
20. CLAIMS PROCESSING

A. Claims Processing

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Providers.

POLICY:

- A. All Capitated Providers are delegated the responsibility of claims processing for non-capitated services and are subject to review by IEHP. IEHP provides oversight of the Capitated Providers by monitoring, reviewing, and measuring claims processing systems and dispute resolution mechanisms to ensure timely and accurate claims processing and dispute resolution.
- B. Contracted Providers of Service must be given at least ninety (90) days from date of service to submit an initial clean or corrected claim. Non-contracted Medi-Cal providers of service have up to one (1) year from the date of service to submit an initial clean or corrected claim.¹
- C. Capitated Providers must identify and acknowledge the receipt of all claims within two (2) working days if the claim was received electronically or within fifteen (15) working days if a paper claim was received.²
- D. Misdirected claims must be forwarded to the appropriate financially responsible entity within ten (10) working days of receipt.³
- E. Capitated Providers must pay or deny all initial clean or corrected claims for non-contracted Providers providing services to Medi-Cal Members within thirty (30) calendar days of receipt of the claim.⁴ Claims for contracted Providers must be paid or denied within forty-five (45) working days, or within other contractual timeframes.
- F. Late payment of claims requires payment of interest penalties within five (5) working days of the claim payment date.⁵
- G. Overpayments or adjustments must be identified and written notification sent to Providers of Service within three hundred sixty-five (365) days of the date the original claim was paid. Providers of Service must either contest or pay the requested monies within thirty (30) working days of receipt of the notification of overpayment or adjustment.⁶
- H. All Capitated Providers must have a dispute resolution mechanism in place that allows Providers of Service to file a dispute within three hundred sixty-five (365) days of payment or denial. All disputes must be acknowledged within two (2) working days if received electronically and fifteen (15) working days if a paper dispute was received. All disputes must

¹ Title 28 California Code of Regulations (CCR) § 1300.71

² Ibid.

³ Ibid.

⁴ California Welfare and Institutions Code (Welf. & Inst. Code), §14104.3 (3)

⁵ 28 CCR §1300.71

⁶ Ibid.

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be resolved within forty-five (45) working days of receipt of the dispute as outlined in Policy 20A1, “Claim Processing - Provider Dispute Resolution Process - Initial Claims Dispute.”⁷

- I. All claims must be processed (paid or denied), and disclosures made in accordance with federal and state laws and regulations governing all IEHP Programs, plus all other applicable laws, regulations, and contractual stipulations pertaining to IEHP standards.
- J. IEHP will process claims for Indian Health Services (IHS) and Tribal Federally Qualified Health Centers (Tribal FQHC) at the required Office of Management Business (OMB) and Alternate Payment Methodology (APM) rates.^{8,9}

PROCEDURES:

- A. Capitated Providers must have written procedures for claims processing that are available for review. In addition, Capitated Providers must disclose claims filing instructions, fee schedules and Provider dispute filing guidelines, via contract, written notification, Explanation of Benefits (EOB) or Remittance Advice (RA) at the time of payment, denial or adjustment, and/or via a website, as applicable. These written procedures and disclosures must comply with state, federal and IEHP contractual standards and requirements. Such disclosures must also be made available upon request to Providers of Service, IEHP, or a regulatory agency. For a sample of IEHP’s RA, (See Attachment, “IEHP Remittance Advice” in Section 20).
- B. The claims processing systems for Capitated Providers must identify and track all claims and disputes by line of business and/or program, as well as claims related phone calls and inquiries, and be able to produce claims and dispute related reports as outlined in Policy 20G, “Claims and Provider Dispute Reporting.”
- C. Contracted Providers of Service must submit a claim (including any corrected claims) within the timely filing period specified in their Provider contract. A contracted Provider must allow a minimum of ninety (90) days from the date of service to submit a claim.¹⁰
- D. Non-contracted providers must submit a claim (including any corrected claims) within one (1) year from the date of service.¹¹ Non-contracted Medi-Cal Providers of service must submit initial clean or corrected claims within one hundred eighty (180) days after the month of service to be eligible for full reimbursement. Initial clean or corrected claims may be submitted up to one (1) year from the date of service, subject to the following reductions for any claims received after one hundred eighty (180) days:¹²

⁷ 28 CCR §1300.71

⁸ Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020, “American Indian Health Programs”

⁹ DHCS APL 21-008, “Tribal Federally Qualified Health Center Providers”

¹⁰ 28 CCR §1300.71

¹¹ Ibid.

¹² Ibid.

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1. Claims received in the 7th through the 9th month, after the month of service, are subject to a payment reduction of 25%;
 2. Claims received in the 10th through 12th month after the month of service are subject to a payment reduction of 50%;
 3. Claims received beyond one (1) year from the date of service will be handled in accordance with Procedure F (below);
 4. Timely filing reductions are applied only to non-contracted Medi-Cal providers and on original received claims. They do not apply to subsequent adjustments.
- E. Claims should be filed in accordance with the financially responsible Payor's submission requirements. Claims involving IEHP as the Payor should be submitted to:

Inland Empire Health Plan
P.O. Box 4349
Rancho Cucamonga, CA 91729-4349

Claims involving PCP P4P reimbursement should be filed in accordance with Policy 19C, "Pay for Performance (P4P)."

- F. Initial clean or corrected claims received after the filing deadline will be denied unless substantiating documentation for good cause associated with the delay in billing or proof of timely filing is provided.¹³ Disputes filed by Providers of Service subsequent to the denial of the claim for untimely filing must include proof of timely filing as defined below or other substantiating documentation of good cause for the delay in order to be reconsidered for payment. IEHP considers adequate proof of timely filing to be one or more of the following:
1. Claim determination letter or EOB/RA from IEHP or one of IEHP's contracted Capitated Providers (See Attachment, "IEHP Remittance Advice" in Section 20).
 2. Copy of a written request for information or other written claim-related correspondence from IEHP or one of IEHP's Capitated Providers, dated and printed on letterhead or form letter with the date and letterhead clearly identified.
 3. Determination letter from other insurance carriers or other financially responsible entities such as California Children's Services (CCS) or Medicare, dated and printed on letterhead, in which the date of determination is documented, that demonstrates the Provider originally presented the claim within the claims filing timelines permitted by law and/or written contractual agreement from the date of receipt of the determination.
 4. Financial ledgers with multiple claim billings for the date of service in question, including name of the billed party (i.e., IEHP, Capitated Provider, Medicare, HMO, etc.).

¹³ 28 CCR § 1300.71

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5. Computer generated claim transaction history that includes the billing history of the claim and history of timely and consistent follow-up attempts made to the original billed entity within the timely filing guidelines permitted by law and/or written contractual agreement. Detailed history should include billing dates and/or ledgers that show follow-up dates, contact names, time of calls (if applicable) and/or address to which the claim was sent.
 6. Other documentation that demonstrates good cause for the delay in being able to submit the claim timely.
- G. Capitated Providers must have the systems in place and be able to identify and acknowledge the receipt of each claim, whether complete or not, and disclose the recorded date of receipt in the same manner as the claim was submitted.¹⁴
1. If the claim was received electronically, acknowledgement must be provided within two (2) working days of receipt of the claim.
 2. If the claim was a paper claim, acknowledgement must be provided within fifteen (15) working days of receipt of the claim.
- H. Capitated Providers must redirect or deny claims that are not their financial responsibility within ten (10) working days, as follows:¹⁵
1. Claims in which the Capitated Provider has an affiliated network relationship with the financially responsible Payor, including both emergency and non-emergency service claims must be forwarded to the financially responsible entity. This includes IEHP as the health plan when the health plan is the financially responsible Payor.
 2. If the Member cannot be identified or the financially responsible entity is not affiliated with the Capitated Provider's network, the claim should be denied and/or returned to the Provider of Service advising the billing Provider to verify eligibility assignment and to bill the appropriate responsible party.
 3. All forwarded and denied misdirected claims must be tracked and reported, See Policy 20G, "Claims and Provider Dispute Reporting."
- I. Complete (clean) claims are those claims and attachments or other documentation that include all reasonably relevant information necessary to determine Payor liability and in which no further information is required from the Provider of Service or a third party to develop the claim. To be considered a complete claim, the claim should be prepared in accordance with The National Uniform Billing Committee and The National Uniform Claim Committee standards and should include, but is not limited to the following information:
1. A complete paper claim form or EDI file that contains:
 - a. A description of the service rendered using valid CPT, NDC, Diagnosis, HCPCS, ICD-10 codes, and/or Revenue codes, the number of days or units for each service

¹⁴ 28 CCR § 1300.71

¹⁵ *Ibid.*

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- line, the place of service code and the type of service code and the charge for each listed service must be indicated;
- b. Member (patient) demographic information which must at a minimum include the Member's last name and first name and date of birth;
 - c. Provider of service name, address, National Provider Identifier (NPI) number and tax identification number;
 - d. Valid date(s) of service;
 - e. Billed Amount;
 - f. Date and signature of person submitting claim or name of physician who rendered service(s); and
 - g. Other documentation necessary in order to adjudicate the claim, such as medical or emergency room reports, claims itemization or detailed invoice, medical necessity documentation, other insurance payment information and referring Provider information (or copy of referral) as applicable.
 - h. Medicare providers billing for dual eligible (Medicare & Medi-Cal) Members are required to submit the NDCs for physician-administered drugs in order that this data can be crossed over to Medi-Cal. In addition to the NDC, the drug quantity must also be submitted on all dual eligible member claims as provided for by the National Uniform Claims Committee (NUCC).
2. Prior authorization documentation, such as an authorization number on the claim, a copy of the authorization form or referral form attached to the claim for services in which authorization is required.
 3. If a paper or EDI claim is missing critical billing information, the claim will be rejected and a request for missing or invalid information will be sent to the submitter. Requests related to a paper claim submission will be sent in the form of a letter or Remittance Advice. Requests related to an EDI claim will be sent in the form of an ANSI 277 return file to the submitter.
- J. Claims received from contracted Providers must be paid or denied within forty-five (45) working days from receipt of a complete claim.¹⁶ Claims from non-contracted providers rendering services to Medi-Cal Members must be paid or denied within thirty (30) calendar days of receipt.¹⁷
1. This standard is based on the timeframe from the day after the date of receipt of the claim (e.g., date stamp) until the payment or denial is sent to the Provider of Service, regardless of when a check is dated.

¹⁶ 28 CCR § 1300.71

¹⁷ CA Welf. & Inst. Code, §14104.3 (3)

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2. The payment date used to meet timeliness standards is either the actual date a check is mailed, deposited into the Provider of Service's account, or transferred electronically. Proof of mailing must be maintained, including the date of mailing, the check number and the check amount.
 3. The date of receipt is the date the claim is first received by the financially responsible entity as indicated by its date stamp on the claim. In cases of a misdirected claim, the date of receipt is the date the claim is first received by the financially responsible entity. Claims with multiple date stamps should be deemed priority and processed immediately.
- K. Any claim, whether from a contracted or non-contracted Provider, that is not paid at billed charges must include an explanation of the adjustment (e.g., contractual rate, non-covered service, included in other service, etc.), language prohibiting balance billing of the Member, and the process for filing a dispute of the paid amount, on the EOB/RA (See Attachment, "IEHP Remittance Advice" in Section 20).
- L. Reimbursement for services rendered to an IEHP Medi-Cal Member by a non-contracted Provider is as follows:
1. IEHP applies National Correct Coding Initiative (NCCI) edits for claims processed on or after March 28, 2011 with dates of service on or after October 1, 2010.
NCCI edits consist of two types:
 - a. Procedure-to-procedure (Column1/Column2) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons; and
 - b. Medically Unlikely Edits (MUE), which are units of service edits, that define for each HCPCS/CPT code identified, the allowable number of units of service; units of service in excess of this value are not feasible for the procedure under normal conditions (e.g., claims for excision of more than one gall bladder or more than one appendix).
 2. For outpatient services, the Fee for Service rates specified in the Medi-Cal schedule of reimbursement (RFO500); or
 3. Inpatient Facility claims from private inpatient general acute care hospitals, California non-designated hospitals and out-of-state hospitals are paid using an all patient refined Diagnosis-Related Group (APR-DRG) payment methodology.
Psychiatric hospitals and designated public hospitals are excluded from DRG reimbursement methodology. Claims submitted for these facilities follow the guidelines that were in place prior to implementation of the DRG model.
 4. If a Member's IEHP coverage ends during an inpatient hospital stay, all services performed after their eligibility ends are not covered by IEHP.
 5. For emergency services, the ER rate listed in the Medi-Cal schedule of reimbursement (RFO500).

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6. For Family Planning claims, the family planning rates listed for the procedure codes and diagnosis billed as outlined in Senate Bill 94, effective January 1, 2008.
7. Professional and ancillary services are paid at the corresponding Medi-Cal schedule of reimbursement in effect at the time services were performed.
8. Federally Qualified Health Centers (FQHC) - FQHCs are paid at the FQHC prospective payment system (PPS) for primary health services and qualified preventive health services.
9. Rural Health Clinic (RHC) - RHC's are paid the lesser of the provider specific AIR or a national per-visit limit. The AIR is determined for each center based on historical costs.
10. American Indian Health Providers are paid based on the applicable IHS provider type designation as listed below:¹⁸
 - a. IHS-MOA Clinic Providers, whether contracted or not, are paid the applicable encounter rate published annually in the Federal Register by the Indian Health Service (IHS) the Office of Management and Budget (OMB) encounter rate for covered services provided to Indian enrollees who are eligible to receive services from such Providers.¹⁹
 - b. Effective January 1st, 2021, IHS-MOA clinic providers that elect to participate in Medi-Cal as Tribal FQHCs are paid DHCS's Alternate Payment Methodology (APM) rates as follows for each visit:²⁰
 - 1) For Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, irrespective of Medicare Part D coverage, the required payment is the difference between the "APM Rate (Excluding Medicare)" and 80 percent of the Medicare FQHC prospective payment system rate.²¹
 - 2) For Medi-Cal beneficiaries that do not have Medicare Coverage or have Medicare Part A only, irrespective of Medicare Part D coverage, the required payment is the "APM Rate (Excluding Medicare)."²²
 - 3) APM rates will be effective for a calendar year and may have a retroactive effective date. Tribal FQHCs will be paid the most current applicable payments during the calendar year for which the rate applies and as an interim rate in a subsequent calendar year if an updated APM has not been published. Interim payments are reconciled to the applicable updated rate for the specific calendar year in accordance with contractual prompt payment requirements.²³ Tribal FQHCs must be reimbursed at the applicable APM rate for up to a maximum of three visits per day, per Member, in any combination of different visits in the

¹⁸ DHCS APL 21-008

¹⁹ 42 CFR § 438.14(b)(2)

²⁰ DHCS APL 21-008

²¹ Ibid.

²² Ibid.

²³ Ibid.

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following visit categories: medical, mental health, and ambulatory. For example, Tribal FQHCs can be reimbursed for:²⁴

- A combination of three (3) different medical visits with a Primary Care Provider (PCP), Nurse Practitioner, and a Specialist;
 - A combination of three (3) different mental health visits with a Psychiatrist, Psychologist, and a licensed clinical social worker;
 - A combination of three (3) different ambulatory visits for audiology, physical therapy, and optometry services.
 - Certain covered services will continue to be reimbursed outside the APM, including Non-Medical Transportation, Non-Emergency Medical Transportation and Pharmacy.²⁵
- c. Non-Medical Transportation provided by an Indian Health Center or Tribal FQC is payable separately from the OMB rates. Contracted Providers are paid at their respective contracted rates. Non-Contracted providers are paid at the prevailing Medi-Cal Fee Schedule amount.
- d. 90% of IHS claims must be processed within thirty (30) working days and ninety-five percent (95%) must be processed within forty-five (45)-working days.²⁶
11. For Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, the required payment is the difference between the “Outpatient Per Visit Rate (Excluding Medicare)” listed in the Federal Register and 80 percent of the Medicare FQHC prospective payment system (PPS) rate.²⁷
12. For Medi-Cal beneficiaries that do not have Medicare Coverage or have Medicare Part A only, the required payment is the “Outpatient Per Visit Rate (Excluding Medicare)”.
- M. An interest penalty must automatically be paid on any claim not paid within the required timeframe, beginning with the first calendar day after the forty-five (45) working day period. The forty-five (45) working day requirement for the payment of interest applies to both contracted and non-contracted providers. Failure to pay interest due automatically requires a \$10.00 penalty to be paid in addition to any interest due.²⁸
1. Automatically means that interest due to the Provider of Service must be paid within five (5) working days of the payment of the claim or dispute resolution determination resulting in payment of additional monies, without the need for any reminder or request by the Provider of Service.²⁹

²⁴ DHCS APL 21-008

²⁵ Ibid.

