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| ST. JOSEPH'S HEALTH A Member of Trinity Health; ST PETER'S HEALTH PARTNERS A Member of Trinity Health | **Effective Date:** April 1, 2024 |

**Category:** **E. Billing and Payment**

**Title:** **3. Denied Claims**

**Applies to:**

☐ St. Peter's Health Partners (SPHP)

☐ All SPHP Component Corporations **OR** ☐ Only the following Component Corporations: (Click here for a list)
☐ _____

☐ All SPHP Affiliates **OR** only the following Affiliates: (Click here for a list)
☒ **All Community Health Connections Care Management Agencies**

☐ St. Peter's Health Partners Medical Associates (SPHPMA)

## Contents



## PURPOSE

To ensure that any denied Health Home billing claims are addressed and reconciled in a timely manner.

## POLICY STATEMENTS

It is the policy of Community Health Connections to ensure that services indicated as billable meet the minimum requirements for a billable Health Home service as defined by the New York State Department of Health (NYSDOH). Despite this, there may be times when Health Home claims for services rendered are denied by the Member's Managed Care Organization or New York State Medicaid. This policy does not seek to standardize the process for handling denied Health Home claims across all Care Management Agencies (CMA's). CMA's may choose to

implement policies that are different from the policies in this document, however CMA's must follow the policies and guidance in this document at a minimum.

## SCOPE OF AUTHORITY / COMPETENCY

All Care Management Agencies that comprise the Community Health Connections Health Home program.

## DEFINITIONS

***Health Home Member:*** An individual who is enrolled in Health Home services

***Managed Care Organization (MCO)*:** Payer for non-fee-for-service Health Home Members; includes CDPHP, MVP and Fidelis

***NYSDOH:*** New York State Department of Health; the regulating State entity for Health Homes

## PROCEDURE

### *A. Notification of Denied Claims*

1. Health Home claims may be denied for services rendered to Members for several reasons, including the following.
   - Demographic information on the claim does not match State records (Member sex, date of birth, etc.)
   - The Member is not eligible for Health Home services due to Medicaid not being active at the time of service provision, or the Medicaid coverage is not compatible with Health Home services.
   - The rate code being billed is incorrect.
   - Member has dis-enrolled from Managed Care Organization being billed.
   - Dates of service are incorrect or duplicative with other claims.
   - Provider information is incorrect such as zip code or NPI number.

2. Community Health Connections, on a monthly basis, will send each CMA a Denial Report listing denied claims from the previous month to each agency's identified point of contact for billing matters.

### *B. Rectifying Denied Claims*

1. Each CMA is responsible for thoroughly reviewing the denied claims sent by CHC to determine if the claim needs to be re-billed with corrected information or written off.

2. Each CMA must notify the CHC Outcome Analyst within ten (10) business days of receiving the notification of the denied claim of the action needed (re-bill or write off).

3. Upon notification, CHC will re-bill any denied claims that require re-billing.

4. Should notification to the Health Home for claims that need to be re-billed exceed ten (10) days, the CMA must contact the CHC Outcome Analyst directly.

5. Each CMA should have its own internally processes to review written off claims.

## REFERENCES

New York State Medicaid Program (February 7, 2018). Information for All Providers: General Billing.
(https://www.emedny.org/providermanuals/allproviders/pdfs/information_for_all_providers-general_billing.pdf)

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| **Approving Official: Senior Vice President, Population Health, Advocacy** | | **Effective Date: April 1, 2024** |
| **Key Sponsor: Regional Health Home Director** | | |
| **Reviewed By: Regional Health Home Operations Manager** | | **Original Date: April 16, 2018**<br>**Reviewed/Revised Date: April 1, 2024** |
| **Search Terms:** | | ***Reviewed, No Revisions**<br>****Revised without Full Review** |
| **Replaces: Billing and Payment: Denied Claims (April 16. 2018)**<br>**Billing and Payment: Denied Claims (March 1, 2022)** | | |