13. CLAIMS PROCESSING

A. Claims Processing

APPLIES TO:

A. This policy applies to all IEHP Covered Providers.

POLICY:

A. IEHP and its Capitated Providers must reimburse, contest, or deny all clean or corrected claims submitted by contracted and out of network provider in accordance with this policy, unless the Plan and the contracted Provider have agreed in writing to an alternate payment schedule.
B. All claims must be reimbursed, contested, 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.

DEFINITIONS:

A. Complete (clean) Claim – A claim 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.[1] A complete claim should be prepared in accordance with The National Uniform Billing Committee and The National Uniform Claim Committee standards. Electronic (EDI) claims should be prepared and submitted according to ANSI X12 standard listed in IEHP's EDI policy.
B. Contested Claim – A claim or a portion of the claim is reasonably contested when IEHP or its Capitated Provider have not received an accurately completed claim or requires additional information necessary to determine payer liability, or has not been granted reasonable access to needed information.[2]

PROCEDURES:

Capitated Provider Responsibilities

A. All Capitated Providers are delegated the responsibility of claims processing for services covered under their capitated agreement and are subject to review by IEHP. IEHP provides oversight of 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. 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), Remittance Advice (RA), or an Electronic Remittance Advice

[1] California Health and Safety Code § 1371(a)(3)
[2] California Health and Safety Code § 1371(a)(3)

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 13.

C. 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 originally received.[3]

1. If the claim was received electronically, acknowledgement must be provided within two (2) working days of receipt of the claim.[4]
2. If the claim was a paper claim, acknowledgement must be provided within fifteen (15) working days of receipt of the claim.[5]

D. 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.[6]

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 more than 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 overpayment request, 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 13.D, "Provider Dispute Resolution Process – Initial Claims Disputes."

E. 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 13G, "Claims and Provider Dispute Reporting."

F. 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

[3] Title 28 California Code of Regulations (CCR) § 1300.71
[4] Title 28 California Code of Regulations (CCR) § 1300.71
[5] Title 28 California Code of Regulations (CCR) § 1300.71
[6] Title 28 California Code of Regulations (CCR) § 1300.71

be resolved within forty-five (45) working days of receipt of the dispute as outlined in Policy 13.D, "Provider Dispute Resolution Process – Initial Claims Disputes".

G. 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.

Claims Submission

H. Contracted Providers of Service must be given at least ninety (90) days from date of service to submit an initial clean or corrected claim.[7] Out of network IEHP Covered providers of service have up to 180 days from the date of service to submit an initial clean or corrected claim.[8]

I. Contracted Providers of Service must submit a claim (including any corrected claims) within the timely filing period specified in their Provider contract.

J. Out of network provider and members must submit a claim (including any corrected claims) within one hundred eighty (180) days from the date of service.

K. Paper 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 4409
Rancho Cucamonga, CA 91729-1800

Electronic (EDI) claims should be prepared and submitted according to ANSI X12 standard listed in IEHP's Provider EDI manual.

Claims Processing and Reimbursement

L. 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.[9]

M. Initial clean or corrected claims received after the filing deadline indicated in the Claims Submission section above will be denied unless substantiating documentation for good cause associated with the delay in billing or proof of timely filing is provided.[10] Disputes filed by Providers of Service after the claim denial 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:

[7] Title 28 California Code of Regulations (CCR) § 1300.71
[8] Title 28 California Code of Regulations (CCR) § 1300.71
[9] Title 28 California Code of Regulations (CCR) § 1300.71
[10] Title 28 California Code of Regulations (CCR) § 1300.71

1. Claim determination letter or Explanation of Benefits (EOB), Remittance Advice (RA), or an Electronic Remittance Advice from IEHP or one of IEHP's contracted Capitated Providers (See Attachment, "IEHP Remittance Advice" in Section 13).
2. Copy of a written request for information or other written claim-related correspondence from IEHP dated and printed on letterhead or form letter with the date and letterhead clearly identified.
3. Financial ledgers with multiple claim billings for the date of service in question, including name of the billed party.
4. 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.
5. Other documentation that demonstrates good cause for the delay in being able to submit the claim timely.

N. 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 HIPAA compliant 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 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.

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. Please see policy 09.D "Pre-service Referral Authorization Process" for authorization requirements.
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.