²⁶ 42 CFR § 438.14(b)(2)

²⁷ Title 42 United States Code (U.S.C) § 1395w-4(e)(6)(A)(ii)

²⁸ 28 CCR § 1300.71

²⁹ 28 CCR § 1300.71

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2. For claims not paid within the required timeframe, or that are identified as underpaid, interest must be paid for the period of the time that the payment is late or underpaid portion as follows:
 - a. Non-emergency claims, including adjustments - 15% per annum, per claim; or
 - b. Emergency service claims, including adjustments - the greater of \$15 per claim for each twelve (12) month period or portion thereof, on a non-prorated basis; or 15% per annum.
 - c. Interest is due for each calendar day exceeding the 45th working day, beginning with the first calendar day after the 45th working day.
3. If the amount of interest due on an individual claim is less than \$2.00 at the time the claim is paid, the interest on that claim or other such claims must be paid within ten (10) days of the close of the month in which the claim was paid.³⁰
4. Depending on the circumstances surrounding the claim or adjustment, interest methodology³¹ is as follows:
 - a. Initial clean claims and corrected claims should calculate interest based on the period of the day after receipt to the date the payment is mailed. Interest accrues for each calendar day beyond forty-five (45) working days (if applicable).
 - b. Claim adjustments due to a processing error should calculate interest based on the period of the day after receipt of the initial clean claim to the date the payment is mailed. Interest accrues for each calendar day beyond forty-five (45) working days (if applicable).
 - c. Claim adjustments not involving a processing error should calculate interest based on the period of the day after receipt of the additional information that warranted the adjustment to the date the payment is mailed. Interest accrues for each calendar day beyond forty-five (45) working days (if applicable).
- N. Any and all payments of interest must be listed separately on the EOB/RA to the Provider of Service (See Attachment, “IEHP Remittance Advice” in Section 20). Providers of Service that file a claim tracer or a corrected claim must identify the claim as such. Tracers should not be submitted prior to sixty (60) days from the date the claim was originally submitted to the financially responsible party.
- O. California Children’s Services (CCS) claims or other claims in which there was potential responsibility for payment by another party, and subsequently denied by that party for non-coverage of service, termination of coverage or partial payment which is less than Medi-Cal rates, are considered timely if submitted within contract submission timelines for contracted Providers of Services, or one (1) year for non-contracted Medi-Cal Providers of Service from

³⁰ Ibid.

³¹ Ibid.

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the date services were denied or partially paid³², when accompanied by the notice of denial or partial payment. Claims submitted after the above noted timeframes from the date services were denied or partially paid can be denied.

- P. Payment or notification of denial must be sent to the Provider of Service within forty-five (45) working days of the date a complete claim is received if a contracted Provider or thirty (30) calendar days if a non-contracted Provider, accompanied by an EOB or RA.³³ The date of payment or notification of denial is the date the payment or notice is actually mailed or transmitted to the Provider of Service.
- Q. Any claim that is denied, adjusted or contested must include an accurate and clear written explanation of the actions taken. The Provider of Service and Member, when applicable, must be appropriately notified if a claim is denied within forty-five (45) working days of receipt of a complete claim if contracted³⁴ or thirty (30) calendar days if non-contracted.³⁵
1. All denial notifications, including an EOB or RA, to the Provider of Service must include mandated language involving balance billing and the right to appeal the denial, including the process for filing a dispute. For a sample of IEHP's RA and disclosure language (See Attachment, "IEHP Remittance Advice" in Section 20).
 2. Members do not need notification of a denial when services are paid at a lower level than billed (e.g. ED services that have been down coded resulting in payment of the triage fee only), there is no Member liability, or the denial is Provider specific, such as duplicate claims.
- R. If a Capitated Provider determines that a claim has been overpaid, the Provider of Service must be notified in writing of the overpayment within three hundred sixty-five (365) days from the date the original claim was paid.³⁶
1. The written notice must clearly identify the claim, the name of the Member, the date of service and a clear explanation of the basis upon which the Capitated Provider believes the amount paid was in excess of the amount due, including interest and penalties.
 2. Providers of Service have thirty (30) working days from the receipt of the notice of the overpayment to contest or reimburse the overpayment.
 - a. If a Provider of Service contests the request for overpayment, the Provider of Service must send a written notice to the Capitated Provider stating the reason why the Provider of Service believes the claim was not overpaid.
 - b. The contested notice of overpayment must be tracked, resolved and reported as a Provider Dispute, See Policy 20A1, "Claims Processing - Provider Dispute Resolution Process – Initial Claims Disputes."

³² 28 CCR § 1300.71

³³ Ibid.

³⁴ 28 CCR § 1300.71

³⁵ CA Welf. & Inst. Code, § 14104.3 (3)

³⁶ 28 CCR § 1300.71

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- S. Uncontested notices of overpayment can only be offset against a Provider of Service’s future reimbursement when the Provider requests the retraction, in writing; or the Provider fails to reimburse the monies due within thirty (30) working days and the Provider of Service’s contract allows for the offset. Any offsets must be clearly explained at the time of the offset via the EOB/RA or other written documentation, including identifying the specific overpayment(s). Capitated Providers must establish and maintain a Provider Dispute Resolution Mechanism for all Providers of Service that meets or exceeds the requirements, See Policies 16C1, “Dispute and Appeals Resolution for Providers - Initial” and 20A1, “Claims Processing - Dispute Resolution Process – Initial Claims Disputes.” In general, the Provider Dispute Resolution Mechanism must include the following:
1. Providers of Service have three hundred sixty-five (365) days from the date of the original payment, denial, adjustment or contest, or other last action on a claim (i.e., Provider inquiries), to dispute or appeal the claim decision.
 2. All disputes must be acknowledged within two (2) working days of receipt, if received electronically, or within fifteen (15) working days if received via paper.
 3. All disputes must be resolved within forty-five (45) working days after the date of receipt.
 4. Any dispute resolved in favor of the disputing Provider and resulting in additional payment must include interest and penalties, See Policy 20A1, “Claims Processing - Dispute Resolution Process – Initial Claims Disputes.” Any payment including interest must be made within five (5) working days of the date of the written determination.
 5. Any dispute involving an issue of medical necessity or utilization review that is upheld by the Capitated Provider through the dispute mechanism may be submitted to IEHP for secondary review and resolution within sixty (60) working days of the determination date of the dispute from the Provider. Appeals must be submitted to IEHP, See Policies 162, “Dispute and Appeals Resolution Process for Providers - Health Plan” and 20A2, “Claims Processing - Health Plan Claims Appeals” for appeals involving adjudication of claims or billing matters.
 6. All Provider disputes must be reported to IEHP, See Policy 20G, “Claims and Provider Dispute Reporting.” For reporting and monitoring purposes, issues resolved through arbitration are not considered a dispute and are not subject to the requirements noted above.
- T. IEHP’s Provider Relations Team is available from 8:00am - 5:00pm PST, Monday through Friday at (909) 890-2054 or (866) 223-4347 to assist and answer any claim related inquiries. Contracted Providers where IEHP is the Payor may also verify claim status on IEHP’s website at www.iehp.org.
- U. The responsibility for a claim payment as outlined above continues until all claims have been paid or denied for services rendered during the period a Capitated Agreement existed.

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INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	September 1, 1996
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2023

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1. Provider Dispute Resolution Process - Initial Claims Disputes

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Providers.

POLICY:

- A. Providers must submit all claims related disputes, including those involving claims payment or denial, billing, contracting or Utilization Management (UM)/medical necessity to the financially responsible Payor (contracted capitated IPAs, Hospitals or IEHP) for the initial dispute resolution process.
- B. All disputes must be submitted to Payor within three hundred sixty-five (365) days of the last date of action on the claim requiring resolution.¹
- C. Payors must identify and acknowledge the receipt of all disputes within two (2) working days if the dispute was received electronically or fifteen (15) working days of receipt of a written dispute.²
- D. Payors must resolve disputes and issue a written determination within forty-five (45) working days of receipt.³
- E. A Provider may submit a 2nd level appeal regarding the outcome of a Payor's dispute resolution involving claims or billing to IEHP within six (6) months of receipt of the written dispute determination letter from the Payor.

DEFINITION:

- A. "Provider" means any Practitioner or professional person, Acute Care Hospital organization, health facility, Ancillary Provider, or other person or institution licensed by the State to deliver or furnish healthcare services directly to the Member.

PROCEDURE:

- A. Providers must submit all disputes, including claims payment or denial, billing, contracting issues, or those involving UM/medical necessity, in writing to the Payor within three hundred sixty-five (365) days of the last date of action on the claim requiring resolution. If a dispute is received beyond this timeframe, a denial letter is issued, (See Attachment, "Determination Letter" in Section 20). Justification and supporting documentation must be provided with the written dispute.⁴

¹ Title 28 California Code of Regulation (CCR)§ 1300.71.38

² Ibid.

³ Ibid.

⁴ Ibid.

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1. Provider Dispute Resolution Process - Initial Claims Disputes

1. Disputes are categorized as follows, for reporting, tracking, and monitoring purposes:
 - a. Claims/Billing – any formal written disagreement involving the payment, denial, adjustment or contesting of a claim, including overpayments, payment rates, billing issues or other claim reimbursement decisions.
 - b. Denial of a claim for any reason including eligibility, benefits, untimely filing, etc. See Policy 20A, “Claims Processing.”
 - c. Contract – Any formal written disagreement concerning the interpretation of a contract as it relates to claim payment.
 - d. UM/Medical Necessity – any formal written disagreement concerning the need, level or intensity of health care services provided to Members.
2. Written claims and billing related disputes must be submitted to the Payor in accordance with the dispute filing guidelines issued by the Payor.
 - a. For claims or billing disputes involving IEHP as the Payor, disputes must be sent to:

IEHP - Provider Claims Resolution and Recovery Unit
P.O. Box 4319
Rancho Cucamonga, CA 91729-4319
 - b. IEHP Provider dispute forms are available upon request and are also available on IEHP’s website at www.iehp.org.
3. Emergency and/or Post Stabilization services rendered by a non-contracted provider must be submitted to the Payer in accordance with the dispute filing guidelines.
 - a. If the non-contracted provider disagrees with the Payers dispute determination the dispute may be submitted for resolution to:

Department of Health Care Services
Office of Administrative Hearings and Appeals
3831 North Freeway Blvd. Suite 200
Sacramento, CA 95834
 - b. If the Department of Health Care Services (DHCS) determines the Emergency Services and/or Post Stabilization is reimbursable the Payer will reimburse the non-contracted provider within 30 calendar days of the DHCS determination and provide proof of reimbursement to DHCS.
4. Any dispute involving Primary Care Provider (PCP) Pay For Performance (P4P) reimbursements should be filed in accordance with Policy 19C, “Pay For Performance (P4P). “Written disputes must include the Provider name, Provider identification, contact

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1. Provider Dispute Resolution Process - Initial Claims Disputes

information, original claim number of the claim in dispute, date of service, a clear identification of the disputed item, a clear explanation of the basis upon which the Provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment, or other action is incorrect.

5. If the dispute is not about a claim/billing, the written request must include a clear explanation of the issue and the Provider's position, See Policy 16C1, "Dispute and Appeal Resolution Process for Providers – Initial."
- B. Payors must identify and acknowledge in writing the receipt of each dispute, whether complete or not, and disclose the recorded date of receipt⁵ as follows:
1. If the dispute was received electronically, acknowledgment must be provided within two (2) working days of receipt of the dispute; or
 2. If the dispute was received in paper form, acknowledgement must be provided within fifteen (15) working days of receipt of the dispute.
- C. If the Provider dispute does not include the required submission elements as outlined in Procedure A.3, the dispute is rejected, and a written statement is issued to the Provider requesting the missing information necessary to resolve the dispute. The Provider must resubmit an amended dispute along with the missing information within the time frame for dispute submissions and the amended dispute must include the information requested and required to make the dispute complete.
- D. Payors must make every effort to investigate and take into consideration all information on file or received from the Provider and may further investigate and/or request additional information or discuss the issue with the involved Provider as needed to make a determination.
- E. Payors must send a written notice of the resolution, regardless of whether the dispute is upheld or overturned (See Attachment, "Determination Letter" in Section 20), including pertinent facts and an explanation of the reason for the determination, within forty-five (45) working days of receipt of the dispute. If the written determination results in payment to the disputing Provider, payment must be made within five (5) working days of the date of the written determination.⁶
- F. Determinations involving Medi-Cal claims made in favor of the disputing Provider that result in payment of additional monies are subject to interest penalties in the following situations⁷⁻⁸:

⁵ 28 CCR § 1300.71.38

⁶ 28 CCR § 1300.71.38

⁷ Ibid.

⁸ Department of Health Care Services (DHCS) All Plan Letter (APL) 23-020, "Requirements for Timely Payment of Claims"

20. CLAIMS PROCESSING

A. Claims Processing

1. Provider Dispute Resolution Process - Initial Claims Disputes

1. If the determination is made to pay additional monies based on information originally provided and/or available at the time the claim was first presented to the financially responsible Payor for adjudication, or a result of a processing error, interest penalties are due as follows:
 - a. Claims not involving emergency services, including adjustments - 15% per annum
 - b. Claims involving emergency services, including adjustments - the greater of \$15.00 or 15% per annum
 - c. Interest must be paid within five (5) working days of the determination to pay
 - d. Failure to pay interest automatically requires a \$10.00 penalty to be paid in addition to any interest due
 - e. Interest is calculated on a calendar day basis
 - f. Interest begins with the first calendar day after the 45th working day from the original date of receipt of the first claim filed that is being disputed through the day the payment is mailed or electronically deposited.
 - g. If the resolution of a Provider Dispute results in additional payment, IEHP will automatically include the appropriate interest amount if payment is not issued within the required timeframes.
 2. If the determination to pay additional monies is based on information obtained subsequent to the initial adjudication decision, such as a request for retro-authorization or is made as a goodwill gesture, interest penalties are not due.
- G. Providers that are dissatisfied with the resolution of any dispute not involving claims or billing (i.e. capitation, contracts) may appeal to IEHP See Policy 16C2, "Dispute and Appeal Resolution Process for Providers - Health Plan Appeals."
- H. Providers that are dissatisfied with the initial resolution and written determination by the Payor that involves payment or denial decisions on adjudicated claims or billing, including denials for procedures, referrals or services may submit a written appeal of the Payor's determination to IEHP by following the process See Policy 20A2, "Claims Processing - Health Plan Claims Appeals."
- I. Providers that are not satisfied with the initial determination by the Payor, and the determination is related to medical necessity or utilization management, the Provider has the right to appeal directly to IEHP within sixty (60) working days of receipt of the written determination by submitting a written request for review See Policies 16C2, "Dispute and Appeal Resolution Process for Providers - Health Plan" and 20A2, "Claims Processing -

20. CLAIMS PROCESSING

A. Claims Processing

1. Provider Dispute Resolution Process - Initial Claims Disputes

Health Plan Claims Appeals.”⁹

- J. Furthermore, Providers that are dissatisfied with the outcome of a dispute originally filed with the Payor that involves pre-service referral denials or modifications may submit an appeal to IEHP See Policy 16C2 – Dispute and Appeal Resolution Process for Providers – Health Plan.
- K. If disputes require IEHP or its IPA to change contracting arrangements with their network Providers and/or Subcontractors that are deemed significant, IEHP or its IPAs must meet notification and reporting requirements as outlined in APL 21-003.
- L. No retaliation can be made against a Provider who submits a dispute in good faith.¹⁰
- M. Copies of all Provider disputes, and related documentation, must be retained for at least five (5) years. A minimum of the last two (2) years must be easily accessible and available within five (5) days of request from IEHP or regulatory agency.¹¹
- N. Payors must track and report all disputes received and submit monthly summary reports to IEHP in accordance with Policy 20G, “Claims and Provider Dispute Reporting.” A principal officer of the entity must be assigned responsibility for the Dispute Resolution Process and sign as to the validity and accuracy of all dispute related reporting.¹²

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⁹ 28 CCR § 1300.71.38

¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid.

