EVOLENT HEALTH LLC
POLICY AND PROCEDURE

POLICY TITLE: **Timeliness of Claims Payment & Paying Interest**
DEPARTMENT: **Provider Claims**
ORIGINAL DATE: **February 2016**

Approver(s): Delilah Foreman, Sr. Manager, Rework Claims

Policy Review Committee Approval Date: September 30, 2019

Product Applicability: mark all applicable products below:

COMMERCIAL	[ ] HMO [ ] PPO *Products:* [ ] Small [ ] Indiv. [ ] Large *Exchange:* [ ] Shop [ ] Indiv. [ ] All
	States: [ ] GA [ ] MD [ ] OH [ ] TX [ ] _____
GOVERNMENT PROGRAMS	[ ] MA HMO [ ] MA C-SNP [ ] MA D-SNP [ ] MSSP [ ] Next Gen ACO [ ] MA All
	[X] Medicaid *States:* [ ] DC [X] KY [ ] MD [ ] _____
OTHER	[ ] Self-funded/ASO

Regulatory Requirements: KRS 304.17A-700-730, KRS 205.593, KRS 304.14-135, KRS 304.99-123, 907 KAR 17:030, 42 U.S.C. 1396a (a) (37), 42 C.F.R. 447.45, Balanced Budget Act (BBA) Section 4708 and the Kentucky Department for Medicaid Services Contract Section 30.0

Related Documents: N/A

PURPOSE

The purpose of this policy is to detail the requirements of paying interest and claims timely. The claims processing system is programmed to automatically generate interest payment for all claims, new and adjusted, that are processed greater than 30 days from the original claim received date. The policy below will document timely filing requirements for the plan.

DEFINITIONS

Rework – Rework is the department that handles the research and rework of provider claims.

Explanation of Benefits – EOB – Detailed information on processed claims sent to the provider in order to provide the final determination of payment or denial.

POLICY

It is the policy of Evolent Health (Evolent) to work in accordance with the Balanced Budget Act (BBA) Section 4708, Evolent shall implement claims payment procedures that ensure 90% of all provider claims for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) calendar days of the date of receipt of such claims and that 99% of all claims are processed within ninety (90) calendar days of the date of receipt of such claims. In addition,

Below are the requirements and exceptions.

Timely Filing Requirements

- Original invoices must be submitted within 180 calendar days from the date services were rendered or compensable items were provided.
- Resubmission of previously processed claims with corrections and/or requests for adjustments must be submitted within two years of the last process date.
- Claims originally rejected for missing or invalid data elements must be corrected and resubmitted within 180 calendar days from the date of service. Rejected claims are not registered as received in the claims processing system.

Timely Filing Exceptions

- Submission of claims for members retroactively enrolled by the Department for Medicaid Services must be submitted within 180 calendar days from the date of notification of enrollment.
- Claims with Explanation of Benefits (EOBs) from Medicare Part A must be submitted within 180 calendar days of the date of the Medicare EOB.
- Claims with EOBs from primary insurers, other than Medicare Part A, must be submitted within 60 calendar days of the date of the primary insurer's EOB.
- Any Medicare crossover claim is exempt from normal timely filing guidelines.
- Claims for services to children in out of home placement (Foster care, adoptive assistance, department of juvenile justice, psychiatric, residential treatment facilities and group homes) and mommy steps are exempt from the timely filing guidelines.

PROCEDURE

The claims processing system is programmed to generate the appropriate tier interest payment for new payable claims when a claim is initially processed based on the received date (clean claim date)

- There are three tiers of interest, based on how long after the received date that the claim is being processed:
    - Tier 1: Claims paid 31-60 calendar days after received date - 12%

  - Tier 2: Claims paid 61-90 calendar days after received date - 18% from day 30
  - Tier 3: Claims paid more than 91 calendar days after received date - 21% from day 30

Provider Notification & How Interest Date is calculated based on the below:

- Incoming call to PCSU
  - Date of call
- Correspondence/Letter
  - "Received" date of letter or "received" date of medical records
- Claims projects (mailed, e-mailed or submitted)
  - Provider notification of claims inquiry
- Non-First alert claims audits
  - Identified by Evolent - Use the “process” date
  - Claim audits identified by the provider - First documented date when the provider first reported the claim problem.
- Claim audits identified by first alert
  - Issues identified by Evolent - Use the “process” date
  - Issues identified by the provider – Use the date of notification (Call, letter, etc.)
- Retroactive changes to codes, fees or agreements
  - Use “process” date

RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE REVISED
New Policy	09/16
Due to dept split, updated according to new dept functions	03/18
Updated with a processing change	09/19