EVOLENT HEALTH LLC
POLICY AND PROCEDURE

POLICY TITLE: **Provider Claims Statutory Reporting**
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: Appendix K of the Kentucky Department for Medicaid Services contract

Related Documents: N/A

PURPOSE

It is the purpose of this policy to define the Provider Claims process for reviewing credit balance report and system accuracy.

DEFINITIONS

DMS – Department of Medicaid Services (DMS)

Funding Recovery Specialist – A member of the Funding Recovery team that processes the letters.

POLICY

It is the policy of Evolent Health (Evolent) to establish a process to minimize costs and maximize reimbursement to the company by identifying potential overpayments that are

thirty (30) calendar days or older.

PROCEDURE

I. Report 71 – Credit Balance, Monthly Report

- This report is generated by the Business Analyst. The report contains the following information:
  - Date credit created/Date range of claims
  - Current balance
  - Provider number
  - Provider name
  - EIN/Tax ID
  - Original balance
  - Reason for credit balance
  - Number of letters sent
  - Dates letter sent
  - Provider's Medicaid identification number
  - Provider's national provider identification (NPI) number
  - Comments
- The Business Analyst maintains a running report, adding the new providers, and forwards the completed report by the 7th of each month.
- The employee reviews the report for accuracy, reviewing the provider's balance owed.
- If the balance does not add up correctly, the employee must contact the Business Analyst for the correction needed.
- The spreadsheet will have claims information. These will have to be reviewed and approved by the employee so that the Funding Recovery Specialist can send the first letter.
- The employee will update the spreadsheet with all balance, the age, and any current status updates sent from the Business Analysts' spreadsheet.
- If the provider ends up in collections, the employee will receive, from the cost containment unit, all updates from the collection agency and must update the spreadsheet with all new updates from the collection agency.
- After all updates have been made on the spreadsheet, the employee must submit the spreadsheet to provider claims manager for review by the 13th of the month. The spreadsheet must be submitted to DMS by the 15th of the month.

- Provider claims manager will send to the appropriate functional department, so data can be forwarded to DMS.

New Providers

- If there are new providers that have shown on the spreadsheet, the employee must search the claims system to see why the money cannot be recouped on future payments. Such as the provider is termed, no money going out, etc.
- If the provider has been termed, you must check:
    - If the provider has changed names or practice name
    - If the provider has left the existing group and have gone to a new group.
        - If active under a new group and in the provider's notes in the claim system state "tax liability accepted" and they have the same tax ID and management has approved, liability can be transferred.
- If the provider is active, you must:
    - Verify if the "bypass overpayment recovery" has been selected in the system. If it has been selected, the employee has to contact a representative in the appropriate functional department to make the update in the system so the money can be recouped.

Existing Providers

- The second letter will be sent out after 30 calendar days from when the first letter was sent.
- After an additional 30 calendar days after the second letter goes out (60 calendar days total), the provider goes into collections once approved by management.
- Collections then take over the process and sends updates as necessary.

Completion

- If the letters and the collection process fail, the Business Analyst asks the management team on how they should pursue such as writing off the money or other possible scenarios.

II. Certification Forms

All statutory reports outlined in the above policy require the certification form to be completed by the report's owner.

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
Annual Review	9/19