CLAIMS	ASPIRE HEALTH PLAN	Effective Date 01/01/2018	
		Policy # AHP ASO – CL006	
	Contested and Denied Claims Notification	Review Date 05/09/2023	Applicable to: ☐ Medicare Advantage ☐ Commercial ☑ Anthem HMO ☑ Blue Shield Trio
	Approver's Name & Title	Elisabeth Fagan, Director of Health Plan Operations	

1.0 PURPOSE

1.1 To explain the process of a contested/denied claim notification.

2.0 POLICY

2.1 In order to meet the requirements set by the California Department of Managed Healthcare, all non-ERISA member denials, including ER claim denials, will be adjudicated and mailed within 45 Working Days (60 calendar days) from date received.

2.2 In order to meet the requirements set by the California Department of Managed Healthcare, all ERISA member denials, including ER claim denials, will be adjudicated and mailed within 30 Working Days (45 calendar days) from date received.

2.3 ER claim denials consider a standard where an emergency medical condition exists from the member's/enrollee's subjective point of view.

3.0 DEFINITIONS

3.1 Refer to the Definitions Manual.

4.0 PROCEDURE

4.1 Members are notified in writing of a denied claim by the standard denial letter mandated by Industry Collaboration Effort (ICE) guidelines.

4.2 Providers are notified in writing of denied or contested claims primarily by use of the Explanation of Benefits (EOB).

4.2.1 Non-contracted providers also receive a written denial letter.

4.3 The non-contracted provider and member denial letter (in the case where balance billing may be a possibility) provides:

4.3.1 Information for filing an appeal;

4.3.2 The mailing address for submission of the appeal;

4.3.3 Resources to help the member.

4.4 The Explanation of Benefits (EOB) provides:

4.4.1 Information for filing a provider dispute;

4.4.2 Procedure for obtaining a provider dispute form;

4.4.3 The mailing address for submission of the dispute;

4.4.4 The information/documentation required for a contested claim.

4.5 Verbiage included on the Explanation of Benefits (EOB) includes:

4.5.1 You have the right to appeal any adverse benefit determination: that is any denial, reduction, or failure to make payment in whole or in part. Internal appeals: Per AB1455 for Commercial HMO business, you have 365 days from the date you receive the adverse benefit determination to request an appeal in writing. The request for appeal should include the plan number, member number, date of birth, dependent's name and date of birth if applicable, date(s) of service, provider name, amount of charges, return address, and day time phone number with area code. The plan provides two levels of appeal. The Claims Administrator will acknowledge your appeal within 15 days of receipt of your request and resolution will be made within 45 days of receiving appeal; should a second appeal be conducted the Plan Sponsor will conclude the second appeal within 45 days. In both cases, the review(s) shall be conducted by individuals different and not subordinate to anyone involved in the original denial.

4.6 Contested Claims - when an incomplete claim is received, it will be contested by use of the Explanation of Benefits (EOB). Aspire Health Plan will not exceed requests of 3% for professional provider medical records and 20% for ER services over a 12 month period per CCR section 1300.71(a)(8)(l).

4.6.1 Incomplete claim may be one of, but not limited to:

4.6.1.1 Missing medical records to substantiate billing or modifiers;

4.6.1.2 Missing anesthesia time;

4.6.1.3 Missing NDC code for injectables;

4.6.1.4 Missing info required by contract, e.g., EVLT vein descriptions;

4.6.1.5 Any information that is required for adjudicating the claim that cannot be obtained internally via health plan documentation, e.g., copy of authorization.

4.6.2 The EOB will indicate what is missing via:

4.6.2.1 Adjustment code;

4.6.2.2 Remittance advice.

4.7 Member Responsibility Denials

4.7.1 Claims Analyst determines claim to be a member denial according to DMHC processing guidelines.

4.7.2 Claims Analyst processes denial.

4.7.3 Letter is generated by Check Vendor through automated process upon completion of the check run.

4.7.4 Denial letters are mailed on a weekly basis with the weekly check run.

4.7.4.1 Letters may be mailed more frequently if additional check runs are processed.

4.7.5 Letters can be re-generated from the system for audits if necessary.

5.0 TRAINING

5.1 Training for employees will occur within 90 days of hire, and upon updates to the policy.

6.0 REVIEW PERIOD

6.1 Annually.

7.0 REGULATORY REQUIREMENTS AND REFERENCES

California Health and Safety Code Sections 1367, 1371, 1371.35, 1371.36, 1371.37, 1371.38, and 1371.39

California Code of Regulations (CCR) Title 28 Rule 1300.71(a)(8)(l)

8.0 POLICY VIOLATION

8.1 Any AHP associate or contractor who fails to abide by this policy may be subject to disciplinary action, up to, and including termination. Please refer to AHP's Disciplinary Guidelines and Enforcement Policy for further details.