20. CLAIMS PROCESSING

- A. Claims Processing
 - 2. Health Plan Claims Appeals
-

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Providers.

POLICY:

- A. Providers may submit a second level appeal to IEHP if they disagree with the written determination rendered by the financially responsible Payor for any dispute involving payment, denial, adjustment or contesting of a claim, including overpayments, payment rates, billing issues or other claim reimbursement decisions that they deem were unfairly upheld or underpaid.
- B. Second level appeals to IEHP involving claims or billing must be submitted in writing within six (6) months from the date of determination of the dispute received from the Payor. Appeals received beyond this timeframe are denied. Justification and supporting documentation must be provided with the written appeal. IEHP reviews Provider appeals as an intermediary to determine the appropriateness of the denial.
- C. IEHP will identify and acknowledge appeals within fifteen (15) working days of receipt.
- D. IEHP reviews the appeal to determine the appropriateness of the denial/reduction and renders a decision within forty-five (45) working days of receipt of all necessary information.

DEFINITION:

- A. Delegate is defined as a medical group, health plan, independent physician association, individual or entity contracted with IEHP to provide administrative services or health care services for a Medi-Cal eligible IEHP Member.
- B. “Provider of Service” means any Provider or professional person, acute care hospital organization, health facility, ancillary Provider, or other person or institution licensed by the State to deliver or furnish health care services directly to the Member.

PROCEDURES:

- A. Claim appeals relate to the initial determination of a dispute by the Payor involving the original adjudication decision of a claim or billing issue and are primarily complaints concerning reduced payment or denial of services that were not resolved to the satisfaction of the appealing Provider.
- B. Inquiries regarding the status of a claim, or requests for intervention by IEHP on behalf of the billing Provider in an attempt to get an initial adjudication decision (payment or denial) made on a claim by the Payor, are not considered disputes or appeals and are handled in accordance with Policy 20C, “Claims Deduction From Capitation – 7-Day Letter.”

20. CLAIMS PROCESSING

A. Claims Processing

2. Health Plan Claims Appeals

- C. A Provider who has been denied payment for services or feels that the claim has been underpaid or who has other claims or billing related issues must first file a dispute with the responsible Payor as outlined in Policy 20A1, “Claims Processing - Provider Dispute Resolution Process - Initial Claims Disputes.”
- D. If IEHP receives an initial claim or billing dispute directly from a Provider, IEHP will forward the claim or billing dispute to the Payor for resolution as applicable and notify the Provider.
- E. Upon receipt of an appeal, IEHP will acknowledge by issuing a letter to the Provider within fifteen (15) working days (See Attachment, “Acknowledgement Letter” in Section 20).
- F. Providers that disagree with the written determination of the dispute by the Payor may appeal to IEHP in writing within six (6) months of the date of the written determination.

- 1. Appeals should be submitted to:

IEHP – Provider Claims Resolution and Recovery Unit

**P.O. Box 4319
Rancho Cucamonga, CA 91729-4319**

- 2. The following information must be included with the written appeal, as applicable:
 - a. Claim Appeal Cover Letter
 - b. Written Determination from the responsible Payor
 - c. Claim Form
 - d. Denial Letter/Explanation of Benefits
 - e. Transcribed Notes
 - f. Hardcopy Authorization if Prior Authorization Received
 - g. If Verbal Authorization Received:
 - 1) Services Authorized
 - 2) Any Limitations to the Authorization
 - 3) Name of Person Providing Verbal Authorization
 - 4) Date and Time Verbal Authorization Given(Follow up calls for additional services require the same information.)
 - h. Documentation proving an attempt was made to obtain authorization from the IPA/Hospital should indicate the phone number called, the date and time call was made, and whom the Provider spoke to, if applicable.

20. CLAIMS PROCESSING

A. Claims Processing

2. Health Plan Claims Appeals

- i. If the responsible entity denied the claim due to timeliness, evidence of timely billing or other documentation that substantiates good cause for the delay in billing, that includes but is not limited to the following, must be submitted with the appeal:
 - 1) Claim determination letter or Explanation of Benefits (EOB)/Remittance Advice (RA) from IEHP or one of IEHP's contracted Delegates.
 - 2) Copy of a written request for information or other written claim-related correspondence from IEHP or one of IEHP's Delegates, dated and printed on letterhead or form letter with the date and letterhead clearly identified.
 - 3) Determination letter from other insurance carriers or other financially responsible entities, such as California Children's Services (CCS) or Medicare, dated and printed on letterhead, in which the date of determination and date of receipt is documented, that demonstrates the Provider presented the claim within the claims filing timelines permitted by law and/or written contractual agreement from the date of receipt of the determination.
 - 4) Financial ledgers with multiple claim billings for that day, including name of the billed party (i.e., IEHP, Delegate, Medicare, HMO, etc.).
 - 5) Computer generated claim transaction history that includes the billing history of the claim and history of timely and consistent follow-up attempts made to the original billed entity within the timely filing guidelines permitted by law and/or written contractual agreement. Detailed history should include billing dates and/or ledgers that show follow-up dates, contact names, time of calls (if applicable) and/or address to which the claim was sent.
 - 6) Other documentation that demonstrates good cause for the delay in being able to submit the claim timely.
 - j. Any other information to assist IEHP in validating the appropriateness of services rendered.
- G. If the appealing party does not provide the above required documentation, the appeal will be closed and returned to the Provider indicating the missing information.
- H. If additional information is needed from the Payor, IEHP will request documentation from the Payor that has reduced payment or denied the services (See Attachment, "Demand for Payment Letter" in Section 20). This documentation must be provided within the timeline outlined in the letter.
1. If the Payor fails to provide evidence of appropriate medical review, as applicable, the original adjudication decision is overturned based on procedural grounds. IEHP issues a letter indicating the Payor is financially liable for the claim in question (See Attachment, "Demand for Payment Letter" in Section 20). The Payor has seven (7) days to pay the claim, with appropriate interest and penalties, and provide evidence to IEHP that payment

20. CLAIMS PROCESSING

A. Claims Processing

2. Health Plan Claims Appeals

was made. If the Payor does not pay or provide evidence that the claim was paid then IEHP pays the claim on the Payor's behalf and deducts the payment from future capitation payments, due to the Provider.

- I. Once IEHP receives all necessary documentation, the appeal undergoes review.
- J. Medical and non-medical claims-related appeals are resolved separately:
 - 1. Medical claims-related appeals are forwarded to the IEHP Medical Director. Medical claims-related appeals involve denials for non-authorized services, denials or down-coding of emergency services, UM/medical necessity decisions, etc.
 - 2. Medical disputes involving current patient care are resolved in accordance with Policy 16B3, "Dispute and Appeal Resolution Process for Providers - UM Decisions" and the immediacy of the situation.
- K. IEHP conducts a review of the appeal and renders a decision within ten (10) days. A written determination of the decision is sent to the appealing party within forty-five (45) working days of receipt of the appeal (See Attachment, "Determination Letter" in Section 20).
 - 1. If the reduced payment or denial is upheld, the appealing party and Payor are notified in writing of the decision and no further action is taken by IEHP (See Attachment, "Determination Letter" in Section 20).
 - 2. If the reduced payment or denial is overturned, the Payor is notified in writing, of their financial obligation. IEHP instructs the Payor to pay the claim, including interest and penalties as applicable, within seven (7) days (See Attachment, "Demand for Payment Letter" in Section 20). Interest must be paid Policy 20A1, "Claims Processing - Provider Dispute Resolution Process – Initial Claims Disputes."
 - a. If Payor fails to respond to an IEHP inquiry, a demand letter will be issued requiring proof of payment within the timeline outlined in the Notice of CAP Deduction letter (See Attachment, "Notice of CAP Deduction" in Section 20). If evidence is not provided of claim payment, IEHP will pay the claim on the Payor's behalf and deduct the payment from the next capitation payment.
- L. If, after seven (7) days, the Payor has not paid the claim, IEHP pays the claim on the Payor's behalf and deducts the payment from future capitation payments due to the Payor, as follows:
 - 1. For outpatient services the rates specified in the Medi-Cal schedule of reimbursement; or
 - 2. Inpatient Facility claims from private inpatient general Acute Care Hospitals, California non-designated hospitals and out-of-state hospitals are paid using an All Patient Refined Diagnosis-Related Group (APR-DRG) payment methodology.
 - 3. Psychiatric Hospitals and designated public Hospitals are excluded from DRG reimbursement methodology. Claims submitted for these facilities follow the guidelines that were in place prior to implementation of the DRG model.

20. CLAIMS PROCESSING

A. Claims Processing

2. Health Plan Claims Appeals

4. For emergency services, the Emergency Room (ER) rate listed in the Medi-Cal schedule of reimbursement.

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20. CLAIMS PROCESSING

B. Billing of IEHP Members

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members and Providers.

POLICY:

A. Providers under the Medi-Cal program, as defined in this policy, must not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service.¹

DEFINITION:

A. Balance Billing - The practice of billing Members for any charges related to covered services that are not reimbursed by Medicare or Medi-Cal. Balance billing is prohibited by state and federal law.

B. Provider – Any individual or entity who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State.²

PROCEDURES:

A. When IEHP is notified by a Member or their representative, stating they are being billed, IEHP obtains all pertinent information to determine financial responsibility for the services rendered.

1. If the Member is determined to be financially responsible for the services, the Member is advised accordingly.
2. If the Member's IPA is determined to be financially responsible, IEHP will contact the billing Provider on the Member's behalf and advise to bill the IPA. IEHP instructs the billing Provider in writing to cease and desist from billing the Member for covered services (See Attachment, "Cease and Desist Letter" in Section 20). Please see Policy 20C, "Claims Deduction from Capitation – 7-Day Letter" for information on IEHP's process for ensuring claims payment by the IPA.
3. If IEHP is determined to be financially responsible, IEHP instructs the billing Provider in writing to cease and desist from billing the Member for covered services (See Attachment, "Cease and Desist Letter" in Section 20).

B. A Member has the right to file a grievance at any time following any incident or action that is the subject of Member dissatisfaction, including those pertaining to inappropriate billing, in accordance with Policy 16A, "Member Grievance Resolution Process."

¹ Title 22 California Code of Regulations (CCR) § 51002

² Title 42 Code of Federal Regulations (CFR) § 422.2

20. CLAIMS PROCESSING

B. Billing of IEHP Members

- C. If the services provided are deemed medically necessary and the Member was sent to collections, IEHP reserves the right to pay the Provider and reduce the responsible Provider's next monthly capitation check, as applicable.
- D. IEHP will take disciplinary action against Providers that continue to inappropriately bill Members after being educated on IEHP's policy against billing Members or sends the Member's account to a collections agency. This may include but not be limited to Provider education, issuing a Corrective Action Plan, reporting to regulatory agencies, up to and including termination of contract.
- E. Contracted and non-contracted providers who continue to inappropriately bill Members are reported to IEHP's Compliance Special Investigation Unit (SIU) for further investigation and may be reported to the Department of Health Care Services (DHCS), as deemed appropriate.

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20. CLAIMS PROCESSING

C. Claims Deduction From Capitation –7-Day Letter

APPLIES TO:

- A. This policy applies to all IEHP Providers who have been delegated to pay claims for IEHP Medi-Cal Members.

POLICY:

- A. Payor must appropriately pay or deny complete claims for contracted Providers of Service within forty-five (45) working days from original receipt. Non-contracted providers of service must be paid within thirty (30) calendar days. This standard is based on the timeframe from the initial receipt of the claim (date stamped) until the check or denial letter is mailed to the Provider of Service.¹
- B. In the event the Payor fails to meet IEHPs claims processing standards as indicated above, IEHP may elect to pay these claims on behalf of the Payor by deducting such payments from the Payor’s next monthly capitation check.
- C. The 7-Day letter process is an escalation mechanism for Providers who have submitted a claim to an IPA and have not received a response within the regulatory timeframes.

PROCEDURES:

- A. The 7-Day letter is a tool used by IEHP to expedite payment of any claims that may have fallen outside of the indicated claims processing timelines.
- B. IEHP’s 7-Day letter process is available to Providers of Service under the following circumstances:
 - 1. A Provider of Service notifies IEHP that no status has been provided on claims submitted to the appropriate Payor for over forty-five (45) working days (approximately sixty (60) calendar days).
 - 2. IEHP identifies a claim that has not been paid within the claims processing timeframes above.
- C. The 7-Day letter process is available for unprocessed claim inquiries. Providers may avail themselves to the 7-Day letter process for up to one (1) year and sixty (60) days after the date of service.
- D. As outlined in Policy 20A2, “Claim Processing - Health Plan Claims Appeals” Providers of Service should submit documentation demonstrating an attempt to obtain payment from the Payor. Documentation should include:
 - 1. A Clean Claim (See Attachment “CMS 1500 Form”, “UB04 Inpatient Form” and “UM Outpatient Form” in Section 20)

¹ Title 28 California Code of Regulations (CCR) § 1300.71

20. CLAIMS PROCESSING

C. Claims Deduction From Capitation –7-Day Letter

2. Appeal Cover Letter from Provider
3. Written Determination from the responsible Payor
4. EOB from the responsible entity
5. Denial Letter/Explanation of Benefits
6. Medical Records
7. Claim Tracers
8. Transcribed Notes
9. Hardcopy authorization if prior authorization received
10. Phone Logs
11. Authorization received:
 - a. Services authorized
 - b. Any limitations to the authorization
 - c. Name of person providing verbal authorization
 - d. Date and time verbal authorization given.

(Follow up calls for additional services require the same information.)

12. Or any other necessary information that supports the appropriateness of services rendered.
- E. Upon receipt of the claim, IEHP verifies Member eligibility on the date of service, and ensures that the claim was sent to the appropriate Payor. If the Member is not eligible with IEHP for the date of service, the request is rejected and a denial letter is issued to the Provider of Service explaining the reason for the rejection. If the claim was sent to the incorrect Payor, IEHP returns the claim to the Provider of Service advising them to re-bill the correct Payor.
- F. IEHP sends a secure email 7-Day letter (See Attachment, “Demand For Payment Letter” in Section 20) to the Provider. The 7-Day letter requests information on the status of the claim, which must be completed by the Provider and returned to IEHP within seven (7) days from the sent date.
- G. Payor must respond to IEHP with the following claim information:
1. The date the claim was originally received
 2. If it was paid or denied
 3. The date paid or denied
 4. The amount paid
 5. The check number of payment and/or

20. CLAIMS PROCESSING

C. Claims Deduction From Capitation –7-Day Letter

6. The reason for the denial.
- H. The following are examples of unacceptable responses to the 7-Day letter:
1. Not Provider’s Responsibility (IEHP confirms financial responsibility prior to 7-day notification).
 2. Member Not Eligible (IEHP confirms eligibility prior to 7-day notification).
 3. Not Authorized (it is inappropriate to deny a claim due to “No Authorization” as medical review must be performed prior to denial).
- I. In the event the Payor fails to provide an acceptable written response to IEHP within seven (7) days, or the requested information is returned incomplete, IEHP pays the Provider of Service directly and deducts the amount paid from the Payor’s monthly capitation check.
1. Outpatient services are paid the rates specified in the Medi-Cal schedule of reimbursement (RFO500)
 2. Inpatient Facility claims from private inpatient general acute care hospitals, California non-designated hospitals and out-of-state hospitals are paid using an All Patient Refined Diagnosis-Related Group (APR-DRG) payment methodology.

