20. CLAIMS PROCESSING

A. Claims Processing

APPLIES TO:

A. This policy applies to IEHP and its Delegates (Payers) delegated for claims payment for IEHP DualChoice (HMO D-SNP).

POLICY:

A. All claims must be paid or denied in accordance with all federal and state laws, regulations and the contract between the Centers for Medicare and Medicaid Services (CMS), California Department of Health Care Services (DHCS), and IEHP.

B. Payers are delegated the responsibility of claims processing for non-capitated services and are subject to review by IEHP. IEHP provides oversight of the Payers by monitoring, reviewing, and measuring claims processing systems and payment appeals to ensure timely and accurate claims processing and appeal resolution.

C. Delegates are required to submit initial clean or corrected claims in accordance with the provisions outlined in their contract with the Payer.[1] If the contract is silent on a timeframe for submission or the Provider of Service is non-contracted, the Provider of Service has 12 months from the date of service to submit an initial clean or corrected claim.[2]

D. Misdirected claims must be forwarded to the appropriate financially responsible Payer within 10 calendar days of receipt.

E. Payer must pay clean claims for non-contracted providers rendering services to IEHP Members within 30 calendar days of receipt of the claim. All other claims for non-contracted providers must be paid or denied within 60 calendar days of receipt.[3] Calendar day timeframes include all Holidays and weekends. Payment to contracted Providers should be made in accordance with the provisions outlined in their contract with the payer.

F. If the Payer pays clean claims from non-contracted providers after 30 calendar days, interest must be paid at the rate used for such late payments.[4]

G. Payer is expected to identify and recover overpayments resulting from a payment error or when it has been determined that the Provider of Service or Member was liable for the services, in accordance with federal regulations.

PROCEDURES:

A. Payer must have written procedures for claims processing that are available for review. In addition, Payer must disclose claim filing directions, payment rates and disposition of Provider payment disputes in accordance with Policy 20A2, "Claims Processing - Provider Payment Dispute Resolution." These written procedures and disclosures must comply with

[1] Title 42 Code of Federal Regulations (CFR) § 422.520(a)(2)
[2] 42 CFR § 424.44 (a)(1)
[3] 42 CFR § 422.520(a)(2)
[4] Ibid.

federal regulations and IEHP contractual standards and requirements. Such disclosures must also be made available upon request to Providers of Service, IEHP or a regulatory agency.

B. Payers' claims processing systems must identify and track all claims and payment disputes by line of business and/or program and be able to produce claims and dispute related reports as outlined in Policy 20F, "Claims and Payment Appeal Reporting."

C. Delegates are allowed up to 365 days from the date of service or date of discharge to submit a new or corrected claim.[5]

1. Claims received after 365 days from the date of service or date of discharge are not deemed payable.[6]

2. New or corrected claims received after the filing deadline are reconsidered for payment only when the Provider of Service has submitted an explanation of the circumstances as outlined in Policy 20A2, "Claims Processing - Provider Payment Dispute Resolution" surrounding the late filing, or the Provider of Service believes IEHP or the Provider are responsible due to an administrative error.

D. Payers must redirect claims that are not their financial responsibility to the appropriate responsible party within 10 calendar days of receipt.

1. If the Member cannot be identified or the financially responsible entity is not affiliated with the Payer's network, the claim may 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

2. All redirected claims must be tracked and reported as outlined in Policy 20F, "Claims and Payment Appeal Reporting."

E. Clean claims are those claims and attachments or other documentation that includes all reasonably relevant information necessary to determine Payer 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 clean claim,[7] the claim should be prepared in accordance with The National Uniform Billing Committee and The National Uniform Claim Committee standards and should include,[8] but is not limited to the following information:

1. A claim form or Electronic Data Interchange (EDI) file that contains:

a. A description of the service rendered using valid Current Procedural Terminology (CPT), National Drug Code (NDC), International Classification of Diseases (ICD) codes, Healthcare Common Procedure Coding System (HCPCS), Revenue codes and/or Present on Admission (POA) indicator as applicable. Additionally, the

[5] 42 CFR §424.44 (a)(1)
[6] Ibid.
[7] 42 CFR § 422.520
[8] 42 CFR § 422.500 (b)(1&2)

number of days or units for each service line, the place of service code, the type of service code and the charge for each listed service must be indicated.

b. Other claim specific information as dictated by Medicare for Provider of Service type (i.e., Hospital, lab, etc.);

c. Member (patient) demographic information, which must, at a minimum, include the Member's last name, first name and date of birth;

d. Provider of Service name, address, state license number, tax identification number; Medicare Health Insurance Claim Number (HICN), and National Provider Identifier (NPI) number and National Supplier Clearing House Number, if applicable;

e. Information pertaining to existence of another Payer, if applicable;

f. Valid date(s) of service;

g. Amount billed;

h. Signature (or signature on file) of person submitting claim; and

i. Medicare Providers billing for dual eligible (Medicare & Medi-Cal) Members are required to submit the National Drug Code (NDC) 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. Other documentation necessary to adjudicate the claim, such as medical records, claims itemization or detailed invoice, medical necessity documentation, other insurance payment information and referring Provider information (or copy of referral) as applicable.