O. IEHP and its Capitated Providers must reimburse, contest, or deny all initial clean or corrected claims for Providers providing services to IEHP Covered Members as follows:

1. Out of network provider claims - 95% within 45 working days from receipt of the claim. [11]
2. Contracted Provider claims - 95% within 45 working days from receipt of the claim, unless otherwise stated in the Provider contract. [12]

P. The above requirements are based on the timeframe from the day after the receipt date of the claim (e.g., date stamp) until the payment, contested claim or denial date is sent to the Provider of Service, regardless of when a check is dated.

The payment, contested claim or denial 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.

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. Claims with multiple date stamps should be deemed priority and processed immediately.

Late claim payment requires an additional payment of interest within five (5) working days of the claim payment date as described in section T below. [13]

Q. Any claim, from a contracted or out of network 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.), the process for filing a dispute of the paid, contested, or denied amount, on the Explanation of Benefits (EOB), Remittance Advice (RA) (See Attachment, "IEHP Remittance Advice" in Section 13), or an Electronic Remittance Advice (X12 – 835 Health Care Claim Payment/Advice).

[11] CA Health and Safety (Health & Saf.) Code § 1371(a)(1)
[12] CA Health and Safety (Health & Saf.) Code § 1371(a)(1)
[13] Title 28 California Code of Regulations (CCR) § 1300.71

R. IEHP applies claim coding edits published by CMS and the American Medical Association (AMA). Additionally, IEHP applies National Correct Coding Initiative (NCCI) claim edits.

NCCI edits consist of three 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).

c. Add-on Code Edits

S. Reimbursement for services rendered to an IEHP Covered Member by an out of network provider are as follows:

1. Emergency Services are paid at the Reasonable and customary value for the health care services rendered based upon the factors stated in Cal. Code of Regs., tit. 28, section 1300.71(a)(3)(B).

2. Out of network providers performing non-emergency health services in a contracted facility are paid at the greater of the average contracted rate, or 125% of the Medicare Reimbursement Rate as defined in Section 1371 of the Knox Keene Act.

3. Out of network urgent care services, while out of area are paid at 1) IEHP's average contracted rate for such service(s), or 2) 100% of the published Medicare rate for such service(s), whichever is less.

4. IEHP authorized out of network services are paid at the rate specified in the single case agreement with IEHP.

T. IEHP and its Capitated Providers must automatically pay interest (in addition to the claim payment) on any clean and complete claim not paid within forty-five (45) working days, 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 out of network provider. Failure to automatically pay interest due requires a $10.00 penalty to be paid to the Provider in addition to any interest due.[14][15]

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

[14] CA Health & Saf. Code § 1371(a)(2)
[15] Title 28 California Code of Regulations (CCR) § 1300.71

in payment of additional monies, without the need for any reminder or request by the Provider of Service.[16]

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 until payment is issued.
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.[17]
4. Depending on the circumstances surrounding the claim or adjustment, interest methodology[18] is as follows:
   a. Initial clean claims and corrected claims should calculate interest based on the period of the calendar day after receipt to the date payment is issued. 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 calendar 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 calendar 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).
   d. 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.[19]

Notification Requirements

[16] Title 28 California Code of Regulations (CCR) § 1300.71
[17] Title 28 California Code of Regulations (CCR) § 1300.71
[18] Title 28 California Code of Regulations (CCR) § 1300.71
[19] Title 28 California Code of Regulations (CCR) § 1300.71

U. Incomplete claims and claims for which "information necessary to determine payer liability" that has been requested, which are held or pended awaiting receipt of additional information shall be either contested or denied in writing within the timeframes set forth in Section O above. The denial or contest shall identify the individual or entity that was requested to submit information, the specific documents requested and the reason(s) why the information is necessary to determine payer liability.[20]

V. All denial notifications, including an Explanation of Benefits (EOB), Remittance Advice (RA), or an Electronic Remittance Advice, 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 13).[21]

W. IEHP will issue a member explanation of benefits (EOB) on a monthly basis. The EOB will include cost sharing and maximum-out-of-pocket (MOOP) information, and claim payment details for the prior calendar month.

X. Any and all payments of interest must be listed separately on the Explanation of Benefits (EOB), Remittance Advice (RA), or an Electronic Remittance Advice to the Provider of Service (See Attachment, "IEHP Remittance Advice" in Section 13). 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 forty-five (45) working days from the date the claim was originally submitted to the financially responsible party.

Provider Dispute Resolution

Y. If a provider does not agree with the outcome of a paid, contested or denied claim, he or she may file a dispute in accordance with policy 13D "Provider Dispute Resolution Process-Initial Claims Disputes."

