Policy and Procedure			
Policy Name:	Claim Processing	Policy ID:	CL.001.01
Approved By:	Dental Director (signature on file)	Effective Date:	1/1/2013
States:	All	Revision Date:	12/01/2014
Application:	All Programs		

This policy applies for operations under Premier Access Insurance Company and Access Dental Plan. For the purposes of this Policy, Premier Access Insurance Company and Access Dental Plan shall be collectively referred to as "Premier Access".

Purpose

To ensure timely and accurate payment of claims for dental services.

Policy

Under Access Dental Plan, claims shall be processed for payment and paid within five days of determining a payment dispute or within 45 calendar days of receipt of a "clean" claim or receipt of all required documentation and information. If a claim is contested or denied by Access Dental Plan, claimant shall be notified in writing within 45 calendar days after the receipt of the claim.

Under Premier Access Insurance Company claims shall be processed for payment and paid within 30 calendar days of receipt of a "clean" claim or receipt of all required documentation and information. If a claim is contested or denied by Premier Access Insurance Company, claimant shall be notified in writing within 30 calendar days after the receipt of the claim.

A sample of claims data shall be reviewed each quarter for accuracy.

Dental Necessity: Title 22, California Code of Regulations, Section 51307, states that the outpatient and inpatient dental services which are reasonable and necessary for the prevention, diagnosis, and treatment of dental disease, injury, or defect are covered to the extent specified in Section 51307 when fully documented to be medically necessary.

The underlying principle of whether a service is reasonable and necessary is whether or not the requested service or item, which is a program benefit, is fully documented to be immediately necessary, is in accord with generally accepted standards of dental practice and is indispensable to the oral health of the beneficiary. Reimbursement shall be made only for the lowest cost covered service appropriate to the presenting adverse condition.

California Medi-Cal GMC and LAPHP Programs: Review and approval of medically necessary dental covered services is conducted in accordance with the Medi-Cal Dental Manual of Criteria.

Procedure

1. Claims for services provided to members must be sent via mail to the following:

   Premier Access Insurance Co., P.O. Box 659010, Sacramento, CA 95865-9010

   Access Dental Plan, P.O. Box: 659005, Sacramento, CA 95865-9005

2. All claims and related appeals must be submitted to ***Premier Access*** for payment for services no later than 6 months or (180 days) after the date of service, unless otherwise specified by regulatory requirement, program requirement, or terms of a provider contract. Required claims submission timeframes vary based on regulatory requirements, program requirements, and/or terms and conditions agreed to by participating contracted dental providers.

   - ***California Government Programs and Commercial DHMO:*** All claims must be submitted to ***Premier Access*** for payment for services no later than 6 months or (180 days) after the date of service.

3. The provider must include the name of the program under which the member is covered (e.g., GMC, LAPHP or Group Name, etc.) and all the information and documentation necessary to adjudicate the claim. For emergency

services, the provider must submit a standard claim form which must include all the appropriate information and an explanation of the emergency circumstances which prevented the member from receiving treatment from member's own Primary Care Dentist () or obtaining authorization to receive the services from a ***Premier Access*** specialist.

4. Any non-emergency dental services, with the exception of preventive dental services, may require preauthorization from Premier Access. Procedures requiring preauthorization vary based on the specific program requirements. (see ***Policy CL.002.01, Prior Authorization, Policy CL.002.02, Prior Authorization – California Medi-Cal Programs, Policy CL.003.01, Referrals for Specialty Care – General, Policy CL.003.02, Referrals for Specialty Care – California Medi-Cal Programs)***
5. Upon receipt of a claim, the claim will be date stamped showing the date of receipt by the Mail Room Clerk who delivers the claims to the Claims Department.
6. Claims are sorted in batches of 100 with a unique batch number.
7. Claims are scanned with the cover letter and unique batch number to off-shore operation using a secure FTP site or the local claims entry data entry team, in accordance with specific program requirements.