Psychiatric hospitals and designated public hospitals are excluded from DRG reimbursement methodology. Claims submitted for these facilities follow the guidelines that were in place prior to implementation of the DRG model.
- J. Claims capitation deductions are outlined on a detail report, sent with the capitation payment (See Attachment, “Capitation Payment Deduction” in Section 20).
- K. Once IEHP receives all necessary documentation, the appeal undergoes review. Medical and non-medical claims-related appeals are resolved separately:
1. Medical claims-related appeals are forwarded to the IEHP Medical Director. Medical claims-related appeals involve denials for non-authorized services, denials or down-coding of emergency services, utilization management (UM)/medical necessity decisions, etc.
 2. Medical appeals involving current patient care are resolved in accordance with Policy 16B3, “Dispute and Appeal Resolution Process for Providers - UM Decisions” and the immediacy of the situation
- L. If Payor fails to respond to an IEHP inquiry, a demand letter will be issued requiring proof of payment within the timeline outlined in (See Attachment, “Notice of Cap Deductions” in Section 20) Notice of Cap Deductions letter.

20. CLAIMS PROCESSING

C. Claims Deduction From Capitation –7-Day Letter

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Chief Approval: <i>Signature on File</i>	Original Effective Date:	September 1, 1996
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20. CLAIMS PROCESSING

D. Claims and Compliance Audits

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Delegates.

POLICY:

- A. IEHP provides oversight of claims processing by Delegates through monitoring, reviewing, and measuring claims payments and denial processes, Provider dispute mechanisms and assessing for demonstrable and unjust payment patterns on an on-going basis.
- B. IEHP audits all Delegates annually or as necessary.
- C. Audits may include on-site review and evaluation of specific claims, disputes, adjustments, reports, personnel, written policies and procedures, contracts, management involvement and oversight, claims processing systems and functions, dispute resolution mechanism and regulatory and contractual compliance. These audits are conducted in accordance with IEHP standards and state and federal requirements.
- D. Audited Delegates are required to cure any deficiencies in their systems to bring them into contractual and regulatory compliance.
- E. Delegates can submit a rebuttal to dispute the result of an audit through the IEHP Rebuttal process by submitting a written rebuttal to IEHP using the IEHP Rebuttal Form included with the Preliminary Report.

DEFINITION:

- A. Delegate – A medical group, health plan, independent physician association, individual or entity contracted with IHEP to provide administrative services or health care services for a Medi-Cal eligible IEHP Member.

PROCEDURES:

- A. IEHP provides comprehensive oversight of Delegate’s responsibilities to process claims and resolve disputes in accordance with contractual and regulatory requirements. IEHP performs this oversight through routine audits and review of monthly and quarterly reporting to IEHP by the Delegates.
- B. Audits ensure Delegates:
 - 1. Delegates are paying and denying claims and resolving Provider disputes in accordance with regulatory and contractual requirements.
 - 2. Delegate have adequate system protocols in place to log, acknowledge, track, monitor and appropriately adjudicate or resolve all claims and disputes received and that these systems are operating as designed and do not result in unfair payment patterns.
 - 3. Delegates’ claims processing systems are adequate to meet the terms of the IEHP contract

20. CLAIMS PROCESSING

D. Claims and Compliance Audits

as well as regulatory requirements.

4. Delegates have contracts in place with subcontracted entities that meet regulatory requirements as they pertain to claims processing and dispute resolution.
 5. Delegates are financially viable and able to manage risks associated with capitation and not presenting undue risk to IEHP or its Providers or Members.
- C. IEHP monitors the performance of Delegates in between audits through monthly and quarterly reporting. Review of reports enables IEHP to assess compliance with regulatory and contractual requirements, as well as to perform comparative analysis and trending for possible indicators of potential or emerging patterns of unfair payment practices or inability to perform delegated functions.
- D. Delegates must submit the following monthly and quarterly reports to IEHP within the specified timeframes.
1. By the 15th of each month, Delegates must submit to IEHP the Monthly Timeliness Report (MTR) for the previous month's activity. The MTR contains information regarding claims processing timeliness and activity, See Policy 20G, "Claims and Provider Dispute Reporting."
 2. Delegates must also submit to IEHP by the 15th of each month detailed reports for the previous month's activity. The required reports, See Policy 20G, "Claims and Provider Dispute Reporting", are:
 - a. Paid Claims
 - b. Denied Claims
 - c. Provider Dispute Resolution (PDR)
 - d. Redirected Claims
 3. By the 30th of the month following the end of the quarter, for the previous quarter, Delegates must submit information regarding disputes and adjustments. The required reports, See Policy 20G, "Claims and Provider Dispute Reporting," are:
 - a. Quarterly Provider Dispute Resolution (PDR) Report; and
 - b. Quarterly Statement of Deficiencies Report.
 4. Delegates must also submit to IEHP by November 30th of each year, an Annual Claims Payment and Provider Dispute Report (Annual Report) for the reporting period covering October 1st through September 30th, as outlined in Policy 20G, "Claims and Provider Dispute Reporting."
 5. IEHP reserves the right to request additional reports as deemed necessary.
 6. Failure to submit required reports that include all required information in a complete and accurate manner in IEHP's required format, within the indicated timeframes, may result in the Delegate being subjected to a focused audit and negatively impacting the

20. CLAIMS PROCESSING

D. Claims and Compliance Audits

Delegate's contract renewal terms.

- E. IEHP audits the claims processing system of each Delegate on an annual basis. Audits may be conducted more frequently (Focused Audits) if circumstances arise that in the judgment of IEHP management requires closer scrutiny including but not limited to the following circumstances:
1. Failure to meet IEHP Financial Viability Standards.
 2. Non-compliance with monthly and quarterly self-reporting requirements to IEHP or to California Department of Managed Health Care (DMHC) under SB260, or discovery during an audit or through other means, deficiencies that were not self-reported.
 3. Excessive claims appeals that are overturned by IEHP for denial of payment or underpayment.
 4. Excessive number of insufficient or inappropriate responses to 7-day letters that result in payment by IEHP to the Provider of Service that is deducted from capitation.
 5. Excessive claims grievances, Provider disputes, Provider inquiries or other information received by IEHP from subcontracted entities or other outside sources.
 6. Failure to submit accurate and completed reports to IEHP within specified timeframes.
 7. Failure to meet claims payment standards, dispute resolution standards and other indicators and measures based on IEHP review of periodic reports and other internally and externally available information.
 8. Identification of potential or emerging unfair payment patterns or other indicators of payment practices that possibly pose undue risk to IEHP and/or its Members or Providers based on claims inquiries, grievances and appeals, IEHP review of periodic reports, contracts or other internally or externally available information.
 9. Failure to cooperate with IEHP in report resolution, issue resolution or other matters with respect to determination of compliance with IEHP requirements.
 10. Change in claims processing system.
 11. Change in management oversight, including Management Services Organization (MSO).
- F. IEHP notifies Delegates in writing at least six (6) weeks in advance of the scheduled audit. The notice is explicit in the timeframe being audited, the request for reports, documents, and access to Delegate staff. For Focused Audits, IEHP reserves the right to give a minimum of three (3) working days prior notice.
1. Routine Audits may include a Webinar Audit and an on-site review.
 2. Webinar Audit: Approximately two (2) weeks prior to the scheduled audit, Delegates

20. CLAIMS PROCESSING

D. Claims and Compliance Audits

must submit the following detailed reports, covering the audit period, to IEHP for review and selection of claims:

- a. Paid Claims
- b. Denied Claims
- c. Closed Overpayments
- d. Post-Payment Adjustments
- e. Resolved Disputed Claims
- f. Redirected Claims
- g. Pre-Audit Issues Summary

3. On-Site Review: The following reports must be provided:.

- a. Received Claims (including identification of emergency service claims, separately subtotaled)
- b. Pended Claims (including identification of emergency service claims, separately subtotaled)
- c. Open Claims (including identification of emergency service claims, separately subtotaled)
- d. Report or Log of Redirected Claims
- e. Signed Check Mailing/Attestation or Log
- f. Customer Service Inquiry/Call Log
- g. IEHP also reserves the right to request additional reports and/or documents as deemed necessary

G. IEHP selects claims to audit based upon a focused, targeted approach. The number of claims selected varies depending on the type and scope of the audit and generally covers a three (3) month period.

1. For routine annual audits, the type of claims selected (for both contracted and non-contracted Providers unless noted otherwise) is as follows:
 - a. Paid, Contested and Denied claims
 - b. Emergency Services claims
 - c. Family Planning claims
 - d. Disputed claims
 - e. Post-Payment Adjustments
 - f. Interest Paid on late paying, adjusted or disputed claims

20. CLAIMS PROCESSING

D. Claims and Compliance Audits

- g. Overpayment Recovery Requests (refunded, retracted, or disputed)
 - h. Redirected claims
 - 2. The claim selections will be forwarded to Delegates one (1) hour prior to the start of the scheduled audit.
 - 3. IEHP performs the claims review noted above via webinar and is scheduled for three (3) days. IEHP may also schedule a one (1) day on-site visit.
 - 4. At the time of the onsite visit, IEHP will review current received, open and pend reports (as of the date of the audit), as well as a report or log of redirected claims, and may select additional claims for review.
 - 5. IEHP may also randomly select Provider contracts for review.
 - 6. IEHP reserves the right to request additional claims, reports, or other documents on-site for review.
 - 7. For verification and focused audits, the number and type of claims selected for review depends on the nature and issue of the deficiencies identified.
- H. One week before the scheduled first day of the claims audit, a Universe Integrity Audit (UIA) is performed. The UIA is conducted for all claim universes submitted to ensure that multiple data elements generated from the Delegate's claims processing are accurate. The sample selection is based on a focused, targeted approach and cases that are outliers with potential risk of data element errors are selected. Generally, five (5) cases are selected from each universe to validate against the Delegate's system and documentation to ensure the information is consistent and accurate. Delegates must successfully pass three (3) of the five (5) cases selected from each universe in order to pass the UIA. A failed UIA will result in IEHP requesting the Delegate's resubmission of a corrected universe. Three failed universe resubmissions will result in an audit finding.
- I. The claims audit consists of a review of three (3) areas: timeliness, appropriateness, and systems. Within each area, claims are reviewed to determine compliance with contractual and regulatory standards pertaining to the processing of claims or dispute resolutions.
 - 1. Timeliness
 - a. Timeliness measures include turnaround times for claims, disputes, redirected claims, claims and dispute acknowledgement and other elements in which a specific turnaround time requirement is stipulated by law or IEHP's contract for the payment of claims and resolution of disputes. Regulatory standards pertaining to potential unfair payment patterns as they pertain to turnaround times and timeliness are also measured under this area.
 - b. Timeliness standards for claims are measured from the day after the date of receipt as evidenced by the first date the claim is received by the financially responsible entity until the check or denial Explanation of Benefits/Remittance Advice letter is

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D. Claims and Compliance Audits

mailed to the Provider of Service. In addition to the physical date stamp on the claim, the lag between the billing date on the claim and the date of the receipt is also measured to validate the date of receipt. In general, IEHP allows a ninety (90) day lag for non-contracted providers and one hundred eighty (180) day lag for contracted Providers.

- c. Timeliness standards for disputes are measured from the day after the date of receipt of the dispute as evidenced by the first date the dispute is received by the financially responsible entity until the resolution letter is mailed to the complainant. When a payment is made, timeliness includes the five (5) working day lag between the date of the resolution letter and the date the check is mailed.
 - d. To confirm mailed date, IEHP tracks the timeframe between the check date and the date the check is presented for payment by the Provider of Service. The current standard allows for a twenty (20) day period between the check date and for the funds (e.g., claim check) to clear. This timeframe allows for variances in the mail delivery system and individual office practices for billing and handling accounts receivable.
 - e. Signed proof of mailing of checks must be maintained (check mailing/attestation). IEHP reserves the right to request and review the check mailing/attestation log (or other proof of mailing) as part of any audit to confirm mailing dates and/or to research check clearing patterns.
2. Appropriateness
- a. Appropriateness includes review of the validity and accuracy of claims adjudication (payment, denial or contest) and dispute resolution and includes, but is not limited to, accuracy and appropriateness of claims payment, including automatic payment of interest as applicable; validity of denial reasons, documentation and written notification; accuracy, validity and appropriateness of adjustments, including applicability and payment of interest and notifications; mandatory disclosures and notification language for denials, adjusted claims and disputes and other regulatory and contractual requirements; accuracy and appropriateness of notifications, resolution and written determination and other regulatory or contractual requirements as it pertains to the resolution of disputes; or other measures that may constitute unfair payment practices.
 - 1) Both overpayments and underpayments are considered non-compliant.
 - 2) Adjustments to correct an underpayment that are made because of a review of claims selected for an audit are considered non-compliant. If an adjustment is made because of routine operational activities, such as a Provider inquiry, the adjustment is compliant. If a selected claim is adjusted during the period between the time the audit confirmation letter is received and the date of the audit due to routine activities, proof must be provided to support the adjustment, such as claim notes or a fax. Otherwise, that adjustment will be considered non-

20. CLAIMS PROCESSING

D. Claims and Compliance Audits

compliant.

- b. When a dispute involves payment of interest, interest is calculated from the day after the date of receipt of the original claim that is being disputed until the date the check is mailed to the Provider of Service on the adjusted payment.

3. Systems

- a. The systems portion of the audit assesses regulatory standards that cannot be captured as timeliness or appropriateness, such as those pertaining to mandatory contract provisions or potential unfair payment patterns such as failure to provide required disclosures.
- b. The systems portion of the audit also assesses the Delegate's internal control and processes with respect to claims processing and dispute resolution mechanisms, and includes but is not limited to claims processing and Provider dispute resolution documentation; policies and procedures; template forms and letters; contractual provisions that are not designated a specific standard through regulatory or contractual requirements; staff interviews; review of inventory control methodology, logging, tracking and control; review of methodology for logging, tracking, and control, including outcome of Provider of Service claims and dispute related phone calls, reporting capabilities; internally or externally available information specific to Delegate compliance including periodic Delegate reporting to IEHP; and a physical walk-through of the claims department before and/or after the audit.

- J. IEHP may conduct a preliminary exit interview with the Delegate at the end of the audit to discuss preliminary results, areas of concern, need for and timing of corrective actions to rectify noted system deficiencies and the timeframe for the next audit.
- K. If IEHP suspects fraud during the course of or subsequent to the audit the findings are submitted to IEHP's Compliance Department.
- L. IEHP determines the significance of audit findings based on results of the claims review and impact analysis, if applicable. Audit findings can result in a Corrective Action Required or Observation as described below:
 1. Corrective Action Required (CAR) – A CAR is the result of a systemic deficiency identified during an audit that must be corrected. These issues may affect beneficiaries but are not of a nature that immediately affects their health and safety. Generally, they involve deficiencies with respect to non-existent or inadequate policies and procedures, systems, internal controls, training, operations or staffing.
 2. Observations (OBS) – Observations are identified conditions of non-compliance that are not systemic or represent a “one-off issue”. A “one-off issue” may be an issue dealing with one employee or a singular case.
 3. Invalid Data Submissions (IDS) – An IDS condition is cited when an IPA fails to produce an accurate universe within three (3) attempts.