Z. IEHP's Provider Call Center Team is available from 8:00am - 5:00pm PST, Monday through Friday at (909) 890-2054 or (844) 248-4347 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.

[20] Title 28 California Code of Regulations (CCR) § 1300.71
[21] CA Welfare and Institutions Code § 14019.4

13. CLAIMS PROCESSING

A. Claims Processing

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
Revision Effective Date:		

13. CLAIMS PROCESSING

B. Billing of IEHP Members

APPLIES TO:

A. This policy applies to all IEHP Covered Providers.

POLICY:

A. IEHP Covered Providers, as defined in this policy, must not submit claims to or demand or otherwise collect reimbursement from a IEHP Covered beneficiary, or from other persons on behalf of the beneficiary, for any service included in the IEHP Covered program's scope of benefits in addition to a claim submitted to the IEHP Covered 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 IEHP Covered . 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. Providers who accept an IEHP Covered Member as a patient shall accept payment from IEHP as payment in full for IEHP Covered once the Member has met his or her share of cost requirements.

B. Providers are prohibited from billing a IEHP Covered Member for services including, but not limited to:

   1. Covered services once the Member meets his or her share of cost requirements.
   2. Pended, contested, or disputed claims.
   3. Fees for missed, broken, cancelled or same day appointments.
   4. Fees for completing paperwork related to the delivery of care.

C. Provider may bill a Member only for services not covered by IEHP Covered, if:

   1. The Member agrees to the fees in writing prior the actual delivery of the non-covered services.
   2. A copy of the written agreement is provided to the member and placed in his or her medical record.

[1] Title 22 California Code of Regulations (CCR) § 51002
[2] Title 42 Code of Federal Regulations (CFR) § 422.2

13. CLAIMS PROCESSING

B. Billing of IEHP Members

D. Provider must not bill a Member for a claim that has been denied due to lack of authorization or due to untimely filing. The Provider is solely responsible for seeking authorization of services and for submitting claims in a timely manner.

E. Provider must not require a Member to submit a claim to IEHP for payment or involve the Member in any of the steps to collect payment from IEHP.

F. 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 10A, "Member Grievance Resolution Process."

G. IEHP will take disciplinary action against contracted and non-contracted Providers that continue to inappropriately bill IEHP Members that include but is not limited to:

1. Provider Education.
2. Instruct the billing Provider in writing to cease and desist from billing the Member.
3. Issue a Corrective Action Plan (CAP).
4. Report the billing Provider to IEHP's Compliance Special Investigation Unit (SIU).
5. Report the billing Provider to the appropriate regulatory agencies.
6. Terminate the Provider's contract.

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	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
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13. CLAIMS PROCESSING

C. Claims Deduction from Capitation –7-Day Letter

APPLIES TO:

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

POLICY:

A. Payor must appropriately pay or deny complete claims for contracted Providers of Service within 45 working days from original receipt. Non-contracted providers of service must be paid within 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 IEHP Covered claims processing standards as indicated above, IEHP Covered 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 a delegated Provider and have not received a response within the regulatory timeframes.

PROCEDURES:

A. The 7-Day letter is a tool used by IEHP Covered to expedite payment of any claims that may have fallen outside of the indicated claims processing timelines.

B. IEHP Covered 7-Day letter process is available to Providers of Service under the following circumstances:

   1. A Provider of Service notifies IEHP Covered that no status has been provided on claims submitted to the appropriate Payor for over 45 working days (approximately 60 calendar days).

   2. IEHP Covered 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 13.E.1, "Provider Dispute Resolution - Health Plan Claims Appeals" Providers of service must submit documentation that demonstrates an attempt to obtain payment from the Payor. Failure to provide the required documentation will result in the payment dispute being closed by IEHP Covered. Providers are required to submit the following documents:

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

1. A Clean Claim (See Attachment "CMS 1500 Form", and "UB04 Inpatient Form" & "UM Outpatient Form" in found on the IEHP website[2]).
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. Hardcopy authorization if prior authorization received.
8. If Verbal Authorization received:
    a. Name, title, phone, and fax number of the staff member providing the verbal authorization.
    b. Date and time verbal authorization given.
    c. Diagnosis code(s).
    d. Services authorized and associated code(s).
    e. Start and end date of authorization.
    f. Authorization number.

    (Follow up calls for additional services require the same information.)
9. Or any other necessary information that supports the appropriateness of services rendered.

