KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Claims Adjudication Processing and Accuracy	**Policy #**	6.40-P
Policy Owner	Claims	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	12/8/2025
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

The purpose of this policy is to establish guidelines for the accurate processing of all claims going through the adjudication process. This policy is designed to ensure that claims are processed accurately from both a clerical and payment perspective, are processed timely, and that they are processed in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines and regulations. Implementation of this policy will support Kern Health Systems (KHS's) efforts to promote accuracy in claims adjudication and mitigate risks that are associated with processing errors.

II. POLICY

All claims processed through the claim adjudication system will be processed in a prompt, accurate manner that is aligned with CMS rules and regulations, provider contractual agreements, and plan policies.

III. DEFINITIONS

TERMS	DEFINITIONS
Auto-Adjudication	The automatic processing of claims to pay or deny without manual intervention.
Beneficiary	A person who is entitled to Medicare benefits and/or has been deemed eligible for Medicaid.
Claims Adjudication	The process of evaluating and processing claims submitted by providers, suppliers, and other entities to determine payment responsibility and payment accuracy in accordance with CMS regulations or contractual obligations.
Clean Claim	A claim that includes all required information necessary to adjudicate and determine payer liability. In addition to the claim form, necessary

TERMS	DEFINITIONS
	information can include, but is not limited to, necessary consents, releases, assignments, medical records, or other information necessary to determine the medical necessity of the services provided.
CMS	Centers for Medicare & Medicaid Services, the Federal agency within the Department of Health and Human Services (DHHS) that administers the Medicare program and oversees all Medicare Advantage Plan (MAPD) and Prescription Drug Plan (PDP) organizations.
Contracted Provider	A healthcare provider that has an agreement with a health plan to accept patients at an agreed-upon rate.
D-SNP/SNP	Dual Special Needs Plan or Special Needs Plan. Medicare Advantage coordinated care plans that serve the special needs of certain groups of individuals including institutionalized individuals (as defined by CMS), those entitled to Medical Assistance under a State Plan under Title XIX and individuals with severe or disabling chronic conditions, as defined by CMS.
Explanation of Benefits (EOB)	A statement sent to beneficiaries explaining which services were paid for or denied on their behalf, and the beneficiary's financial responsibility if any. Includes information about the right to appeal any denials.
Non-Contracted Provider	A provider or supplier that does not contract with the Medicare Advantage (MA) plan to provide services covered by the MA plan.
Medicare Advantage (MA)	Medicare Advantage Plans are another way to get your Medicare Part A and Part B coverage. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by Medicare-approved private companies that must follow rules set by Medicare. Most Medicare Advantage Plans include drug coverage (Part D).
Unclean Claim	A claim that fails to meet one or more of the criteria used to identify an otherwise "clean" claim.

IV. PROCEDURES

Clean claims will be processed within thirty (30) days of receipt if they are submitted by, or on behalf of, an enrollee of the plan. "All other" claims from contracted and non-contracted providers must be paid or denied within sixty (60) calendar days from the receipt date on the claim.

Claims that do not pass the criteria of a clean claim are determined to be "unclean" and are either returned to the provider as unprocessable or developed to determine claim resolution. Claims requiring additional information are developed by contacting the provider for the additional information needed to complete and/or

make a claim resolution determination within the sixty (60) day timeframe. If requested information is received, the claim will be adjudicated based upon the received date of the new information, and processed accordingly. If the requested information is not received within fifty (50) days of the receipt of the original claim, the claim will be denied for lack of information needed to adjudicate the claim.

Claims that are successfully entered into the adjudication system for processing must be validated for accuracy. Some accuracy requirements include, but are not limited to:

A. Correct coding of procedure and diagnosis codes
B. Appropriate documentation
C. Compliance with National Correct Coding Initiative (NCCI) and other regulatory or industry standards

Claims that have gone through the adjudication process and are ready to pay or deny must be clearly identified. KHS requires that a process be in place to submit claims for payment and closure. Additionally, after a claim has been paid or denied, KHS is required to notify both the provider and the beneficiary of the claim decision, payment or denial details, and a notice of appeal rights. Member notification is required if patient responsibility is determined.

This policy also mandates that the claim adjudication system is updated routinely with the most recent CMS fee schedule and pricing file releases to ensure proper claim handling. This also includes the updating of CMS pricers. This also includes utilizing the CMS NCCI coding edits as well as other industry standard applications to ensure accurate payment.

As part of monitoring and oversight, KHS is required to have a post-payment quality assurance process in place that examines both auto-adjudicated claims and manually adjudicated claims. These Quality Assurance (QA) reviews are required to examine and validate specific aspects of the claim, including but not limited to whether the correct Member and provider were selected, that the Member was determined to be eligible on the date of service, that correct benefits were automatically applied or the proper benefit network was selected, and that the claim processed against applicable Medicare processing guidelines, and that the claim was correctly paid or denied. This QA random sample review should be performed daily with an expected overall goal of 97%.

V. ATTACHMENTS

Attachment A:	N/A

VI. REFERENCES

Reference Type:	Specific Reference:
Regulatory	42 Code of Federal Regulations (CFR) § 422.520 Prompt payment by MA

	organization
Regulatory	Medicare Claims Processing Manual Chapter 1 – General Billing Requirements, § 80.2 – Definition of Clean Claim

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	01/01/2026	New Policy created to comply with D-SNP	Claims

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		