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D. Claims and Compliance Audits

- M. Within thirty (30) days of the last day of the audit IEHP sends a preliminary audit report to the Delegate documenting the outcome of the audit, findings, and recommended corrective actions. Delegates have one (1) week to review the preliminary report and notify IEHP if they disagree with any of the findings through the formal rebuttal process.
- N. Within two (2) weeks of receipt of the Delegate's rebuttal to the preliminary report, IEHP sends a Final Findings Report and Corrective Action Plan Request (CAPR).
- O. The CAPR lists IEHP's findings with respect to deficiencies, along with specific recommendations to bring the Delegate into regulatory and contractual compliance. Delegates are required to respond in writing to the CAPR by submitting a CAP within the timeframe specified by IEHP, generally thirty (30) days from the date of the Final Findings Report. The CAP should explain in detail how the Delegate has modified (or will modify) its claims processing system to address the findings of the CAPR. If the CAP caused changes to the Delegate's written policies and procedures and workflow charts, copies of this information must be submitted along with the CAP.
- P. IEHP evaluates and issues a letter of acceptance or rejection of the submitted CAP within two (2) weeks of receipt.
1. If the CAP is accepted, IEHP issues a letter of acceptance.
 2. If the CAP is rejected, the reasons, along with recommendations as to how the CAP should be changed, are included in the rejection letter.
 3. Delegates must submit a revised CAP within fifteen (15) days after the IEHP rejection letter is issued. IEHP evaluates the revised CAP within fifteen (15) days of receipt.
 - a. If accepted, an acceptance letter is issued.
 - b. If rejected, the matter is referred to IEHP's Delegation Oversight Committee.
- Q. Failure to provide an adequate CAP within the required timeframe is deemed as a contractual breach and may result in the Delegate being sanctioned and subjected up to a 2% reduction of their monthly capitation payment until such time as an acceptable CAP is received. An untimely or inadequate CAP may also impact the Delegate's contract renewal terms.
- R. CAP verification audits are performed to verify the implementation of corrective actions required as a result of receiving a Corrective Action Required (CAR) in the previous audit.
1. The number and type of claims selected for a CAP verification audit will vary depending on the nature and scope of the deficiencies noted during the annual or focused audit.
 2. Delegates failing the verification audit may be subjected to a 2% monthly capitation deduction, weekly monitoring, or possible contract termination.
 3. Delegates passing their CAP verification audit will be scheduled for their next annual audit approximately six (6) months from the date of the last CAP verification audit and every twelve (12) months thereafter.

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D. Claims and Compliance Audits

- S. Delegates who do not receive a CAR in their annual audit are scheduled for the next annual audit approximately twelve (12) months from the date of the last audit and every twelve (12) months thereafter; subject to the focused or verification audit provisions noted herein.
- T. Delegate's audits that result in contract conversion/termination may request that IEHP's outside auditor, a contracted Certified Public Accountant firm, conduct an audit to confirm or overturn said audit results. The timeframe reviewed for the confirmation audit will be the same timeframe initially audited. In the event the results are upheld, contract termination/conversion will be initiated, and the Delegate is responsible for paying the outside auditors' fees.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	September 1, 1996
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2023

20. CLAIMS PROCESSING

E. Disputes Between Contracted Relationships

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

- A. IPAs and/or IEHP are responsible for authorizing medical care.
- B. The IEHP IPA capitated agreement binds the IPA and its Physicians to use the designated assigned Hospital as the exclusive Provider for all hospital services, as applicable.
- C. In the event that a particular service is not available at the assigned Hospital the IPA must coordinate with the Hospital, if capitated, or IEHP for per diem contracted Hospitals, to provide care for the Member at a mutually agreed upon facility.
- D. In the event of an emergency, the IPA must inform the Hospital, if capitated or IEHP for per diem contracted Hospitals that care is being rendered at another facility.
- E. Members cannot be transferred when Member refuses to be transferred.

PROCEDURES:

- A. In the event an authorization for hospital services is provided by an IPA representative that is in breach of the above policy, the following may occur:
 - 1. Hospital/IEHP reviews its incoming claims and identifies IPA contract violations that do not meet the above criteria such as:
 - a. Authorized hospital services provided at a non-contracted facility;
 - b. Authorized hospital services provided at another contracted facility that could have been provided at the assigned facility; and
 - c. Authorized ER services for non - emergent care. Review for medical appropriateness must be performed by appropriately licensed medical staff.
 - 2. If the Hospital, or IEHP as applicable, was not notified or not amenable to these arrangements, the Hospital or IEHP may deny payment of these authorized services.
 - 3. Upon denial, the Hospital or IEHP must send a copy of the claim to the IPA for payment with a denial letter explaining the reasons for the denial. If denied by the Hospital a copy of the denial letter, claim, records, and all supporting documentation should also be sent to IEHP at the following address:

Inland Empire Health Plan
Attention: Claims Appeal Resolution Unit
P.O. Box 4319
Rancho Cucamonga, CA 91729-4319

20. CLAIMS PROCESSING

E. Disputes Between Contracted Relationships

4. Hospitals may send the Provider a letter informing them that the claim has been forwarded to the IPA for payment; however, a denial should not be sent to the Provider.
5. The IPA must pay the claim for these hospital services unless the IPA feels the services provided were emergent or that the service was justified. In the event of the latter the IPA should submit the claim with the appropriate supporting documentation to IEHP at the above address with a letter of appeal explaining their position. The appeal must be submitted to IEHP within three hundred sixty- five (365) days of the denial or payment.
6. IEHP will follow the procedures outlined in Policy 20A2, “Claims Processing - Health Plan Claims Appeals,” in determining the appropriateness of the appeal and whose financial responsibility it is to pay the claim.
7. Payment will be issued by the responsible party as outlined in Policy 20A2, “Claims Processing - Health Plan Claims Appeals.”

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	September 1, 1996
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2023

20. CLAIMS PROCESSING

F. Coordination of Benefits

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

- A. State law requires Medi-Cal to be the payer of last resort for services which there is a responsible third party, including Medicare.¹
- B. Medi-Cal Members with Other Health Coverage (OHC) must utilize their OHC for covered services prior to accessing their Medi-Cal benefits.²
- C. Cost avoidance is the practice of requiring Providers to bill liable third parties prior to seeking payment from IEHP.
- D. IEHP should rely on the Medi-Cal eligibility record for cost avoidance and post payment recoveries. See policy 14A3, “Review Procedures – Other Health Coverage.”³
- E. If IEHP becomes aware of OHC from sources other than the Medi-Cal eligibility record, IEHP may use this OHC information, but must report the OHC to the Department of Health Care Services (DHCS) within (10) calendar days of discovery.⁴
- F. IEHP must report new OHC information not found on the Medi-Cal eligibility record or OHC information that is different from what is found on the Medi-Cal eligibility record to DHCS within ten (10) calendar days of discovery.⁵
- G. Beginning April 1, 2021, IEHP must include OHC information in its notification to the Provider when a claim is denied due to the presence of OHC. OHC information includes, but is not limited to, the name of the OHC, Provider, the policy number and contact or billing information. Prior to April 1, 2021, IEHP may direct Providers to access the necessary Member OHC information utilizing the Automated Eligibility Verification System at (800) 427-1295 or the Medi-Cal online eligibility portal. Information regarding OHC carriers can be found in the Health and Human Services Open Data Portal.⁶
- H. IEHP does not process claims for a Member whose Medi-Cal eligibility record indicates OHC, other than a code of A or N, unless the Provider presents proof that all sources of payment have been exhausted, or the provided services meet the requirement for billing IEHP directly.⁷

¹ Department of Health Care Services (DHCS) All Plan Letter (APL) 21-002, “Cost Avoidance & Post-Payment For Other Health Coverage”

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

20. CLAIMS PROCESSING

F. Coordination of Benefits

- I. IEHP and its Delegates are responsible for identifying Payers that are primary to Medi-Cal and must coordinate benefits for Members in accordance with state and federal law.⁸
- J. California Children’s Services (CCS) is the sole responsible payer if a Medi-Cal Member utilizes services for CCS eligible conditions.⁹
- K. If OHC is discovered retroactively or the Member had an OHC indicator of ‘A’ on their Medi-Cal eligibility record at the time of service, IEHP and its Delegates must engage in post payment recovery.
 - 1. Post payment recovery must be initiated within twelve (12) months from the date of payment of a service.
 - 2. IEHP is required to submit detailed claim information regarding OHC recoveries to DHCS no later than the 15th of every month.
 - 3. IEHP and its Delegates are entitled to retain all monies recovered within twelve (12) months from the date of payment.
 - 4. If a re-payment plan with a Provider is established within twelve (12) months, but the recoupment extends beyond twelve (12) months from the date of service, IEHP and its Delegate will retain the recovered money.
 - 5. If a recovery is received after twelve (12) months from the date of payment and no re-payment plan was initiated with the Provider prior to, IEHP must remit payment to DHCS.

DEFINITIONS:

- A. Cost Avoidance - The practice of requiring Providers to bill liable third parties prior to seeking payment from IEHP.
- B. Delegate – A medical group, health plan, independent physician association, individual or entity contracted with IHEP to provide administrative services or health care services for Medi-Cal eligible IEHP Member.

PROCEDURES:

State Programs

- A. Unless otherwise indicated, if a Medi-Cal Member has OHC excluding tort liability of a third party, See Policy 19D, “Third Party Liability.” Providers of Service should bill Medicare or the OHC as primary. IEHP should be billed as the secondary payer along with the primary payers’ payment amount or proof that all sources of payment have been exhausted.¹⁰

⁸ DHCS APL 21-002

⁹ Ibid.

¹⁰ Ibid.

20. CLAIMS PROCESSING

F. Coordination of Benefits

- B. IEHP coordinates benefits with other health insurance carriers, including Medicare. Exceptions include claims where the Provider is reimbursed under an IEHP capitation agreement and claims for services that meet the requirement for billing Medi-Cal directly.¹¹
- C. The following is a partial list of insurance that is not considered to be OHC:
1. Personal injury and/or medical payment covered under automobile insurance
 2. Life insurance
 3. Workers' compensation
 4. Homeowners insurance
 5. Umbrella insurance
 6. Accident insurance
 7. Income replacement insurance (e.g., Aflac)
- D. Other Health Coverage (OHC) Cost-Sharing Providers are prohibited from billing Medi-Cal recipients, or individuals active on their behalf, for any amounts other than the Medi-Cal copayment or Share of Cost (SOC). Therefore, if the recipient's OHC requires a copayment, coinsurance, deductible or other cost-sharing, the Provider is not permitted to bill the recipient. If the Provider bills the OHC and the OHC denies or reduces payment because of its cost-sharing requirements, the Provider may then bill IEHP.¹²
- E. When coordinating benefits, IEHP will reimburse Providers up to the Medi-Cal allowable or the Provider's contract amount (if applicable) minus any payment(s) the Provider has received from the Member's primary insurance. Payment will not exceed the Member's OHC cost sharing amount or the Medicare deductible and coinsurance amount.¹³
- F. If IEHP receives a claim for a Member containing evidence of primary OHC coverage and IEHP has no record of the OHC coverage, IEHP will process the claim as the secondary payer and notify DHCS of the other coverage within ten (10) calendar days of discovery.
- G. When a claim is denied due to the presence of OHC, IEHP provides OHC information to the outgoing paper and electronic remittance advices (as applicable) to the Provider.
- H. Providers of Service retain any monies collected through COB, in addition to any capitation received.
- I. Members with Medicare Part A coverage have a Hospital inpatient deductible for each benefit period. There is also a specified daily coinsurance per day for each benefit period sixty-one (61) days and beyond.¹⁴

¹¹ DHCS APL 21-002

¹² Ibid.

¹³ Medi-Cal Program and Eligibility (medi-cal.gov.ca)

¹⁴ CMS.GOV Centers for Medicare & Medicaid Services 2020 Medicare Parts A & B Premiums and Deductibles

20. CLAIMS PROCESSING

F. Coordination of Benefits

- J. Members with Medicare Part B coverage have an annual deductible. There is also a coinsurance requirement of 20% of the Medicare allowable amount for most services.¹⁵
- K. When IEHP is coordinating benefits between Medicare or an OHC, Medicare or the OHC is primary and Medi-Cal rates shall be used as the basis of coordination of benefits up to the maximum allowed by Medi-Cal fee-for-service. If the Medi-Cal maximum allowed is less than or equal to the Medicare or OHC reimbursement, then there will be no additional IEHP payment. If a Provider of Service is contracted, the contract may require that the contracted rate be used as the base rate for COB comparison.¹⁶
- L. When OHC overpayments are identified, IEHP and its Delegates will initiate post payment recovery within twelve (12) months from the date of payment.
- M. Delegates must submit to IEHP a detailed post payment recovery report of OHC recoveries by the 5th of every month via IEHP's Secure File Transfer Protocol (SFTP) utilizing the template provided by IEHP.
- N. Delegates must remit to IEHP all recovered OHC monies that are thirteen (13) months or older from the date of payment of a service by the 5th of every month and IEHP will send the payments to DHCS.
- a. To remit payment by mail, payment must be sent to:

Inland Empire Health Plan
Attn: Accounts Receivable
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800
 - b. To remit payment electronically, payment must be sent to:

MUFG Union Bank, N.A.
1980 Saturn Street
Monterey Park, CA 91755
Routing Number: 122000496
Account Number: 2740019794
Beneficiary: IEHP-Concentration account
- O. Delegates must submit to IEHP a report of all recovered OHC monies that are thirteen (13) months or older from the date of payment of a service by the 5th of every month via IEHP's SFTP utilizing the template provided by IEHP.

¹⁵ DHCS APL 21-002

¹⁶ Ibid.

20. CLAIMS PROCESSING

F. Coordination of Benefits

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Chief Approval: <i>Signature on file</i>	Original Effective Date:	September 1, 1996
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2023

20. CLAIMS PROCESSING

G. Claims and Provider Dispute Reporting

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Delegates.

POLICY:

- A. IEHP provides oversight of claims processing by Delegates through monitoring of the Delegate's claims payments and denial processes, Provider dispute mechanisms and assessing for demonstrable and unjust payment patterns on an on-going basis.
- B. As part of the monitoring process and to comply with state and federal regulatory requirements, Delegates are required to submit Claims Payment and Dispute Mechanism Reports to IEHP.
- C. Failure to submit required reports within the indicated timeframes may result in the Delegate being subjected to a focused audit which may negatively impact the Delegate's contract renewal terms and may lead to contract termination or conversion.

DEFINITION:

- A. Delegate – A medical group, health plan, independent physician association, individual or entity contracted with IEHP to provide administrative services or health care services for Medi-Cal eligible IEHP Member.

PROCEDURES:

- A. Delegate's claims processing systems must be able to identify, track and report all claims and Provider disputes and produce the following reports:
 - 1. Received Claims – all claims received for a specified period, regardless of status.
 - 2. Paid Claims – all claims paid for services rendered to Members.
 - 3. Denied Claims – all claims denied for services rendered to Members. (Note: IEHP considers denied claims to be all claims adjudicated in which the total dollars paid is \$0.00. This includes all claims denied for non-contracted and contracted Providers, such as duplicates or non-authorized services, as well as those in which the Member may be liable).
 - 4. Pended/Contested Claims – claims pended and/or contested for development or in which a determination to pay or deny cannot be made without further information. Examples include claims forwarded for medical review and claims for which written requests for additional information was sent.
 - 5. Claims Inventory – all claims received and open (i.e. received, however a check or denial has not been issued), whether entered or not in the claims system. Reports should be able to be run at summary level, Provider level or claim level.

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G. Claims and Provider Dispute Reporting

6. Claims Overpayments – all claims in which an overpayment has been identified and requests for reimbursement have been sent to the rendering Provider.
 7. Claims Adjustments – all claims in which a post-payment adjustment has been made due to internal audits, disputes or appeal resolutions, inquiries, retroactive contract, or rate adjustments, etc.
 8. Claims Aging – all claims by age of claim, regardless of status based on receipt date of the claim.
 9. Provider Disputes – all claims, billing, contract, Utilization Management (UM)/medical necessity and other disputes received from Providers of Service.
 - a. Claims/Billing – any formal written disagreement involving the payment, denial, adjustment, or contesting of a claim, including overpayments, payment rates, billing issues or other claim reimbursement decisions.
 - b. Contract – any formal written disagreement concerning the interpretation, implementation, renewal, or termination of a contractual agreement.
 - c. UM/Medical Necessity – any formal written disagreement concerning the need, level or intensity of health care services provided to Members.
 10. Interest Paid – any claim in which interest was paid, including late paying claims, disputes, or adjustments.
 11. Redirected Claims – all misdirected claims forwarded to another Payor or denied to the Provider of Service, whether entered or not in the claims system.
 12. Emergency Services Claims – all claims received, regardless of status, for emergency services. Emergency services are defined as claims with a place of service ‘23’ or revenue code ‘450’.
 13. Denied Claims by Type/Volume – number of claims denied by type (reason).
 14. Paid Claims by Date/Volume – number of claims paid by check run date.
 15. Pended Claims by Type/Volume – number of claims pended by type (reason).
 16. Disputed Claims by Type/Volume – number of resolved disputed claims by reason code (i.e., underpayment of contract rate).
 17. Check Mailing/Attestation – an accounting of all checks mailed per check run whether scheduled or not.
 18. Customer Service Calls – an accounting of all incoming claim or dispute related phone calls from Providers of Service, including claims status calls.
- B. IEHP requires Delegates to submit monthly, quarterly, and annual reports to self-report compliance with contractual and regulatory standards pertaining to claims and dispute processing. Each report must be submitted in IEHP’s required format, using IEHP provided templates.

