEALTH Enrollee shall first conduct an appropriate medical screening pursuant to 42 CFR §489.24 to determine that the Enrollee does not require Emergency Services. The Contractor shall instruct its provider network of the following emergency room services copayment and My Rewards Account deduction policies and procedures, as well as the circumstances under which the hospital shall waive or return the copayment:

- A. Inform Enrollees in the Copayment Plan of the amount of their cost sharing obligation for non-emergency services provided in the emergency room;
- B. Inform Enrollees with a My Rewards Account that non-emergency visits shall result in a deduction to the My Rewards Account, and the deduction amount shall escalate for each inappropriate visit during the Benefit Year;
- C. Provide the Enrollee with the name and location of an available and accessible alternative non-emergency services provider;
- D. Determine that the alternative provider can provide services to the Enrollee in a timely manner with the imposition of a lesser cost sharing amount; and
- E. Provide a referral to coordinate scheduling for treatment by the alternative provider.

27.0 PROVIDER SERVICES

27.10 Provider Grievances and Appeals

The Contractor shall have in place a provider grievance and appeals process, distinct from that offered to Enrollees. The Contractor shall process provider grievances and appeals promptly, consistently, fairly, and in compliance with state and federal law and Department requirements. The Contractor shall submit its Provider Grievances and Appeals Policy and Procedures to the Department for review ninety (90) Days after Contract execution. The Contractor shall submit changes to the Policy and Procedures to the Department for review prior to implementation of such changes.

The Contractor shall allow for Providers to have the right to file an internal appeal with the Contractor regarding Denial of the following:

- A. A health care service;
- B. Claim for reimbursement;
- C. Provider payment;
- D. Contractual issues.

Appeals received from Providers that are on the Enrollee’s behalf for denied services with requisite consent of the Enrollee are deemed Enrollee appeals and not subject to this Section. See Section 24.0 “Enrollee Grievances and Appeals” for requirements for Enrollee appeals.

The Contractor’s Provider Grievance and Appeals Policy and Procedures shall include the following, at a minimum:

- A. A grievance process for providers to submit complaints or disputes for which remedial action is not requested to the Contractor and that requires use of a standard Department provided Provider Grievance Form by the Contractor to initiate its Provider grievance process;
- B. An appeals process for providers to raise challenges to specific Contractor decisions that includes:
 1. A committee to review and make decisions on provider appeals. The committee must consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal;
 2. Written notification to the Provider regarding a Denial;
 3. Right to request an external third party review of Contractor decisions after the internal process has been exhausted.

- C. Requirements for recording all grievances and appeals filed by a provider to include the date filed, type of issue, identification and contact of the individual filing the grievance or appeal, identification of the individual recording the grievance or appeal, disposition of the grievance or appeal, corrective action required and date resolved;
- D. Requirements that any form of correspondence with the provider about the appeal be directed to the designee who filed the appeal.
- E. Process for ongoing review and monitoring of types of grievances and appeals submitted and their resolutions for use in determining if additional provider education or changes to MCO operations is necessary to address trends;

The Contractor shall resolve Provider grievances or appeals and provide written notification of the resolution that is received by the Provider within thirty (30) Days. If the grievance or appeal is not resolved within thirty (30) Days, the Contractor shall request a fourteen (14) Day extension from the Provider. If the Provider requests the extension, the extension shall be approved by the Contractor. The Contractor shall ensure that there is no discrimination against a Provider solely on the grounds that the Provider filed an Appeal or is making an informal Grievance. The Contractor shall submit Provider Grievances and Appeals reports as required in Appendix D "Reporting Requirements and Reporting Deliverables."

A Provider who has exhausted the Contractor's internal appeal process shall have a right to a final Denial, in whole or in part, by the Contractor to an external independent third party in accordance with applicable state laws and regulations including Denials, in whole or in part, involving Emergency Services. The Contractor shall provide written notification to the Provider of its right to file an appeal. A Provider shall have a right to Appeal a final decision by an external independent third party to the Cabinet for Health and Family Services Division of Administrative Hearings for a hearing in accordance with applicable state laws and regulation. If the Provider prevails, in whole or in part, the Contractor shall comply with any Final Order within sixty (60) Days unless the Final Order designates a different timeframe.

3.7 Compliance with Federal Law

- A. The Contractor shall be prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):
 - 1. Furnished by any individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX of the Social Security Act or Sections 1128, 1128A, 1156, or 1842(j)(2), [203] of the Social Security Act;
 - 2. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or pursuant to Section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);
 - 3. Furnished by an individual or entity to whom the Department has suspended payments during any period when there is a pending investigation of a credible allegation of Fraud against the individual or entity, unless the Department determines there is good cause not to suspend such payments;
 - 4. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;
 - 5. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan; or
 - 6. For home health care services provided by an agency or organization, unless the agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

36.0 PROGRAM INTEGRITY

The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 C.F.R. 438.608 and Section 6032 of the Federal Deficit Reduction Act of

2005, governing Fraud, Waste and Abuse requirements. The Contractor shall have sufficient investigatory capacity necessary to comply with all applicable requirements and standards under the Contract as well as all federal and state requirements and standards to detect Fraud, Waste and Abuse. The

PURPOSE:

To describe Humana Medicaid Plan policy related to claims processing and timeliness. The purpose is also to provide guidance to claims adjusters on meeting contractual requirements to ensure compliance.