   *a**. California Medi-Cal GMC and LAPHP Programs:*** Claims are not sent to the off-shore operation for data entry.

   b. Off-shore operation enters claims on the BAS system database according to the date received and completes any additional clerical work needed to prepare the claims for review and adjudication by the claim staff of **Premier Access**.
8. ***Premier Access*** will verify and acknowledge the receipt of each claim, whether complete or not and disclose the recorded date of receipt via the ***Premier Access*** website at www.premierlife.com. Once on the website, on the Provider Services menu item, a drop down box will display when scrolled over and the last item on the list is the Claims Acknowledgement. After the providers select this item, an acknowledgement login page will appear and the providers will need to enter the office phone # and the last 4 digits of the tax ID. Once a claim has been posted on the site, it will remain there for at least 30 days. If providers do not have internet access, providers may also verify ***Premier Access'*** receipt of their claim by contacting the ***Premier Access*** Customer Service Department.
9. BAS system will run auto-adjudication of claims and will determine benefit and eligibility.
10. The Claims' system prices claims automatically and claims are adjudicated either for payment or for denial of payment with a description reason of denial.
11. Claims requiring clinical review are forwarded to ***Premier Access'*** dental consultant for further evaluation, prior to adjudication.
12. Claims not auto-adjudicated by BAS system are reviewed and adjudicated by ***Premier Access'*** claims processors.
13. On a weekly basis, ***Premier Access'*** Claims Manager, or designee, shall run a payables report for all claims processed/adjudicated since the last payables report.
14. ***Premier Access'*** Claims Manager, or designee, approves all claims for payment.
15. Payable report is reviewed by ***Premier Access'*** Claims Manager, or designee, to ensure proper adjudication.
16. Reports are forwarded to accounting for processing of payment. Checks are then generated and mailed out to providers, by the accounting department.
17. The payment record and check numbers are automatically populated on claim after checks are generated.
18. ***Premier Access'*** claims staff will review five percent (5%) of each batch against hard copy of claim for quality control.
19. If **Premier Access** determines that it has overpaid a claim, ***Premier Access*** will notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service(s) and a clear explanation of the basis upon which ***Premier Access*** believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.
20. If the provider contests ***Premier Access'*** notice of overpayment of a claim, the provider, within 30 working days of the receipt of the notice of overpayment of a claim, must send written notice to ***Premier Access*** stating the basis upon which the provider believes that the claim was not overpaid. ***Premier Access*** will process the contested notice in accordance with ***Premier Access'*** contracted provider dispute resolution process.
21. If the provider does not contest ***Premier Access'*** notice of overpayment of a claim, the provider must reimburse ***Premier Access*** within thirty (30) working days of the provider's receipt of the notice of overpayment of a claim. In the event that the provider fails to reimburse ***Premier Access*** within 30 working days of the receipt of overpayment of claim, ***Premier Access*** is authorized to offset the uncontested notice of overpayment of a claim from the provider's current claim submissions.

22. ***Premier Access*** may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse ***Premier Access*** within the timeframe set forth in above, and (ii) ***Premier Access'*** contract with the provider specifically authorizes ***Premier Access*** to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, ***Premier Access*** will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.
23. ***Premier Access*** must pay clean claims filed electronically and non-electronic timely within the timeframes specified above. If Premier Access fails to pay claimant (Provider or insured) timely, they must pay an additional late payment adjustment or interest at the rate set by the regulators for the unpaid balance due beginning with the first calendar day after the required working day period.
24. In the event that a claim, for which late paid interest is due, is payable to a member that is a non-U.S. taxpayer (e.g., resides outside the U.S.) the claim must be pended and guidance on next steps must be obtained by contacting Tamara Saverine in Guardian's Tax Department at (212) 919-2442.

References

This policy was previously tracked as *Quality Management Program Policy and Procedure* ***UM-11 Claim Processing.***

See also related policies:

Policy CL.002.01, Prior Authorization, Policy CL.002.02, Prior Authorization – California Medi-Cal Programs, CL.003.01, Referrals for Specialty Care – General, CL.003.02, Referrals for Specialty Care – California Medi-Cal Programs, Policy CL.004.01, Review Criteria – Specialty Referrals, Policy QM.008.01, Performance Measures

Revision History

Date:	Description
01/01/2013	Annual review and conversion to revised policy and procedure format and naming convention. Updates for program and regulatory compliance.
12/01/2014	Updates related to late payment of claims.