20. CLAIMS PROCESSING

G. Claims and Provider Dispute Reporting

- C. By the 15th of each month, Delegates must submit to IEHP the Monthly Claims Timeliness Summary Report (MTR) for the previous month's activity.
1. Each report must be reviewed and include a signed attestation as to the accuracy and validity of the report by a Designated Principal Officer. If the Designated Principal Officer is different for claims and Provider disputes, both parties must sign the monthly report.
- D. Delegates must also submit to IEHP by the 15th of each month, detailed claims reports for the previous month's activity as outlined below.
1. The required reports are:
 - a. Paid Claims.
 - b. Denied Claims.
 - c. Provider Dispute Resolution (PDR).
 2. Refer to attachment, "Medi-Cal Universe Layout Instructions" in Section 20 for detailed specifications of each report.
- E. On a quarterly basis, Delegates must submit reports for disputes for review and evaluation as outlined below.
1. The required reports are:
 - a. Quarterly Provider Dispute Resolution (PDR); and
 - b. Statement of Deficiencies.
 2. All quarterly reports are due to IEHP by the 30th of the month following the end of the quarter (i.e., the quarterly report for the period 10/1/2022 through 12/31/2022 would be due January 30, 2023) and must be signed by the designated principal officer.
- F. On an annual basis, Delegates must submit an Annual Claims Payment and Provider Dispute Mechanism Report (Annual Report) to IEHP summarizing the disposition of all claims and Provider disputes received by the Delegate.
1. The Annual Report must be submitted to IEHP no later than November 30th of each year, for the reporting period covering October 1 through September 30 and must be signed by the Designated Principal Officer attesting to the accuracy and validity of the reported information.
- G. As outlined in Policy 20D, "Claims and Compliance Audits," Delegates must also generate the following reports for the designated audit period, for review and claims selection (detailed specifications (See Attachment, "Medi-Cal Universe Layout Instructions" in Section 20).
1. Paid Claims Report.
 2. Denied Claims Report.
 3. Overpayments Report.

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G. Claims and Provider Dispute Reporting

4. Adjustments Report.
 5. Resolved Disputed Claims Report.
 6. Interest Paid Claims Report.
 7. Pended Claims Report (covering all unresolved pended claims on day of audit), including identification of the pend reason as well as identification and count of emergency claims and non-emergency services claims.
 8. Claims Inventory Report (covering all open claims on day of audit), including separate identification and count of emergency claims.
 9. Claims Received Report (covering all claims received in the audit period, regardless of status).
 10. Redirected Claims Report.
 11. Claims Inquiry/Customer Call Log (covering the audit period), including reason for the call and outcome.
 12. Signed Check Mailing/Attestation or Log (covering all checks issued for IEHP Members during the audit period), including check number, check amount and date mailed.
- H. IEHP reviews all reports for on-going monitoring of compliance with regulatory and contractual requirements, as well as to identify possible trends or patterns that may be indicators, alone or in conjunction with other information obtained by IEHP (i.e., Provider inquiries), of potential unfair payment practices or other issues that may trigger out-of-cycle corrective actions. Such action includes but is not limited to:
1. Increased reporting and monitoring.
 2. Submission of a Corrective Action Plan (CAP).
 3. Focused audit.
- I. Failure to submit fully completed and accurate reports within mandated timeframes, using IEHP specific templates and formats or to submit amended reports as applicable and/or refusal to cooperate in the identification or resolution of identified issues, concerns, patterns or trends, is considered a breach of contractual requirements and may subject the Delegate to a focused audit, initiation of contract termination and/or other actions as deemed appropriate by IEHP.

The timeliness, completeness, and accuracy of required periodic reporting by Delegates as outlined above is evaluated annually as part of IEHP's Performance Evaluation Tool and contract renewal process. Failure to submit complete accurate reports within the specified timeframes may impact contract renewal terms.

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G. Claims and Provider Dispute Reporting

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	February 1, 2004
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2023

20. CLAIMS PROCESSING

Attachments

<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
Capitation Payment Deduction	20A2, 20C
Claim Processing - Provider Dispute Resolution Process - Initial	20A
Claims Dispute	
CMS 1500 Form	20C
IEHP Remittance Advice	20A
UB04 Inpatient Form	20C
UB04 Outpatient Form	20C
Medi-Cal Universe Layout Instructions	20G
Notice of CAP Deduction	20A2, 20C
Demand for Payment Letter	20A2, 20B, 20C
Determination Letter	20A1, 20A2, 20B
Cease and Desist Letter	20B
Acknowledgement Letter	20A2

ACKNOWLEDGEMENT LETTER

Dear Provider:

Inland Empire Health Plan (IEHP) received an inquiry regarding the claim(s) listed below. We will review and a resolution will be sent.

If you have any questions, please contact the **IEHP Provider Call Center at (909) 890-2054 or (866) 223-4347** and reference the claim number listed.

Patient Acct #	Member Name:	Date(s) of Service:	Total Billed Amount:	IEHP Claim Number:	Date Received:

Sincerely,
Claim Specialist
Inland Empire Health Plan



Month Day, Year

Facility Name

Facility Fax:

Beneficiary Name:

IEHP Member ID:

Account Number:

Claim Number

Claim Receipt Date:

Date of Service:

Amount Billed:

RE: Notice of Prohibition on Balance Billing IEHP Members

To Whom It May Concern:

Inland Empire Health Plan (IEHP) was notified that the above-mentioned IEHP Member was billed for services rendered by your organization, in violation of statutes that protect Medicare or Medi-Cal beneficiaries from balance billing and billing for any covered services.

The purpose of this letter is to request that your organization, **effective immediately**:

- a) Cease and desist from any balance billing or collection activities as it relates to the Member referenced above and any IEHP Medicare or Medi-Cal Members;
- b) Return to IEHP’s Medicare and/or Medi-Cal Members any monies collected from such Members; and
- c) Reverse any negative credit reporting made against any such Members.

The California Supreme Court has made it clear in *Olszewski v. Scripps Health* (2003) 30 Cal.4th 798, 812 that balance billing and collection activities from Medicare or Medi-Cal beneficiaries are strictly prohibited under both federal and state laws.^{1,2,3} This prohibition against the balance billing of IEHP beneficiaries applies irrespective of whether the services are emergent or non-emergent.⁴

Violation of state laws prohibiting the balance billing of Medicare or Medi-Cal beneficiaries constitutes grounds for suspension from the Medicare or Medi-Cal programs.⁵

Thank you for your anticipated cooperation.

Sincerely,

Provider Payment Resolution Team
Inland Empire Health Plan

¹ Title 22 California Code of Regulations (CCR) § 51002(a)

² California Welfare and Institutions Code (Welf. & Inst. Code) § 14019.4

³ Title 42 Code of Federal Regulations (CFR) § 422.2

⁴ Title 28, CCR § 1300.71.39(a)

⁵ CA Welf. & Inst. Code §§ 14123(a)(1); 14123.25



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Form with multiple sections: 1. PICA, 2. PATIENT'S NAME, 3. PATIENT'S BIRTH DATE, 4. INSURED'S NAME, 5. PATIENT'S ADDRESS, 6. PATIENT RELATIONSHIP TO INSURED, 7. INSURED'S ADDRESS, 8. RESERVED FOR NUCC USE, 9. OTHER INSURED'S NAME, 10. IS PATIENT'S CONDITION RELATED TO?, 11. INSURED'S POLICY GROUP OR FECA NUMBER, 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE, 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE, 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP), 15. OTHER DATE, 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION, 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE, 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES, 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC), 20. OUTSIDE LAB? \$ CHARGES, 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, 22. RESUBMISSION CODE ORIGINAL REF. NO., 23. PRIOR AUTHORIZATION NUMBER, 24. A. DATE(S) OF SERVICE, B. PLACE OF SERVICE, C. EMG, D. PROCEDURES, SERVICES, OR SUPPLIES, E. DIAGNOSIS POINTER, F. \$ CHARGES, G. DAYS OR UNITS, H. EPSDT Family Plan, I. ID. QUAL., J. RENDERING PROVIDER ID. #, 25. FEDERAL TAX I.D. NUMBER, SSN EIN, 26. PATIENT'S ACCOUNT NO., 27. ACCEPT ASSIGNMENT?, 28. TOTAL CHARGE, 29. AMOUNT PAID, 30. Rsvd for NUCC Use, 31. SIGNATURE OF PHYSICIAN OR SUPPLIER, 32. SERVICE FACILITY LOCATION INFORMATION, 33. BILLING PROVIDER INFO & PH #

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Secure E-mail Template Demand for Payment

From:
To:
Cc:
Subject: IPA demand for payment notification, <Insert Claim Number>

The claim below was determined to be IPA responsibility, please provide payment information within 7 days from receipt of this e-mail.

Response(s) received after 7 calendar days will be subject to deduction from your next monthly capitation payment.

Member Name	
DOB	
IEHP MEMBER ID	
IEHP Claim Number	
Provider of Service	
Tax ID	
Date of Service	
Amount Billed	
Patient Account No.	

Sincerely,
Claim Specialist
Inland Empire Health Plan
<Insert Processor Initials>



DETERMINATION LETTER

Provider Name

Patient Account No:
Member Name:
Date(s) of Service:
Total Billed Amount:
IEHP Claim No:
Date Received:

Dear Provider:

Inland Empire Health Plan (IEHP) received an inquiry regarding the claim referenced above. Upon careful review, it has been determined that the initial decision is being **overturned** and payment will be made. Payment in the amount of \$ 00.00 is made for the following service(s):

If you require further information regarding the resolution, please contact **the IEHP Provider Call Center at (909) 890-2054 or (866) 223-4347**. Please use the IEHP claim number listed above as reference.

Sincerely,
Claim Specialist
Inland Empire Health Plan

DETERMINATION LETTER

Patient Account No: Member Name:

**Date(s) of Service:
Total Billed Amount:
IEHP Claim No:
Date Received:**

Dear Provider:

Inland Empire Health Plan (IEHP) received an inquiry regarding the claim referenced above. Upon careful review, it has been determined that the initial decision is being **upheld** for the following reason(s):

If you require further information regarding the resolution, please contact **the IEHP Provider Call Center at (909) 890-2054 or (866) 223-4347**. Please use the IEHP claim number listed above as reference.

Sincerely,

Claim Resolution Specialist
Inland Empire Health Plan



Remittance Advice Sample - MediTrac

Inland Empire Health Plan Remittance Advice

Disney Medical Group
PO BOX 1234
LOS ANGELES, CA 12345-6789
123456789

Check Date: 03/18/2018
Check Amount: \$30,888.55
Check No.: 0006000802
Page No.: 1
Previous Balance:

Member #	Line of Business			Patient Name		Provider Name					Interest				
Claim#	Line/ Ver#	Received Date	Service Date From To	Proc	Mod	City	Amount Billed	Amount Allowed	Not Covered	Copay/ Coins	Deduct Amount	Withhold Amount	Net Paid	S T Reason	Adjust
22345678912300	Medi-Cal			MEMBER NAME A		RENDERING PROVIDER NAME									
0000197602	0103	03/09/2018	02/27/2018 02/27/2018	71045	26	1	29.00	7.95	29.00	0.00	0.00	0.00	0.00	D MISD	
	Patient Acct. # 123QP3654		Claim Totals:				29.00	7.95	29.00	0.00	0.00	0.00	0.00		
0000230397	0103	03/12/2018	02/28/2018 02/28/2018	78452	26	1	280.00	83.55	280.00	0.00	0.00	0.00	0.00	D MISD	
	Patient Acct. # 123AB3654		Claim Totals:				280.00	83.55	280.00	0.00	0.00	0.00	0.00		
0000230415	0103	03/12/2018	02/28/2018 02/28/2018	76700	26	1	118.00	33.28	118.00	0.00	0.00	0.00	0.00	D MISD	
	Patient Acct. # 123ZX3654		Claim Totals:				118.00	33.28	118.00	0.00	0.00	0.00	0.00		
0000290836	0103	03/14/2018	02/27/2018 02/27/2018	71275	26	1	279.00	93.08	279.00	0.00	0.00	0.00	0.00	D MISD	
	Patient Acct. # 123QY3668		Claim Totals:				279.00	93.08	279.00	0.00	0.00	0.00	0.00		
			Member Totals:				706.00	217.86	706.00	0.00	0.00	0.00	0.00		
12345678912300	Medi-Cal			MEMBER NAME B		RENDERING PROVIDER NAME									
0000037741	0108	03/02/2018	02/20/2018 02/20/2018	70486	26	1	165.00	62.62	165.00	0.00	0.00	0.00	0.00	D MISD	
0000037741	0208	03/02/2018	02/20/2018 02/20/2018	70450	26	1	123.00	26.12	123.00	0.00	0.00	0.00	0.00	D MISD	
	Patient Acct. # 452IP3656		Claim Totals:				288.00	88.74	288.00	0.00	0.00	0.00	0.00		
			Member Totals:				288.00	88.74	288.00	0.00	0.00	0.00	0.00		
42345678912300	Medi-Cal			MEMBER NAME C		RENDERING PROVIDER NAME									
0000170865	0103	03/08/2018	02/25/2018 02/25/2018	74176	26	1	258.00	72.24	0.00	0.00	0.00	0.72	71.52	P A1	
	Patient Acct. # 625LM5644		Claim Totals:				258.00	72.24	0.00	0.00	0.00	0.72	71.52		
			Member Totals:				258.00	72.24	0.00	0.00	0.00	0.72	71.52		

Medi-Cal Universe Record Layout Instructions
Revised 4/25/2022
Paid, Denied, and Contested Claims

Paid Claim: Any claim paid for non-capitated services within the audit period regardless of the date received, even though one or more line items may have been denied for that claim.

Denied Claim: Any claim adjudicated within the audit period in which the total amount paid is zero, regardless of the date received. Examples include but are not limited to duplicate claims, member eligibility and non-authorized services.

Contested Claim: Any claim contested for development or in which a determination to pay or deny cannot be made without further information. Examples include claims forwarded for medical review and written requests for additional information sent.

Table 1: Requests for Processed Claims, which includes Paid, Partially Paid, Denied and Contested claims.

- Include all requests processed for both contracted and non-contracted providers for paid, denied and contested claims.
- Exclude all requests processed as adjustments to claims and overpayments.
- If a claim has more than one service line item, include all the claim’s service line items in a single row and enter the multiple line items as a single claim.

