SHARP HEALTH PLAN POLICY AND PROCEDURE	
Title: **SHP Claims Negotiations**	**Product Line** (check all that apply)**:** ☒ Group HMO ☒ Individual HMO ☐ PPO ☒ POS ☐ N/A
Division(s): Finance and Health Services	
Department(s): Claims Administration, Contracting, Medical Management	
Owner (Title): Manager Claims Administration	
Relevant Regulatory/Accrediting Agencies/Citations (specify): ☐ CMS: _____ ☒ DMHC: Title 28, California Code of Regulations, Section 1300.71 (AB 1455) ☐ NCQA-HP: _____ ☐ NCQA-WHP: _____ ☐ OTHER: _____	
Approved by: (Signature of VP, Compliance Officer, or CEO)	**Approval date:**

I. PURPOSE: This Policy and Procedure establishes Sharp Health Plan's (Plan) guidelines for processing claims for non-contracted providers.

II. POLICY:

A. It is the policy of Sharp Health Plan (Plan) to process ambulance claims as prescribed by regulations outlined in Title 28, California Code of Regulations (CCR), Section 1300.71 (AB1455).

B. It is the policy of Sharp Health Plan (Plan) to review the appropriate Division of Financial Risk (DOFR) to determine the risk of the claim.

C. It is the policy of Sharp Health Plan (Plan) to review the Prior Authorization Guideline to determine if an authorization is required for each service.

D. It is the policy of Sharp Health Plan (Plan) to negotiate a discount or reprice any non-contracted claim.

III. DEFINITIONS:

A. Date of Receipt: The working day when a claim, by physical or electronic means, is first delivered to Sharp Health Plan or Sharp HealthCare Claims Processing.

B. Date of Service: For Outpatient and Emergency Services, the date upon which the Provider delivered separately billable health care services. For Inpatient Services, the date upon which the enrollee was discharged from the inpatient facility. For Inpatient extended lengths of stay Sharp Health Plan will accept separately billable claims for inpatient services on a bi-weekly basis.

C. Division of Financial Risk (DOFR): The financial risk agreement between Sharp Health Plan and another entity.

D. Letter of Agreement (LOA): A one-time contract agreement between Sharp Health Plan and another entity.

E. Provider: Physicians, hospitals, skilled nursing facilities, home health agencies, pharmacies, medical transportation companies, laboratories, X-ray facilities, durable medical equipment supplies and other licensed health care entities or professionals which or who provide Covered Benefits to Members. A Provider of health care services may or may not be contracted with Sharp Health Plan.

IV. PROCEDURE

A. Non-Contracted Provider Claims Identification.

1. The claim is received by Sharp Health Plan.
2. The Claims Processor reviews the appropriate DOFR.
    a) If the claim is misdirected; the claim will be forwarded to the appropriate payer.
    b) Please refer to the SHP Claims Misdirected Claims Forwarding guidelines for further instructions.
3. The Claims Processor will review the current Prior Auhorization Guideline to determine if the service requires an authorization.
    a) If the claim requires a prior authorization and medical records are attached, the claim will be pended for review by SHP Medical Management, with the exception of Emergency Room and Urgent Care claims.
    b) If the claim requires prior authorization and no medical records are attached the claim will be denied requesting to resubmit with medical records with the exception of Emergency Room and Urgent Care claims, these do not require prior authorization or medical review.

B. Non-Contracted Provider Claims Negotiation Process.

1. Pre-Service Negotiation Process (LOA).

   a) Services that are authorized prior to being rendered with a non-contracted provider and have an LOA. These claims will adjudicate at the agreed upon rate and will not file into the Repricing Workbasket.

   b) LOA's can be created by:

      i) Contracting Department

      ii) Health Services Department

   c) LOA's should be signed by the appropriate parties
      i) For claims that are $1-$10,000 – Signature by the Finance Manager is required

      ii) For all claims over $10,000 – Signature by the Chief Financial Officer (CFO) or the Chief Medical Officer (CMO) is required.

      iii) If the CFO is not available for signatures, then the Finance Manager may sign in place of the CFO.

   d) Copies of these LOA's are scanned and emailed to the SHP Claims Department when the provider does not attach a copy to the claim submitted.

2. Post-Service Negotiation Process.

   a) LOA's should be signed by the appropriate parties
      i) For claims that are $1-$10,000 – Signature by the Finance Manager is required

      ii) For all claims over $10,000 – Signature by the CFO is required.

      iii) If the CFO is not available for signatures, then the Finance Manager may sign in place of the CFO.

   b) Completed LOA's and repricing sheets are scanned into OnBase under the claim correspondence.

      i) For repricing sheets, select OnBase as the printer and print the repricing sheet into OnBase under claim correspondence.

3. Claims with no LOA:

   a) The claim will file into the Repricing Workbasket to be worked by a Claims Processor and a nightly EDI file is sent to Global Excel for rate negotiation.

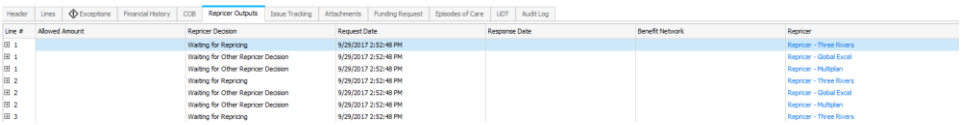
      i) The Claims Processor reviews the Repricing Workbasket in HealthEdge daily.

      ii) Claims are sent to Global Excel for Rate Negotiation

      iii) The Claims Processor works the Repricing Workbasket by the oldest claim received date.

4. Claims Finalization Process for Rate Negotiations.

   1. The Claims Processor will enter the agreed upon rates into the Repricer Outputs in HealthEdge to price the claim.



   2. If no rate can be given by the repricer:
      a. Services provided at a facility contracted with Sharp Health Plan will be paid according to AB72, claims will process according to the applicable Average Contracted Rate (ACR) rate, depending if they fall under ACR for 80% of services or ACR for 20% of services.
      b. Services provided at a facility NOT contracted with Sharp Health Plan will be paid billed charges.

V. REFERENCES:

A. PP SHP Claims Misdirected Claims Forwarding
B. SHP Prior Authorization Guideline
C. ARCH DOFR
D. GTC DOFR
E. PCAMG DOFR
F. RADY CHILDREN'S HOSPITAL DOFR
G. RCHN/CPMG DOFR
H. SCMG DOFR
I. SHC DOFR
J. SRS DOFR
K. PP AB 72

VI. REVISION HISTORY: The original document is always listed first. Each review or revision should be listed. For revisions, include a list of sections that were modified.

Date	Modification (Reviewed and/or Revised)
10/23/2019	Revised
11/16/17	Revised for HealthEdge Process
05/29/15	Revised
08/13/12	Revised
07/03/12	Revised
04/05/12	Revised
03/16/12	Revised
07/11/11	Revised
03/25/11	Revised
02/11/11	Revised
09/17/09	Revised
05/15/09	Revised
01/02/09	Revised
09/25/08	Revised
11/07/07	Revised
10/16/07	Revised
09/16/07	Revised
07/07	Original Document