POLICY AND PROCEDURE:

Policy:

It is Humana's Medicaid policy to ensure timely processing and payment of claims. This policy establishes the appropriate claims payment and denials for all claims. It is policy to ensure that all documentation within this document is compliant with the above contractual requirements.

In addition, Humana will ensure their compliance target and turnaround times for electronic claims to be paid/denied comply within the below timeframes:

- (a) The Managed Care Plan shall pay ninety percent (90%) of all clean claims submitted within thirty (30) days.
- (b) The Managed Care Plan shall pay ninety-nine percent (99%) of all claims submitted within ninety (90) days.

Humana will ensure acknowledgment of all electronically submitted claims for services within the following timeframes:

- Within forty-eight (48) hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.
- Within thirty (30) days after receipt of a clean claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.
- Pay or deny the claim within ninety (90) days after receipt the claim.

For non-electronically claims Humana will ensure their compliance target and turnaround times comply with the below timeframes:

- Within twenty (20) days after receipt of the claim, provide acknowledgment of receipt of the claim to the provider or designee or provide the provider or designee with electronic access to the status of a submitted claim.
- Within thirty (30) after receipt of the claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.
- Pay or deny the claim within ninety (90) days after receipt of the claim.

Procedure:

Processing Paper/Electronic Claims: Claims are received electronically or as a paper claim. Humana policy only accepts electronically transmitted claims from providers in HIPAA compliant formats.

Electronic claims are submitted through a large range of clearinghouses to Humana's preferred clearinghouse Availity or WayStar. Our preferred clearinghouses sends an electronic acknowledgement back to that entity, indicating our receipt of the claim. Availity and WayStar does checks and balances for more than a 100 code checks to ensure the claims has all the necessary fields filled in and coded fields have valid values.

This data is then passed to our Electronic Hub (eHub) platform, which will also validate the information received is valid, based on our systems info prior to the claim hitting our Claims Adjudication System (CAS). eHub automate the claims conversion via the provider's practice management system to an 837 claims file to our claims layout to process the claim within CAS.

The CAS system will automatically perform validation check points during the processing and will auto adjudicate the claims. The claim will deny, auto adjudicate or pend prior to completion. In some cases, if a claim is pended for any reason, the claims adjuster will process the claim per the manual process within our Mentor system.

Provider that submit paper claims to Humana using a standard claims form, mail their claims to the P.O. Box that is listed on the back of the member's identification card. Humana's vendor, Conduent Inc., manages the paper claims process from the time is received until the claim is received by eHub after being converted into an electronic format.

Conduent is required by Humana to retrieve mail two times a day between 6am and 10am EST. They open, sort, and scan all documents. Upon sorting completion, Conduent scans each document received, adds a date and time stamp number sequence called a document control number (DCN). Conduent then sends the scanned claim through an optical character recognition (OCR) scanner to extract the data needed by Humana to process the claim. For claims that are unable to be read by the OCR scanner, Conduent will manually enter the required claims data into their system to accommodate a comprehensive transmission of all necessary details for the claims received.

Processing of all claims should always be entered in the order of oldest to newest. If anything is missing on the claim after the claims adjuster performs validation checks, the claim will be denied at that time. Notification of this denial is sent to the provider.

Once the claims are entered and not denied, the status of the claim will reflect an "entered status". The next status would be "pending status" in which a different adjuster will complete the processing. Please note that each step can be completed by different adjusters.

Once the paper claim is entered, it is assigned to a tank within the system and the claims adjuster will review claims assigned by their skillset within the assigned tank. Again the adjuster will work oldest to newest.

Once the claim is processed and confirmed, twice a week there is a check run that is submitted to Accounts Payable (AP) department located in Louisville office, which is the final completion step for them to process the payment of a claim. The date of the check/ Electronic Funds Transfer (EFT) is the date the claim is paid.

Claims Remit: All claims payment will include a detailed remit that is itemized with the enrollee's name, the date of service, the procedure code, service units, and the amount of reimbursement and the identification of the provider.

Crossover Claims: Claims Adjuster will need to receive the Medicare Explanation of Benefits (EOB) with the claim. The Claims Adjuster will review to ensure that all fields are completed on the EOB and will determine the amount that should be paid out. Crossover claims should not be denied if received within a thirty six (36) months from the date of service. Providers are required to submit claims to the Managed Care Plan in accordance with timelines established in the Medicaid Provider General Handbook.

Timely filing: Initial Medical claims should be filed within three hundred sixty five (365) days from the date of service. The CAS system will process the claim and deny due to claim not filed timely if past the 365 days timeframe.

