

CLAIMS		<u>Effective Date</u> 04/24/2026	<u>Review Date</u> 04/24/2026
		<u>Document #</u> AHP ASO – CL006	
	<u>Document Title:</u> Pended Claims, Contested and Denied Claims Notification	<u>Applicable to:</u> ☐ Medicare Advantage ☐ Self-funded ☒ Anthem HMO ☒ Blue Shield HMO	
		<u>Approver's Name & Title:</u> Elisabeth Fagan, Director of Operations	

1.0 PURPOSE

1.1 To explain the process of a pended claim, as well as contested/denied claim notification.

2.0 POLICY

2.1 The Plan shall not improperly deny, adjust, or contest a claim. For each claim that is either denied, adjusted or contested, the Plan shall provide an accurate and clear written description of the specific reasons for the actions taken.

2.2 The Plan may pend the claim for proper review before adjudication is complete.

2.3 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 as soon as practicable but no later than 30 Calendar Days from receipt of the claim.

2.4 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 Calendar Days from date received.

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

2.6 If a claim or portion thereof is contested on the basis that the plan has not received information reasonably necessary to determine payer liability for the claim or portion thereof, reconsideration of the claim must be completed within 30 Calendar Days after receipt of the additional information.

2.7 The Plan may not contest a claim that is consistent with the procedure or revenue codes and services approved by prior authorization with appropriate documentation included on the claim.

3.0 DEFINITIONS

3.1 Refer to the Definitions Manual.

4.0 PROCEDURE

4.1 All claims entering the Claims department's processing system are processed on a first-in, first-out basis. Each claim is subject to a comprehensive series of checks called edits and audits. The checks validate all data information to determine if the claim should be paid, contested, or denied. Edit/audit checks include verification of:

4.1.1 Data validity

4.1.2 Prior authorization requirements

4.1.3 Recipient eligibility on the date of service

4.1.4 Provider eligibility on the date of service

4.1.5 Procedure/diagnosis, and procedure/modifier compatibility

4.1.6 Other insurance coverage or Medicare benefits

4.1.7 Claim duplication

4.1.8 Verify line(s) or claim level for accurate pricing/payment

4.2 Claims that fail an edit or audit check will "pend" for review by a Claims:

4.2.1 Analyst who will identify the reason for the pended status and examine the scanned image of the claim and attachments (if hard copy received). If input errors are detected, the examiner will correct the error and the claim will continue processing.

4.2.2 Claims requiring medical judgment will be reviewed by a physician or other qualified medical professional in accordance with the provisions of California Code of Regulations (CCR), Title 22 and policies established by the Department of Health Care Services.

4.2.2.1 These claims are routed to the Utilization Management department or a contracted external review organization for clinical review. Expected turnaround time is no more than five (5) business days. The Claims Analyst holds the claim in their active status queue, checks status daily and follows up as required.

4.3 **Suspended Payment Review** - When a provider is under suspended payment review due to a suspected sanction or exclusion, the following process occurs:

4.3.1 The Provider Network team sends a notification email to the Claims team advising that a provider has been flagged due to a suspected sanction or exclusion.

4.3.2 Upon receipt of the notification email, the Claims team identifies all open inventory claims for the provider and moves the claims into a pending queue to be held until the provider has been reviewed by the Credentialing Committee.

4.3.3 Once the Credentialing Committee makes their determination regarding the provider's continued network status, the claims are unpended and:

4.3.3.1 Paid, if the suspected sanction or exclusion is unfounded, or

4.3.3.1 Denied, if the suspected sanction or exclusion is validated and the provider's contract is terminated.

4.4 Members are notified in writing of a denied claim by the standard denial letter mandated by Health Industry Collaboration Effort (ICE) guidelines (see www.iceforhealth.org).

4.4.1 The Plan will not issue denial letters to members when a claim is denied due to timely filing.

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

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

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

4.6.1 The mailing address for submission of the appeal;

4.6.2 Resources to help the member.

4.7 The Explanation of Benefits (EOB) provides:

4.7.1 Information for filing a provider dispute;

4.7.2 Procedure for obtaining a provider dispute form;

4.7.3 The mailing address for submission of the dispute;

4.7.4 The information/documentation required for a contested claim.

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

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. Per CA Health and Safety Code 1300.71(g)(4): Except for applicable co-payments and deductibles, contracted providers shall not invoice or balance bill a plan's enrollee for the difference between the provider's billed charges and the reimbursement paid by the plan or the plan's capitated provider for any covered benefit.

4.9 Contested Claims - when an incomplete claim is received, it will be contested by use of the Explanation of Benefits (EOB).

4.9.1 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).

4.9.2 Contested Claim notice shall identify:

- 4.9.2.1 The portion of the claim that is contested, by procedure or revenue code, and
- 4.9.2.2 The specific information needed from the provider to reconsider the claim, including any defect or impropriety or additional information needed to adjudicate the claim.
- 4.9.2.3 Plans may not contest a claim that is consistent with the procedure or revenue codes and services approved by prior authorization with appropriate documentation included on the claim.
- 4.9.2.4 If a claim or portion thereof is contested on the basis that the plan has not received information reasonably necessary to determine payer liability for the claim or portion thereof, reconsideration of the claim must be completed within 30 calendar days after receipt of the additional information.

4.10 Incomplete claims may be one of, but not limited to:

- 4.10.1 Missing medical records to substantiate billing or modifiers;
- 4.10.2 Missing anesthesia time;
- 4.10.3 Missing NDC code for injectables;
- 4.10.4 Missing info required by contract, e.g., EVLT vein descriptions
- 4.10.5 Any information that is required for adjudicating the claim that cannot be obtained internally via health plan documentation, e.g., copy of authorization.

4.11 The EOB will indicate what is missing via:

- 4.11.1 Adjustment code;
- 4.11.2 Remittance advice.

4.12 Member Responsibility Denials

- 4.12.1 Claims Analyst determines claim to be a member denial according to DMHC processing guidelines.
- 4.12.2 Claims Analyst processes denial.
- 4.12.3 Letter is generated by Check Vendor through automated process upon

completion of the check run.

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

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

4.12.4.2 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

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

7.2 California Code of Regulations (CCR), Title 28 Rule 1300.71(a)(8)(I)

7.3 California Code of Regulations (CCR), Title 22

7.4 29 CFR 2560.503 and the Employee Retirement Income Security Act of 1974

7.5 Industry Collaborative Effort (see www.iceforhealth.org)

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.