SAN FRANCISCO HEALTH PLAN

CL-15: Claims Remittance Advice

APPROVAL/REVIEW/REVISION HISTORY			
Signature	**Title**	**Date**	**Action**
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SFHP POLICY AND PROCEDURE

Claims Remittance Advice

Policy and Procedure number:	**CL15**
Department Owner:	**Claims**
Lines of Business and Coverage Programs Affected:	☒Medi-Cal ☒Healthy Workers HMO ☐Healthy SF ☐City Option ☐ All lines of business and coverage programs as listed above

POLICY STATEMENT

San Francisco Health Plan (SFHP) provides contracted and non-contracted providers with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim within 45 working days after the date of receipt of a complete and "clean" claim.

PROCEDURE

1. The claims processing system, QNXT, adjudicates the majority of SFHP claims and is configured to apply the correct, designated remit messages, based on the system action taken on the claim.

2. When the Claims Examiner manually adjudicates and denies a claim or claim line in QNXT, the system prompts for the selection of an appropriate remit message from a drop down menu. The Claim Examiner(s) shall ensure that the appropriate remit message is selected in QNXT.

3. When the Claims Manager has a remit message created, Compliance Department must approve . ITS department will be notified so that the new message can be cross-walked to a national standard message in the event it is to be used in the generation of a Provider's 835 EDI file. This notification shall be handled through SFHP's issue tracking system.

4. The remit message is included in the check, which is generated by the Finance Department, on the remittance advice (RA), during the Claims payment process.

MONITORING

1. The Claims Manager ensures Remit Messages created and implemented in QNXT provides a clear and accurate explanation of the action taken.
2. On a monthly basis, the Quality Assurance (QA) Analyst reviews a sample of finalized claims to determine whether a clear and accurate written explanation was provided in the remit message.
3. The Claims Manager will review the QA Analyst audit to determine if at least 95% of reviewed claims include a clear and accurate remit message as stated in CCR, Title 28, 1300.71 (a)(8)(F) .
4. If the Claims Manager determines that greater than 5% of the reviewed claims do not have a clear and accurate message, the Claims Manager will develop and implement an appropriate corrective action plan, which will be submitted to the Compliance Officer for review and monitoring.
5. The corrective action plan includes staff training, as needed.
6. On an annual basis, the Claims Manager sreviews the remit messages available and revise and implement as needed.

DEFINITIONS

Complete Claim: means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: “reasonably relevant information” and “information necessary to determine payer liability” as defined in sections (a)(10) and (a)(11,) correspondingly, of Title 28 Section 1300.71.

EDI 835: is the electronic payment and remittance advice standard format for health care claims.

Remittance Advice (RA): is a document that provides notice of and explanation showing payment and reasons for denying, adjusting or contesting a claim.

Remit Message: Plan defined messages to Providers explaining reasons for denying, adjusting or contesting a claim .

AFFECTED DEPARTMENTS/PARTIES

Compliance & Regulatory Affairs
Finance
Health Services – Clinical Operations (including UM) Utilization Management
ITS
Operations - Claims
Operations - Customer Service
Operations - Performance and Process Improvement

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. PP_PPI_ (PPI-01) _Claims Quality Assurance Program
2. PP_FIN_ (FI-02) Claims Disbursement

REVISION HISTORY

Effective Date: March 8, 2013
Revision Date(s): July 2, 2015; October 19, 2017; March 19, 2020

REFERENCES

1. CCR, Title 28, Division 1, Chapter 2, Article 8, 1300.71 Claims Settlement Practices.

2. **1300.71(a)(8)(F) -** The failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section (d)(1) at least 95% of the time for the affected claims over the course of any three-month period;

3. **1300.71(d) (1)** Denying, Adjusting or Contesting a Claim and Reimbursement for the Overpayment of Claims.
   (1) A plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is either denied, adjusted or contested, the plan or the plan's capitated provider shall provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes specified in sections (g) and (h).

4. **1300.71** (g) Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).