Provider Complaint Process: The provider complaint will be initiated outside the Claims department and handled by Customer Service and other internal areas. The Customer Service department, if unable to resolve issue regarding the claim(s) inquiry, will submit inquiry to the Claims department email inbox for review and resolution. *See below the process that customer service and other internal areas will follow:*

Provider Complaint Review: A provider complaint may be filed using the following steps:

1. Kentucky Department for Medicaid Services Complaint

Inquiries are sent from the state to the Humana Provider Complaint's email inbox. A dedicated representative is trained to identify the severity level of the complaint. The complaint is then routed to the appropriate area for resolution. Once issue is addressed and resolved, a response is sent to the state via email with the resolution and request to close issue. Silver Lining call log is updated with the resolution.

2. Verbal Complaint

A Customer Service specialist will receive the initial call and attempt to resolve any issues or concerns at the time of the call. If the Provider requests to file a complaint, the Customer Service specialist will log the details in the database immediately.

All complaints will be acknowledged verbally or in writing within three (3) business days from the initial call. The provider will be notified verbally or in writing that the complaint has been received and the expected date of resolution. The Provider will be notified in writing regarding the results of the inquiry within fifteen (15) calendar days from receipt of the initial complaint.

3. Written Complaint

The Provider will complete the Provider Complaint Form and fax or mail the form. The complaint will be logged in the Provider Relations Module on the same day of receipt.

All complaints will be acknowledged verbally or in writing within three (3) business days from the initial call. The provider will be notified verbally or in writing that the complaint has been received and the expected date of resolution. The Provider will be notified in writing regarding the results of the inquiry within fifteen (15) calendar days from receipt of the initial complaint.

The Provider has forty-five (45) calendar days to file a written complaint for issues that are not claims related.

Upon receipt of a complaint involving claims from the Customer Service department, a Claims Representative or Claims Manager will thoroughly investigate each complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the Plan's written policies and procedures.

Fraud and Abuse: Claims management sends over a Special Investigations Unit (SIU) report monthly to SIU department for further investigation. If the investigation is ruled not fraudulent, the claims will be released back to the claims adjuster to process. If the claim is sent over for investigation, the claim is pended and not processed until investigation is complete. SIU will review the report and follow the guidelines according to their process (See SIU P&P).

Assisted Suicide Funding: The Claims department will abide by the regulations that prohibit federal dollars (such as Medicaid match funds) from being used for assisted suicide/euthanasia.

SNF and Hospice Claims: Skilled nursing, and Hospice claims are processed the same. Both are billed on a UB-04 form. The Claims Adjuster will review the hospice revenue code to identify 658 and 659 codes in order to determine if the hospice claim not related to room and board can be paid on the date of death. For revenue code 101 for skilled nursing the claim for room and board will not be paid on the date of death. All other revenue codes will process according to guidelines outlined in the Humana Mentor document.

Home Health: Home health providers can use two claim formats to bill, the majority bills the electronic HIPAA standard institutional claim transaction, the 837 institutional claim. Or the provider can bill a paper form CMS-1450, also known as the UB-04. These claims are processed according to the claims guidelines and processing.

Reporting and Monitoring Compliance Risks: To monitor inventory, the Humana Claims department has an automated daily inventory report and claims aging report indicating the number of claims entered, pending, duplicate, rework, provider/system/authorization issues.

To monitor correct claims adjudication, Humana claims leadership and Compliance manually tracks production report indicating the number of approvals, denials and pended claims by adjudicator. This report is separate from the Claims Inventory report and it is monitored with the Pay and Deny file. This file allows management to review to ensure that the claims are processed and paid correctly.

Claims leadership hosts inventory calls weekly on Monday, Wednesday, and Friday where inventory is discussed in addition to any complaints from the state and providers, including all compliance issues that are identified. Regulatory Compliance and claims leadership are included on the meeting invite for the weekly meetings.

A weekly dashboard and monthly dashboard is sent out with claims metrics. There are two dashboards sent out monthly. One is sent out from the Operations team and another one is sent out by Contract Management Unit (CMU) team. All Claims leadership, CMU and Regulatory Compliance leaders are included on the distribution list for the dashboards.

The tracking and meetings allows leaders to identify current compliance issues and compliance risks real-time. It is the policy of the Claims department to track and trend all claims production to ensure timeliness.

Claims Quality Review: The Claims department has dedicated representatives to perform quality reviews. The quality for adjusters works as follows:

Each claims adjuster gets audited on ten (10) random claims per month for their processing and 5 random claims per month for entering. They are graded on whether or not the following information shown below on the database was checked and done appropriately. An algorithm then calculates the persons quality percentage based on how well they did. The business goal is to be at ninety-eight percent (98%) or greater for the month.

ADDITIONAL RESOURCES:

The following documents can be found in mentor:

EHUB

HIPAA Electronic Eligibility and Claims Status Transactions

Paper Claim Submissions

Initial Claim Process CAS

Final Claim Process CAS

Medicare Crossover Overview

CareSource Kentucky Only; Medicaid Policy Statement /Out-of-Network Providers Policy for Medically Necessary Services