Column ID	Field Name	Field Type	Field Length	Description
A	Claim #	CHAR Always Required	40	The associated claim number assigned by the organization for this request. If a claim number is not available, please provide your internal tracking or case number. Answer NA if there is no claim or other tracking number available.
B	Member ID #	CHAR Always Required	20	Member identifier assigned by the organization.
C	Member Last Name	CHAR Always Required	50	Last name of member.
D	Member First Name	CHAR Always Required	50	First name of member.
E	Date of Service	CHAR Always Required	10	Date service was performed. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
F	Provider Name	CHAR Always Required	50	Name of the provider of service.
G	Billing Entity	CHAR Always Required	100	Provide the name of the “Pay-To” Billing Provider or Billing Entity.
H	Provider Contract Status	CHAR Always Required	2	Indicate whether the provider who performed the service is a contracted or non-contracted provider. Valid values: C for Contracted Provider

				NC for Non-Contracted Provider
I	Type of Claim Submission	CHAR Always Required	1	Indicate if the claim was submitted in a paper or electronic format. Valid values: P for Paper Claim E for Electronic Claim
J	Diagnosis Code(s)	CHAR Always Required	100	Provide the member's ICD-10 diagnosis/diagnoses codes related to this request. Include all diagnosis codes on the claim.
K	Place of Service* (See Appendix A)	CHAR Always Required	2	Provide the place of service billed. Valid values include, but are not limited to: - 11 for Office visit - 12 for Home Health - 21 for Inpatient - 22 for Outpatient Hospital - 23 for Emergency Room * For Family Planning services, valid value is FP. Include only FP claims with primary diagnosis codes as noted in Appendix A.
L	CPT, HCPCS, or Revenue Code (s)	CHAR Always Required	2,000	Provide the applicable CPT, HCPCS, or Revenue Procedure Code(s) as the service description. Include all procedure codes on the claim.
M	Date Claim Received	CHAR Always Required	10	Provide the date the claim was received by your organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
N	Date Claim Acknowledged	CHAR Always Required	10	Date claim was acknowledged to the provider. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
O	Date Claim Paid/Denied/Contested	CHAR Always Required	10	Date the claim was paid, denied or contested. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
P	Claim Disposition	CHAR Always Required	35	Provide the status of the claim. Valid values: - Paid - Partially Paid - Denied - Contested If a claim has multiple lines that are Denied and Contested, valid value: Denied/Contested
Q	If Fully Contested or Denied, Reason for Contesting or Denial	CHAR Always Required	100	Reason claim was contested or denied. If Paid or Partially Paid, answer NA.
R	Interest Due	CHAR Always Required	1	Indicate whether interest was due on the claim. Valid values: Y for Yes

				N for No
S	Date Interest Paid	CHAR Always Required	10	Date interest was paid. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If interest was not paid, answer NA.
T	Net Amount Paid (excluding interest)	CHAR Always Required	11	Net amount paid on the claim (excluding interest). Submit in the following format: \$xxx,xxx.xx (e.g., \$123,456.78). If payment was not made, answer NA.
U	Interest Amount Paid	CHAR Always Required	11	Amount of interest paid. Submit in the following format: \$xxx,xxx.xx (e.g., \$123,456.78). If interest was not paid, answer NA.
V	RA/EOB Date	CHAR Always Required	10	Provide the date the Remittance Advice / Explanation of Benefits (RA/EOB) was mailed to the provider of service, which is the date the RA/EOB left the organization by US Mail, fax, or electronic communication. Do not enter the date the RA/EOB was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
W	Check Mail Date	CHAR Always Required	10	Provide the date the check was mailed to the provider of service, which is the date the check left the organization by US Mail, fax, or electronic communication. Do not enter the date the check was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If a payment was not made, answer NA.
X	Check #	CHAR Always Required	10	Provide the check number or EFT (Electronic Funds Transfer) record number.
Y	Date Check Cleared	CHAR Always Required	10	Provide the date the check was cleared/cashed, if available. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If not available, answer NA.

Medi-Cal Universe Record Layout Instructions

Redirected Claims

Redirected Claims: Any claim that is either entered into the claims system or manually logged into another tracking mechanism because the Member cannot be identified or the claim is determined to be the financial responsibility of another payer and is denied to the provider of service or forwarded to another payer.

Table 2: Requests for all claims received by the organization that have been redirected to another party such as IEHP, returned to the provider, forwarded to another IPA or organization (i.e., a carved-out service) that is responsible for the claim

- **Include** all redirected claims processed for both contracted and non-contracted providers where all claim lines are forwarded to another payer or denied to the provider of service.
- **Exclude all requests paid, overpayments, and adjusted claims.**
- If a misdirected claim has more than one service line item, include all of the claim’s service line items in a single row and enter the multiple line items as a single claim.
- **Note:** If Redirected claims are not entered into the claims system, the data requested in Table 2 may not be available. If the data is not available, answer NA in these fields.

Column ID	Field Name	Field Type	Field Length	Description
A	Claim #	CHAR Always Required	40	The associated claim number assigned by the organization for this claim. If a claim number is not available, please provide your internal tracking or case number. Answer NA if there is no claim or other tracking number available.
B	Provider Name	CHAR Always Required	50	Name of the provider of service.
C	Billing Entity	CHAR Always Required	100	Provide the name of the “Pay-To” Billing Provider or Billing Entity.
D	Member Last Name	CHAR Always Required	50	Last name of member.
E	Member First Name	CHAR Always Required	50	First name of member.
F	Date Received	CHAR Always Required	10	Date redirected claim was received by your organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
G	Date Redirected	CHAR Always Required	10	Provide the date the claim was redirected to appropriate entity for payment or returned to provider, which is the date the claim left the organization by US Mail, fax, or electronic communication. Do not enter the date the claim was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
H	Diagnosis Code(s)	CHAR Always Required	100	Provide the member’s ICD-10 diagnosis/diagnoses codes related to this

				request. Include all diagnoses codes on the claim.
I	Place of Service* (See Appendix A)	CHAR Always Required	2	Provide the place of service provided. Valid values include but are not limited to: - 11 for Office visit - 12 for Home Health - 22 for Outpatient Hospital - 23 for Emergency Room * For Family Planning services, valid value is FP. Include only FP claims with primary diagnosis as noted in Appendix A.
J	CPT, HCPCS, or Revenue Code (s)	CHAR Always Required	2,000	Provide the applicable CPT, HCPCS, or Revenue Procedure Code(s) as the service description. Include all procedure codes on the claim.
K	Where Redirected	CHAR Always Required	50	Provide the name of the responsible party or entity that the claim was redirected to.

Medi-Cal Universe Record Layout Instructions Provider Dispute Requests (PDR)

Provider Dispute: Any dispute that has been resolved during the audit period regardless of the date it was received.

Table 3: Requests for all Provider Disputes Claims, which includes Paid, Partially Paid, Denied, and Contested claims.

- Include all provider disputes processed for both contracted and non-contracted providers claims, including any adjusted claims as a result of a provider dispute.
- Exclude all requests for processed paid, denied, contested claims, unrelated adjustments, overpayments, and misdirected claims.
- If a claim has more than one service line item, include all of the claim’s service line items in a single row and enter the multiple line items as a single claim.

Column ID	Field Name	Field Type	Field Length	Description
A	Original Claim #	CHAR Always Required	40	The original claim number associated to this dispute as assigned by the organization. If a claim number is not available, please provide your internal tracking or case number. Answer NA if there is no claim or other tracking number available.
B	Dispute #	CHAR Always Required	40	The associated dispute claim number assigned by the organization for this request. If a dispute claim number is not available, please provide your internal tracking or case number. Answer NA if there is no claim or other tracking number available.
C	Member ID #	CHAR Always Required	20	Member identifier used to identify the member. This is assigned by the organization.
D	Member Last Name	CHAR Always Required	50	Last name of member.
E	Member First Name	CHAR Always Required	50	First name of member.
F	Date of Service	CHAR Always Required	10	Date service was performed. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
G	Provider Name	CHAR Always Required	50	Name of the provider of service.
H	Billing Entity	CHAR Always Required	100	Provide the name of the “Pay-To” Billing Provider or Billing Entity.
I	Provider Contract Status	CHAR Always Required	2	Indicate whether the provider who performed the service is a contract or non-contract provider. Valid values: C for Contracted Provider NC for Non-Contracted Provider
J	Type of PDR Submission	CHAR Always Required	1	Indicate if the Provider Dispute Request was submitted in a paper or electronic format. Valid values: P for Paper Claim

				E for Electronic Claim
K	Diagnosis Code(s)	CHAR Always Required	100	Provide the member's ICD-10 diagnosis/diagnoses codes related to this request. Include all diagnoses codes on the claim.
L	Place of Service* (See Appendix A)	CHAR Always Required	2	Provide the place of service provided. Valid values include but are not limited to: - 11 for Office visit - 12 for Home Health - 22 for Outpatient Hospital - 23 for Emergency Room * For Family Planning services, valid value is FP. Include only FP claims with primary diagnosis as noted in Appendix A.
M	CPT, HCPCS, or Revenue Code (s)	CHAR Always Required	2,000	Provide the applicable CPT, HCPCS, or Revenue Procedure Code(s) as the service description. Include all procedure codes on the claim.
N	Date Dispute Received	CHAR Always Required	10	Provide the date the dispute was received in your organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
O	Date Dispute Acknowledged	CHAR Always Required	10	Date acknowledgement letter was issued to the provider. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If a separate acknowledgment letter was not sent to the provider, enter NA.
P	Additional Information Requested	CHAR Always Required	1	Indicate whether additional information was requested for this dispute. Valid values: Y for Yes N for No
Q	Date Additional Information Received	CHAR Always Required	10	Provide the date the additional information was received. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If additional information was not requested or the additional information was not received, answer NA.
R	Dispute Disposition	CHAR Always Required	15	Indicate whether the dispute was overturned or upheld. Valid values: - Overturned - Upheld
S	Date Dispute Resolved	CHAR Always Required	10	Date resolution letter was issued to the provider. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
T	Interest Due	CHAR Always Required	1	Indicate whether interest was due on the claim. Valid values: Y for Yes N for No
U	Date Interest Paid	CHAR Always Required	10	Provide the date interest was paid. Submit in the following format: MM/DD/YYYY (e.g.,

				01/01/2020). If interest was not paid, answer NA.
V	Net Amount Paid (excluding interest)	CHAR Always Required	11	Enter net amount paid. Submit in the following format: \$xxx,xxx.xx. If payment was not made, answer NA.
W	Interest Amount Paid	CHAR Always Required	11	Amount of interest paid. Submit in the following format: \$xxx,xxx.xx. If interest was not paid, answer NA.
X	RA / EOB Date	CHAR Always Required	10	Provide the date the Remittance Advice / Explanation of Benefits (RA/EOB) was mailed to the provider of service, which is the date the RA/EOB left the organization by US Mail, fax, or electronic communication. Do not enter the date the RA/EOB was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If no RA/EOB was mailed, answer NA.
Y	Check Mail Date	CHAR Always Required	10	Provide the date the check was mailed to the provider of service, which is the date the check left the organization by US Mail, fax, or electronic communication. Do not enter the date the check was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If a payment was not made, answer NA.
Z	Check #	CHAR Always Required	10	Provide the check number or EFT (Electronic Funds Transfer) record number.
AA	Date Check Cleared	CHAR Always Required	10	Provide the date the check cleared/cashed, if available. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If not available, answer NA.

Medi-Cal Universe Record Layout Instructions

Claim Adjustments

Adjusted Claims: Any claim that has been re-adjudicated and payment was issued within the audit period regardless of the original date received or original adjudication date.

Table 4: Requests for all adjusted claims if payment was issued as a result of the adjustment.

- Include all adjustments processed for both contracted and non-contracted providers claims.
- Exclude all adjustments if an additional payment was not due, and those adjustments processed because of a provider disputes and/or overpayment.
- If an adjusted claim has more than one service line item, include all of the claim’s service line items in a single row and enter the multiple line items as a single claim.
- Note: Column ID: A through T relates to the adjusted claim.
Column ID: U through AD relates to the original claim.

Column ID	Field Name	Field Type	Field Length	Description
A	Adjusted Claim #	CHAR Always Required	40	The associated adjusted claim number assigned by the organization for this request. If an adjusted claim number is not available, please provide your internal tracking or case number. Answer NA if there is no claim or other tracking number available.
B	Member ID #	CHAR Always Required	20	Member identifier used to identify the member. This is assigned by the organization.
C	Member Last Name	CHAR Always Required	50	Last name of member.
D	Member First Name	CHAR Always Required	50	First name of member.
E	Date of Service	CHAR Always Required	10	Date service was performed. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2018).
F	Provider Name	CHAR Always Required	50	Name of the provider of service.
G	Billing Entity	CHAR Always Required	100	Provide the name of the “Pay-To” Billing Provider or Billing Entity.
H	Provider Contract Status	CHAR Always Required	2	Indicate whether the provider who performed the service is a contract or non-contract provider. Valid values: C for Contracted Provider NC for Non-Contracted Provider
I	Diagnosis Code(s)	CHAR Always Required	100	Provide the member’s ICD-10 diagnosis/diagnoses codes related to this request. Include all diagnoses codes on the claim.

J	Place of Service* (See Appendix A)	CHAR Always Required	2	Provide the place of service provided. Valid values include but are not limited to: - 11 for Office visit - 12 for Home Health - 22 for Outpatient Hospital - 23 for Emergency Room * For Family Planning services, valid value is FP. Include only FP claims with primary diagnosis as noted in Appendix A.
K	CPT, HCPCS, or Revenue Code (s)	CHAR Always Required	2,000	Provide the applicable CPT, HCPCS, or Revenue Procedure Code(s) as the service description. Include all procedure codes on the claim.
L	Date Additional Information was Received to Trigger the Adjustment	CHAR Always Required	10	Provide the date additional information was received by your organization to trigger the adjustment (e.g., the date of the telephone call, the date of the internal audit, etc.). Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
M	Interest Due on Adjusted Claim	CHAR Always Required	1	Indicate whether interest was due on the adjusted claim: Valid values: Y for Yes N for No
N	Date Interest Paid on Adjusted Claim	CHAR Always Required	10	Provide the date interest was paid on the adjustment. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If interest was not paid, answer NA.
O	Net Amount Paid on Adjusted Claim (excluding interest)	CHAR Always Required	11	Net amount paid on the adjustment (excluding interest). Submit in the following format: \$xxx,xxx.xx (e.g., \$123,456.78).
P	Interest Amount Paid on Adjusted Claim	CHAR Always Required	11	Amount of interest paid on the adjustment. Submit in the following format: \$xxx,xxx.xx (e.g., \$123,456.78). If interest was not paid on the adjustment, answer NA.
Q	Adjusted RA/EOB Date	CHAR Always Required	10	Provide the date the Remittance Advice / Explanation of Benefits (RA/EOB) was mailed to the provider of service, which is the date the RA/EOB left the organization by US Mail, fax, or electronic communication. Do not enter the date the RA/EOB was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
R	Check Mail Date for Adjusted Claim	CHAR Always Required	10	Provide the date the check was mailed to the provider of service, which is the date the check left the organization by US Mail, fax, or electronic communication. Do not enter the date the check was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
S	Check #	CHAR Always Required	10	Provide the check number or EFT (Electronic Funds Transfer) record number.

T	Date Check Cleared	CHAR Always Required	10	Provide the date the check was cleared/cashed, if available. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If a payment was not issued for the adjustment, answer NA.
U	Original Claim #	CHAR Always Required	40	The original claim number associated with this claim assigned by the organization. If an original claim number is not available, please provide your internal tracking or case number. Answer NA if there is no original claim or other tracking number available.
V	Disposition of Original Claim	CHAR Always Required	35	Provide the status of the original claim. Valid values: - Paid - Partially Paid - Denied - Contested If original claim has multiple lines that are denied and contested, valid value: Denied/Contested
W	If fully Contested or Denied, Reason for Contesting or Denial	CHAR Always Required	100	Reason the adjusted claim was contested or denied. If Paid or Partially Paid, answer NA.
X	Interest Due on Original Claim	CHAR Always Required	1	Indicate whether interest was due on the original claim. Valid values: Y for Yes N for No
Y	Date Interest Paid on Original Claim	CHAR Always Required	10	Provide the date interest was paid on the original claim. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If interest was not paid, answer NA.
Z	Net Amount Paid on Original Claim (excluding interest)	CHAR Always Required	11	Net amount paid on the original claim (excluding interest). Submit in the following format: \$xxx,xxx.xx (e.g., \$123,456.78). If a payment was not made, answer NA.
AA	Interest Amount Paid on Original Claim	CHAR Always Required	11	Amount of interest paid on the original claim. Submit in the following format: \$xxx,xxx.xx (e.g., \$123,456.78). If interest was not paid, answer NA.
AB	RA/EOB Date for Original Claim	CHAR Always Required	10	Provide the date the Remittance Advice / Explanation of Benefits (RA/EOB) was mailed to the provider of service, which is the date the RA/EOB left the organization by US Mail, fax, or electronic communication. Do not enter the date the RA/EOB was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
AC	Check Mail Date for Original Claim	CHAR Always Required	10	Provide the date the check was mailed to the provider of service, which is the date the check left the organization by US Mail, fax, or electronic communication. Do not enter the

				date the check was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If a payment was not made, answer NA.
AD	Date Check Cleared for Original Claim	CHAR Always Required	10	Provide the date the check was cleared/cashed, if available. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If a check was not issued, answer NA.

