CLAIMS	ASPIRE HEALTH PLAN	Effective Date: 01/01/2018	
		Policy #: AHP ASO - CL010	
	MISDIRECTED CLAIM ROUTING	**Review Date:** 5/9/2023	**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 outline the process for the handling of misdirected claims that are submitted to Aspire Health Plan.

2.0 POLICY

2.1 Claims for beneficiaries, received both in paper form and electronically, that fall outside of the services or groups delegated, are redirected to the appropriate payer by mail within the applicable regulatory timeframes, which is within ten (10) Working Days of receipt.

2.1.1 Payer is to be searched using the member information found on the claim, which must include member identification number.

2.1.2 In the case that the member identification number is not included on the claim, the claim is sent back to the provider by mail.

3.0 DEFINITIONS

3.1 Refer to the Definitions Manual.

4.0 PROCEDURE

4.1 Claims received electronically, that belong to a payer other than those contracted with Aspire Health Plan, are printed to paper.

4.1.1 Once the claim has been printed, the member's eligibility is reviewed to redirect claim to appropriate payer.

4.1.2 Once the appropriate payer has been verified, the Claims Department logs the claim in the Misdirected Claims tracking sheet with appropriate payer information.

4.1.3 If member is ineligible and no other payer information is available, then the claim is sent back to the provider.

4.1.4 Once the claim has been logged, the Claims Analyst will deny the claim electronically in the claims system with one of the following messages based on whether or not a payer was verified:

4.1.4.1 Rerouting claim to appropriate payer: YOUR CLAIM HAS BEEN RE-ROUTED TO <PAYER> BY MAIL. PLEASE REVIEW MEMBER'S ID CARD.

4.1.4.2 Rerouting claim to provider due to no payer listed for date of service: THE DATE YOU RECEIVED MEDICAL SERVICES ON THE ABOVE CLAIM WAS PRIOR TO YOUR EFFECTIVE DATE. PLEASE SUBMIT CLAIM TO THE ACTIVE INS CARRIER.

4.2 Claims received by mail that belong to a payer other than those contracted with Aspire Health Plan are first reviewed for eligibility within the claims system.

4.2.1 If the member can be located in claims system but the claim cannot be processed any further due to ineligibility, the member's eligibility is then checked to redirect claim to the appropriate payer.

4.2.2 Once the appropriate payer has been verified, the Claims Department logs the claim in the Misdirected Claims tracking sheet with appropriate payer information.

4.2.3 If the claim was keyed in the claims system due to locating the member's profile, the claim is denied in the system with one of the following messages, based on whether or not an appropriate payer can be verified:

4.2.3.1 Rerouting claim to appropriate payer: YOUR CLAIM HAS BEEN RE-ROUTED TO <PAYER> BY MAIL. PLEASE REVIEW MEMBER'S ID CARD.

4.2.3.2 Rerouting claim to provider due to no payer listed for date of service: THE DATE YOU RECEIVED MEDICAL SERVICES ON THE ABOVE CLAIM WAS PRIOR TO YOUR EFFECTIVE DATE. PLEASE SUBMIT CLAIM TO THE ACTIVE INS CARRIER.

4.2.4 If the claim was not keyed into the claim system, the Claims Department will make a note in the members account with the claim information, as well as a note stating the claim has been redirected to appropriate payer or provider if appropriate payer cannot be verified.

4.2.5 If a member cannot be located in the claims system, eligibility will be verified and the appropriate payer identified.

4.2.5.1 Once the appropriate payer has been verified, the Claims Department logs the claim in the Misdirected Claims tracking sheet with appropriate payer information.

4.2.6 If member is ineligible and no other payer information is available, then the claim is sent back to the provider.

4.2.7 Once the misdirected claim is logged into the tracking sheet and mailed to either the appropriate payer or back to the provider, the claim is considered complete.

4.3 It should be noted that some payer portals (including, but not limited to, Anthem) only allow eligibility to be checked for dates of services within 12 months, claims received with dates of services prior to 12 months will result in an unsuccessful search.

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

Health and Safety Code Section 1371 and 28 California Code of Regulations Rule 1300.71

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.