FILING NOTICE: Revisions to this policy require filing with the CA Department of Managed Healthcare. Notify the Compliance Department of any edits made to this policy.

CLAIMS			
	ASPIRE HEALTH PLAN	**Effective Date** 01/01/2018	
		Policy # AHP-ASO-CL011	
	Interest Requirements For Late Payments, Appeals and PDRs	**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 ensure that interest and penalties on completed Commercial provider disputes and appeals are paid appropriately.

1.2 Interest calculations for internal audits or other non-Provider Dispute Resolution (PDR) discovery of incorrect payment (including Customer Service issues) are based on the same criteria as PDR payments.

2.0 POLICY

2.1 Interest and penalties on completed provider disputes begin 45 working days from the date of receipt of the complete non-ERISA claim.

2.2 Interest and penalties on completed provider disputes begin 30 working days from the date of receipt of the complete ERISA claim.

2.3 Whenever possible, interest will be paid on the same check run as the claim that resolves the provider dispute or appeal.

3.0 DEFINITIONS

3.1 Refer to the Definitions Manual.

4.0 PROCEDURE

4.1 If the claim was complete when it was originally submitted, the interest calculation will be based on the original received date. Whenever a claim payment is mailed after the working day time limit interest must be paid at 15% per annum. To calculate the interest payment, multiply the daily rate by the number of calendar days late times the paid amount.

4.2 If the delayed claim was for emergency room claims, different rules apply. Interest must be the greater of the following:

- 15% per annum

- $15.00 per each 12-month period or portion thereof on a non-prorated basis.

4.2.1 A $10.00 penalty will apply when interest is not administered automatically.

4.3 The following conditions will necessitate the payment of interest retroactively:

4.3.1 An incorrectly calculated reimbursement was paid on the original claim, such as:

- An inaccurate co-payment was taken.
- Provider was attached to the incorrect fee schedule.
- Claim processor manually calculated an incorrect payment.
- Data entry error on claim detail line (i.e. units, modifier, etc.) caused an inaccurate payment.

4.3.2 A contract negotiation for an expired contract is concluded and the payer must make retroactive adjustments on claims with dates of service after the contract expiration date.

4.3.3 A claim was denied in error.

4.3.3.1 Member was denied as ineligible in error. The member was eligible at the time the claim was processed and there were no retroactive adjustments.

4.3.3.2 Claim was denied as non-authorized, but service was appropriately authorized and processor failed to locate the authorization.

4.3.3.3 Claim was denied as non-authorized but service was ER related and required no authorization.

4.3.3.4 Claim was Provider-denied due to untimely filing, but evidence of timely prior filing to the correct payer is submitted.

4.3.3.5 Claim was erroneously denied as the responsibility of another payer.

4.3.4 Late Notice or Frivolous Requests - If the Plan or its delegate, if applicable, fails to provide the claimant with written notice that a claim has been contested or denied within the allowable time period or requests information from the provider that is not reasonably relevant or requests information from a third party that is in excess of the information necessary to determine payor liability, but ultimately pays the claim in whole or in part, the computation of interest or imposition of penalty pursuant to late payment of a complete clean and/or the penalty for failure to automatically include the interest due on a late claim payment shall begin with the first calendar day after the expiration of the applicable Time for Reimbursement.

4.4 If the claim was not complete when originally submitted, retroactive interest is not required. The following represents some of the situations on which interest and penalty payments will <u>not</u> be paid retroactively:

4.4.1 A contract negotiation is concluded and the payer must make retroactive adjustments to previously paid claims. However, if the original contract was an

"evergreen" contract and the contact/settlement language does not call for interest on the adjustments.

4.4.2 There is new/additional information from an outside source (i.e. a retroactive enrollment form from an employer group) that was not available at the time the original claim was denied.

4.4.2.1 A retroactive enrollment form from the employer group has been submitted to the Health Plan.

4.4.2.2 Medical Records are provided for review that can substantiate medical necessity.

4.4.3 A claim that was provider-denied due to untimely filing is paid but there is legitimate reason for the delay.

4.4.3.1 Evidence is submitted of timely filing to an entity that was not financially responsible.

4.4.3.2 Information about a good cause for the delay is submitted and accepted by the payer.

4.4.4 An exception payment or a "Gesture of good will" payment is made to a provider.

4.5 If the claim is still not complete at the time of the PDR submission, the clock starts on the date the required information that will make the claim complete is received.

4.6 If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan or the plan's capitated provider shall pay any outstanding monies determined to be due, and all interest and penalties required under Health and Safety Code Sections 1371 and 1371.35 and Rule 1300.71 of Title 28, within five (5) working days of the issuance of the written determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement'' as defined in Section 1300.71(g).

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

Title 28 California Code of Regulations Rule 1300.71 et seq.

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.