E. Upon receipt of the claim, IEHP Covered 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 Covered 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 Covered returns the claim to the Provider of Service advising them to re-bill the correct Payor.

F. IEHP Covered sends a secure email 7-Day letter 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) calendar days from the sent date.

G. Payor must respond to IEHP Covered with the following claim information:

1. The date the claim was originally received

[2] https://www.iehp.org/en/providers/provider-resources?target=forms

2. If the claim was paid or denied
3. The date the claim was paid or denied
4. The amount paid
5. The check number of payment and/or
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 Covered confirms financial responsibility prior to 7-day notification).
2. Member Not Eligible (IEHP Covered 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. Once IEHP Covered 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.

J. In the event the Payor fails to provide an acceptable written response to IEHP Covered within seven (7) days, or the requested information is returned incomplete, IEHP Covered pays the Provider of Service directly and deducts the amount paid from the Payor's monthly capitation check.

1. Outpatient services are paid at the rates specified in the Medi-Cal schedule of reimbursement (RFO500).
2. Outpatient dental services are paid at the rates specified in the Medi-Cal Dental fee-for-service schedule.
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.
4. 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.

K. If Payor fails to respond to an IEHP Covered inquiry, a demand letter will be issued requiring proof of payment within the timeline outlined in Notice of Cap Deductions letter.

L. Claims capitation deductions are outlined on a detail report, sent with the capitation payment (See Attachment, "Capitation Payment Deduction" found on the IEHP website[3]).

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	☐ DMHC	☐ NCQA
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[3] https://www.iehp.org/en/providers/provider-resources?target=forms

13. CLAIMS PROCESSING

D. Provider Dispute Resolution Process - Initial Claims Disputes

APPLIES TO:

A. This policy applies to all IEHP Covered Providers.

POLICY:

A. "Providers" 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.

B. 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 for the initial dispute resolution process.

C. 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]

D. 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]

E. Payors must resolve disputes and issue a written determination within forty-five (45) working days of receipt.[3]

F. 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.

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. Justification and supporting documentation must be provided with the written dispute.[4]

1. Disputes are categorized as follows, for reporting, tracking, and monitoring purposes:

    a. Claims/Billing – any formal written disagreement involving the payment, denial,

[1] Title 28 California Code of Regulation (CCR)§ 1300.71.38
[2] Ibid.
[3] Ibid.
[4] Ibid.

b. adjustment or contesting of a claim, including overpayments, payment rates, billing issues or other claim reimbursement decisions.

c. Denial of a claim for any reason including eligibility, benefits, untimely filing, etc.

d. Contract – Any formal written disagreement concerning the interpretation of a contract as it relates to claim payment.

e. 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. Claims or billing disputes must be sent to:

IEHP Claims Appeal Resolution 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. Written disputes must include the Provider name, Provider identification, contact 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.

4. 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.

B. Payors must identify and acknowledge in writing the receipt of each dispute, whether complete or not, and disclose the recorded date of receipt[5] as follows:

1. If the dispute was received electronically, acknowledgment must be provided within two (2) working days of receipt of the dispute; or

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.

[5] 28 CCR § 1300.71.38

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, including pertinent facts and an explanation of the reason for the determination, within forty-five (45) working days of the 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 claims made in favor of the disputing Provider that results in payment of additional monies is subject to interest penalties as follows[7]:

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. Failure to pay interest automatically requires a $10.00 penalty to be paid in addition to any interest due.

   d. Interest is calculated on a calendar day basis.

   e. 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.

   f. 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 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 outlined in Policy "Claims Processing".

[6] 28 CCR § 1300.71.38
[7] Ibid.

H. 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, "Claims Processing - Health Plan Claims Appeals."[8]

I. 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.

J. No retaliation can be made against a Provider who submits a dispute in good faith.[9]

K. 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.[10]

L. Payors must track and report all disputes received and submit monthly summary reports to IEHP. 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.[11]

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[8] 28 CCR § 1300.71.38
[9] Ibid.
[10] Ibid.
[11] Ibid.

13. CLAIMS PROCESSING

E. Health Plan Claims Appeals

APPLIES TO:

A. This policy applies to all IEHP Covered 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 15 working days of receipt.

D. IEHP reviews the appeal to determine the appropriateness of the denial/reduction and renders a decision within 45 working days of receipt of all necessary information.

DEFINITION:

A. Provider of Service - 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.

B. Delegate - An organization authorized to perform certain functions on IEHP's behalf.

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. 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 13D, "Claims Processing - Provider Dispute Resolution Process - Initial Claims Disputes."