Medi-Cal Universe Record Layout Instructions Overpayments

Overpayment Request: A request for an overpayment from the IPA that was subsequently refunded by the provider, retracted by the IPA, disputed by the provider, or closed due to an administrative decision not to pursue the monies owed.

Table 5: Requests for all overpayments made to a provider.

- Include all overpayment requests that were made in writing by the IPA for both contracted and non-contracted provider claims.
- Exclude all overpayment refunds that were voluntarily returned by a provider.

Column ID	Field Name	Field Type	Field Length	Description
A	Claim #	CHAR Always Required	40	The associated claim number assigned by the organization for this overpayment. If a claim number is not available, please provide your internal tracking or case number. Answer NA if there is no claim or other tracking number available.
B	Member Last Name	CHAR Always Required	50	Last name of member.
C	Member First Name	CHAR Always Required	50	First name of member.
D	Member ID #	CHAR Always Required	20	Member identifier used to identify the member. This is assigned by the organization.
E	Provider Name	CHAR Always Required	50	Name of the provider of service.
F	Billing Entity	CHAR Always Required	100	Provide the name of the “Pay-To” Billing Provider or Billing Entity.
G	Provider Contract Status	CHAR Always Required	2	Indicate whether the provider who performed the service is a contract or non-contract provider. Valid values are: C for Contracted Provider NC for Non-Contracted Provider
H	Date of Service	CHAR Always Required	10	Provide the date the service was performed. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
I	Date Originally Paid	CHAR Always Required	10	Date overpayment was originally paid. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
J	Date Overpayment Requested	CHAR Always Required	10	Date recovery request/letter was sent to the provider. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).
K	Overpayment Reason	CHAR Always Required	100	Reason the claim was overpaid or paid in error.
L	Overpayment Amount Recovered	CHAR Always Required	11	Amount of overpayment recovered. Submit in the following format: \$xxx,xxx.xx. If an overpayment recovery was not received, answer NA.

M	Method of Overpayment Recovery	CHAR Always Required	7	<p>Provide the method in which the overpayment recovery was made or otherwise resolved. Valid values:</p> <ul style="list-style-type: none"> - Refund - Refunded by provider - Retract - Retracted through the claims system - Dispute – Disputed by the provider - Closed – Closed due to an administrative decision. <p>If an overpayment recovery was not received, answer NA.</p>
N	Date Overpayment Recovery Received	CHAR Always Required	10	<p>Provide the date the overpayment was recovered by refund or retraction only. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If an overpayment recovery was not received, answer NA.</p>

Medi-Cal Universe Record Layout Instructions
Reporting Elements Definitions

Appendix A – Crosswalk for Type of Service Field for Family Planning

The following ICD-10 CM diagnosis codes, when billed as a primary diagnosis code, indicate comprehensive family planning services.

Z30.011	Z30.017	Z30.41	Z30.433	Z31.430	Z97.5
Z30.012	Z30.018	Z30.42	Z30.44	Z31.438	Z98.51
Z30.013	Z30.02	Z30.430	Z30.45	Z31.440	Z98.52
Z30.015	Z30.09	Z30.431	Z30.46	Z31.441	
Z30.016	Z30.2	Z30.432	Z30.49	Z31.5	

Secure E-mail Template Notice of CAP deduction

From:
To:
Cc:
Subject: Notice of Cap deduction, <Insert Claim Number>

Evidence of payment was not received for the claim below within the required 7 days from demand of payment notification.

Member Name	
DOB	
IEHP MEMBER ID	
Claim Number	
Provider of Service	
Tax ID	
Date of Service	
Amount Billed	
Patient Account No.	
Notification Date	
Cap Deduction Amount	
Process Date Date	

Sincerely,
Claim Specialist
Inland Empire Health Plan
<Insert Processor Initials>



INPATIENT

1										2										3a Pat. CNTL#		4 TYPE OF BILL			
																				b. Pat. CNTL#					
5 FED. TAX. NO.					6 Statement Covers Period From					7 Through															
8 PATIENT NAME										9 PATIENT ADDRESS															
a										b										c		d		e	
10 BIRTHDATE		11 SEX	12 DATE		ADMISSION	13 HR	14 Type	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES			25	26	27	28	29 Acct State	30		
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 CODE		OCCURRENCE SPAN FROM			THROUGH			36 CODE		OCCURRENCE SPAN FROM			THROUGH			37	
38										39 VALUE CODES AMOUNT			40 VALUE CODES AMOUNT			41 VALUE CODES AMOUNT									
a																									
b																									
c																									
d																									
42 REV.CD.		43 DESCRIPTION								44 HCPCS / RATE / HIPPS CODE				45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49			
1																				1					
2																				2					
3																				3					
4																				4					
5																				5					
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PAGE ____ OF ____										CREATION DATE										TOTALS					
50 PAYER NAME					51 HEALTH PLAN ID					52 Rel INFO	53 Asg BEN	54 PRIOR PAYMENTS					55 EST. AMOUNT DUE					56 NPI			
A																						57			
B																						OTHER			
C																						PRV ID			
58 INSURED'S NAME					59 P.rel					60 INSURED'S UNIQUE ID					61 GROUP NAME					62 INSURANCE GROUP NO.					
A																									
B																									
C																									
63 TREATMENT AUTHORIZATION CODES					64 DOCUMENT CONTROL NUMBER					65 EMPLOYER NAME															
A																									
B																									
C																									
66 DX	67	a		b		c		d		e		f		g		h		68							
		i		j		k		l		m		n		o		p		q							
69 ADMIT DX	70 PATIENT REASON DX	a		b		c		71 PPS CODE		72 ECI		73													
74 PRINCIPAL PROCEDURE CODE		DATE		a.		OTHER PROCEDURE CODE		DATE		b.		OTHER PROCEDURE CODE		DATE		75		76 ATTENDING NPI		QUAL					
																		LAST		FIRST					
c.		OTHER PROCEDURE CODE		DATE		d.		OTHER PROCEDURE CODE		DATE		e.		OTHER PROCEDURE CODE		DATE				LAST		FIRST			
																				LAST		FIRST			
80 REMARKS					81 cc	a.																			
					b.																				
					c.																				
					d.																				

REQUIRED

SITUATIONAL

NOT REQUIRED

UB04 INPATIENT: SITUATIONAL FIELDS

FIELD	DESCRIPTION
18-28	CONDITION CODES - This field is required if applicable. The condition codes indicate any conditions/events relating to this bill that may affect processing. This field is required if applicable.
31-34	OCCURRENCE CODE AND DATES - This field is required if applicable. The occurrence code indicates a significant event relating to this bill that may affect processing. This field is required if applicable.
35-36	OCCURRENCE SPAN - This field is required if applicable. The occurrence span code identifies an event that relates to the payment of the claim. This field is required if applicable.
38	The name and address of the party responsible for the bill. This field is required if applicable.
39-41	VALUE CODES AND AMOUNTS The Value Code refers to a code to relate amounts or values to identify data elements necessary to process the claim as qualified by the payer organization.
43	DESCRIPTION Please fill in the standard abbreviated description of the related revenue code included on this bill. The NDC Code is required in this field when billing for injectables, drugs and family planning pharmaceuticals.
44	HCPCS/RATE/HIPPS CODE - This field is required if applicable. HCPCS or Healthcare Common Procedure Coding. The accommodation rate for inpatient bills. HIPPS or Health Insurance Prospective Payment System.
48	NON-COVERED CHARGES - This field is required if applicable. This field reflects the non-covered charges for the destination payer as it pertains to the related revenue code.
51 A-C	HEALTH PLAN ID - This field is required if applicable. This is the alphanumeric identifier used by the health plan to identify itself.
54	PRIOR PAYMENTS - This field is required if applicable. This field should reflect any payment from the health plan for this bill.
55	EST. AMOUNT DUE This field should reflect the estimate how much is due from the payer (estimate less prior payments).
57	OTHER / PRV ID The Provider Medicare ID is required when billing for services rendered to a DualChoice Member or if reimbursement is based on Medicare rates.
61-62	GROUP NAME/ INSURANCE GROUP NUMBER This is the group/plan name through which the insurance is provided to the insured along with the control number/code assigned by the carrier to identify the group under which the individual is covered.
63	TREATMENT AUTHORIZATION CODES An indicator that designates the treatment indicated on this bill has been authorized by the payer.
65	EMPLOYER NAME - The name of the insured's employer.
67 A-Q	OTHER DIAGNOSIS CODE - This field is required when applicable Other conditions that coexist or develop during the patient's treatment.
70	PATIENT REASON DX - This field is required when applicable Is this an unscheduled outpatient visit? If so, please fill in the ICD code that reflects the patient's reason for visit at the time of outpatient registration.
71	PPS CODE - This field is required when applicable. Fill in the Prospective Payment System code for the applicable claim type.
72 A-C	ECI - This field is required when applicable Was the cause for treatment due to injury or poisoning? If so please enter the ECI which is the External Cause of Injury. This is indicated by an ICD code.
74 A-E	PRINCIPAL PROCEDURE - This field is required when applicable This field should indicate the ICD code that identifies the inpatient principal procedure performed at the claim level during the period.
77-79	OPERATING/OTHER - This field is required for surgery This field should be filled with the individual who has primary responsibility for performing the surgical procedure(s). Utilize fields 78-79 for other provider names and identifiers.
80	REMARKS - This field is required when applicable This area may be used to capture any additional information needed to adjudicate the claim.

OUTPATIENT

1										2										3a Pat. CNTL#		4 TYPE OF BILL																			
																				b. Pat. CNTL#																					
																				5 FED. TAX. NO.		6 Statement Covers Period From		7 Through																	
8 PATIENT NAME										9 PATIENT ADDRESS																															
a										a																															
b										b										c		d		e																	
10 BIRTHDATE		11 SEX		12 DATE		ADMISSION		13 HR		14 Type		15 SRC		16 DHR		17 STAT		18		19		20		21		CONDITION CODES		25		26		27		28		29 Acct State		30			
31 OCCURRENCE CODE		DATE		32 OCCURRENCE CODE		DATE		33 OCCURRENCE CODE		DATE		34 OCCURRENCE CODE		DATE		35 CODE		OCCURRENCE SPAN FROM		THROUGH		36 CODE		OCCURRENCE SPAN FROM		THROUGH		37													
38										39 VALUE CODES AMOUNT										40 VALUE CODES AMOUNT										41 VALUE CODES AMOUNT											
a																																									
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c																																									
d																																									
42 REV.CD.		43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49											
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50 PAYER NAME										51 HEALTH PLAN ID										52 Rel INFO		53 Asg BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI													
A																										57															
B																												OTHER													
C																												PRV ID													
58 INSURED'S NAME										59 P.rel		60 INSURED'S UNIQUE ID										61 GROUP NAME										62 INSURANCE GROUP NO.									
A																																									
B																																									
C																																									
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																					
A																																									
B																																									
C																																									
66 DX		67		a		b		c		d		e		f		g		h		i		j		k		l		m		n		o		p		q		68			
69 ADMIT DX		70 PATIENT REASON DX										a		b		c		71 PPS CODE		72 ECI		73																			
74 PRINCIPAL PROCEDURE CODE		DATE		a.		OTHER PROCEDURE CODE		DATE		b.		OTHER PROCEDURE CODE		DATE		75		76 ATTENDING NPI		QUAL				LAST		FIRST															
c.		OTHER PROCEDURE CODE		DATE		d.		OTHER PROCEDURE CODE		DATE		e.		OTHER PROCEDURE CODE		DATE		77 OPERATING NPI		QUAL				LAST		FIRST															
80 REMARKS										81 cc		a.						78 OTHER NPI		QUAL				LAST		FIRST															

REQUIRED

SITUATIONAL

NOT REQUIRED

UB04 OUTPATIENT: SITUATIONAL FIELDS

FIELD	DESCRIPTION
12	ADMISSION DATE Admission/Start of Care Date Required for Inpatient and Home Health. Enter the date admitted for inpatient care, or the date of the outpatient service.
13	ADMISSION HR - This field is required if applicable. Enter the hour during which the patient was admitted for inpatient or outpatient care. This field is required if applicable.
16	DHR - This field is required if applicable. DHR refers to the code indicating the discharge hour of the patient from inpatient care. This field is required if applicable.
18-28	CONDITION CODES - This field is required if applicable. The condition codes indicate any conditions/events relating to this bill that may affect processing. This field is required if applicable.
31-34	OCCURRENCE CODE AND DATES - This field is required if applicable. The occurrence code indicates a significant event relating to this bill that may affect processing. This field is required if applicable.
35-36	OCCURRENCE SPAN - This field is required if applicable. The occurrence span code identifies an event that relates to the payment of the claim. This field is required if applicable.
38	The name and address of the party responsible for the bill. This field is required if applicable.
39-41	VALUE CODES AND AMOUNTS The Value Code refers to a code to relate amounts or values to identify data elements necessary to process the claim as qualified by the payer organization.
43	DESCRIPTION Please fill in the standard abbreviated description of the related revenue code included on this bill. The NDC Code is required in this field when billing for injectables, drugs and family planning pharmaceuticals.
44	HCPCS/RATE/HIPPS CODE - This field is required if applicable. HCPCS or Healthcare Common Procedure Coding. The accommodation rate for inpatient bills. HIPPS or Health Insurance Prospective Payment System.
48	NON-COVERED CHARGES - This field is required if applicable. This field reflects the non-covered charges for the destination payer as it pertains to the related revenue code.
51 A-C	HEALTH PLAN ID - This field is required if applicable. This is the alphanumeric identifier used by the health plan to identify itself.
54	PRIOR PAYMENTS - This field is required if applicable. This field should reflect any payment from the health plan for this bill.
55	EST. AMOUNT DUE This field should reflect the estimate how much is due from the payer (estimate less prior payments).
57	OTHER / PRV ID The Provider Medicare ID is required when billing for services rendered to a DualChoice Member or if reimbursement is based on Medicare rates.
61-62	GROUP NAME/ INSURANCE GROUP NUMBER This is the group/plan name through which the insurance is provided to the insured along with the control number/code assigned by the carrier to identify the group under which the individual is covered.
63	TREATMENT AUTHORIZATION CODES An indicator that designates the treatment indicated on this bill has been authorized by the payer.
65	EMPLOYER NAME The name of the insured's employer.
67 A-Q	OTHER DIAGNOSIS CODE - This field is required when applicable Other conditions that coexist or develop during the patient's treatment.
69	ADMIT DX - Required on inpatient. Required on outpatient if applicable The Admitting Diagnosis Code (ICD) which describes the patient's diagnosis at the time of admission.
70	PATIENT REASON DX - This field is required when applicable Is this an unscheduled outpatient visit? If so, please fill in the ICD code that reflects the patient's reason for visit at the time of outpatient registration.
71	PPS CODE - This field is required when applicable Fill in the Prospective Payment System code for the applicable claim type.
72 A-C	ECI - This field is required when applicable Was the cause for treatment due to injury or poisoning? If so please enter the ECI which is the External Cause of Injury. This is indicated by an ICD code.
74 A-E	PRINCIPAL PROCEDURE - This field is required when applicable This field should indicate the ICD code that identifies the inpatient principal procedure performed at the claim level during the period
77-79	OPERATING/OTHER - This field is required for surgery This field should be filled with the individual who has primary responsibility for performing the surgical procedure(s). Utilize fields 78-79 for other provider names and identifiers.
80	REMARKS - This field is required when applicable. This area may be used to capture any additional information needed to adjudicate the claim.



INLAND EMPIRE HEALTH PLAN

Capitation Deductions Detail by IPA

April 2022

Total Deduction for:

Health Plan Disputes/Decap													
Provider Of Service	LOB	Member Last Name	Member First Name	Date of Service	Member Number	Claim Number	Claim Version	Procedure Code	Primary Modifier Code	Quantity	Amount Paid	Reason Code	