C. 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.

D. IEHP will acknowledge the appeal by issuing a letter to the Provider within 15 working days of receiving the appeal.

E. 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 – Claim Appeal Resolution 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 Payor should indicate the phone number called, the date and time call was made, and whom the Provider spoke to, if applicable.

   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 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.

F. 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.

G. Once IEHP receives all necessary documentation, the appeal undergoes review.

H. 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 expedited.

I. 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 45 working days of receipt of the appeal.

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.

13. CLAIMS PROCESSING

E. Health Plan Claims Appeals

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13. CLAIMS PROCESSING

F. Claims and Compliance Audits

APPLIES TO:

A. This policy applies to all IEHP Covered 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.

***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:

1. Delegates are paying and denying claims and resolving Provider disputes in accordance with regulatory and contractual requirements.
2. Delegates 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

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 13G, "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 13G, "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. The required reports, See Policy 20G, "Claims and Provider Dispute Reporting," are:
   a. Quarterly Provider Dispute Resolution (PDR) Report
   b. Quarterly Statement of Deficiencies Report
4. IEHP reserves the right to request additional reports as deemed necessary.
5. 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 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 appeal 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 include a Webinar Audit and may include an on-site review.
2. Webinar Audit: Approximately two (2) weeks prior to the scheduled audit, Delegates must submit the following detailed reports and documents, 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
h. Operational Questionnaire
i. Bank Statements

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. Signed Check Mailing/Attestation or Log
   e. Customer Service Inquiry/Call Log
   f. IEHP also reserves the right to request a dditional 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. Disputed claims
      d. Post-Payment Adjustments
      e. Interest Paid on late paying, adjusted or disputed claims
      f. Overpayment Recovery Requests (refunded, retracted, or disputed).
      g. 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) 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 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 system and/or other systems 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 consecutively pass three (3) of the five (5) cases selected from each universe in order to pass the UIA. A failed UIA may 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 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 90 day lag for contracted providers and 180 day lag for non-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 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 date of the audit confirmation letter 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-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 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 an Immediate Corrective Action Required, Corrective Action Required, Observation or Invalid Data Submission as described below:

1. Immediate Corrective Action Required (ICAR) – An ICAR is the result of a systemic deficiency identified during an audit that is so severe that it requires immediate correction. An ICAR is not typically a finding in a routine Claims Audit, but it may be included when significant non-compliance claim issues are found, e.g., a provider who is fraudulently billing claims or creating authorization documentation.

2. 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.

3. 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.
4. Invalid Data Submissions (IDS) – An IDS condition is cited when a Delegate fails to produce an accurate universe within three (3) attempts.

M. Within 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. If the Delegate submits a rebuttal, the rebuttal and supporting documentation is reviewed by the Auditor. Only new information not previously provided (or requested but not provided) during the audit will be considered when reviewing the rebuttal. If the Auditor disagrees with the Delegate, the rebuttal is forwarded to IEHP's Oversight Review Team for review and response.

O. 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).

P. 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 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.

Q. 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 15 days after the IEHP rejection letter is issued. IEHP evaluates the revised CAP within 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.

R. 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 4% 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.

S. CAP verification audits are performed to verify the successful implementation of the Delegate's corrective action plan submitted as a result of 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 up to a 4% 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 12 months thereafter.

T. Delegates who were not required to submit a CAP as a result of their annual audit are scheduled for the next annual audit approximately 12 months from the date of the last audit and every 12 months thereafter; subject to the focused or verification audit provisions noted herein.

U. 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.

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13. CLAIMS PROCESSING

G. Claims and Provider Dispute Reporting

APPLIES TO:

A. This policy applies to all IEHP Covered 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.

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 – all 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.
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 and quarterly 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.

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).
    d. Redirected Claims.
2. Refer to attachment, "CCA Universe Layout Instructions" in Section 13 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).
    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 10/1/2023 through 12/31/2023 would be due January 30, 2024) and must be signed by the Designated Principal Officer.

F. 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, "CCA Universe Layout Instructions" found on the IEHP website[1]).

1. Paid Claims Report.
2. Denied Claims Report.
3. Overpayments Report.
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.

[1] https://www.iehp.org/en/providers/provider-resources?target=forms

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.

G. 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.

H. 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 (PET) and contract renewal process. Failure to submit complete and accurate reports within the specified timeframes may impact contract renewal terms.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
Revision Effective Date:		