F. If a non-contracted provider claim is missing required information or requires additional information to complete the claim, the claim will be developed as follows:

1. The Payer must make at least two (2) attempts to obtain the missing information by sending a written notice to the Provider of Service requesting the missing information or other reasonably relevant information necessary to determine Payer liability within 60 calendar days after the date of receipt.[9] If the Payer does not receive the requested information from a Provider of Service after two (2) attempts, the Payer must review the claim and make a decision to pay or deny the claim based on available information. For non-contracted providers, any subsequent payment or denial must be issued within 60 calendar days of receipt of the claim. For contracted Providers, refer to the contract with the payer.[10]

2. Payers must establish administrative processes for claim determination and reimbursement for the following covered services rendered to an IEHP Member:

[9] Medicare Managed Care Appeals Grievance (MMCAG) – 10.6
[10] Ibid.

3. Ambulance services dispatched through 911;
4. Emergency services;[11]
5. Urgently needed services;
6. Post-stabilization care services obtained within or outside the organization that are pre-approved by a Contractor's provider or other Contractor representative or are administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further Post-Stabilization Care Services.;
7. Renal dialysis services when the Member is temporarily out of the service area;
8. Services for which coverage has been denied by the Payer but found to be services the Member was entitled to upon appeal;
9. Services obtained from a non-contracted provider when the services were authorized by IEHP; and
10. Services obtained from a non-contracted provider when the services were referred by a contracted Provider.

G. Payers must coordinate benefits and follow Medicare Secondary Payer rules as outlined in Policy 20E, "Coordination of Benefits." Claims submitted for secondary payment must follow the submission timeframes stated in Procedure D, from the date of the primary Payer's notice of payment or denial in order to be considered timely.

H. Clean claims from Delegates rendering services to IEHP Members must be paid within 30 calendar days of receipt, or 60 calendar days for all other claims that do not meet the definition of "clean claims."[12]

1. Non-contracted claims that do not meet the clean claim requirement may require additional information from the Provider of Service to develop the claim. This includes but is not limited to requests for additional information from the physician/supplier or other external source such as routine data omitted from the claim, medical information, or information to resolve discrepancies.[13]
2. 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.[14] In cases of a misdirected claim, the date of receipt is the date the claim is first received by IEHP. Claims with multiple date stamps should be deemed priority and processed immediately.[15]

[11] 42 C.F.R. § 438.114(c)
[12] Ibid.
[13] Ibid.
[14] Title 28 California Code of Regulations (CCR) § 1300.71 (6)
[15] Ibid.

3. Payment timeliness standards are based on the timeframe from the initial date of receipt of the claim (e.g., EDI receipt date or paper claim date stamp) until the payment or denial is transmitted or mailed to the Provider of Service.[16]
4. The payment date used to meet timeliness standards is the actual date the check is mailed, or payment is electronically deposited into the Provider of Service's account.[17]

I. Reimbursement for services rendered to an IEHP DualChoice Member by a non-contracted provider is as follows:

1. IEHP applies National Correct Coding Initiative (NCCI) edits for claims processed.

   NCCI edits consist of two (2) 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 gallbladder or more than one appendix).

2. Physicians are paid using the lesser of the billed charges, or the Medicare Physician Fee Schedule (MPFS)
3. Acute Care hospitals are paid a DRG amount using the Medicare prospective payment system (PPS) in all States except Maryland per CMS guidelines.

   a. When IEHP coverage begins during an inpatient hospital stay:

      1) The member's previous Medicare Fee for Service or Medicare Advantage health plan will continue to pay for inpatient hospital services until the discharge date. IEHP is not responsible for inpatient hospital services until after the Member's discharge.

      2) IEHP is responsible for non-hospital charges incurred during an inpatient stay beginning on the date the Member is eligible with IEHP.

   b. When IEHP coverage ends during an inpatient hospital stay and the Member becomes eligible under another Medicare Fee for Service or Medicare Advantage health plan:

      1) IEHP is responsible to pay for inpatient hospital services until the discharge date.

      2) IEHP is not responsible for non-hospital charges incurred during the remainder of the inpatient stay.

[16] Ibid.
[17] 28 CCR 1300.71 (6)

4. Skilled Nursing Facilities (SNF), Home Health, Outpatient Hospital Services, Long Term Acute Care Hospital, Acute Psychiatric and Acute Rehab Facility claims are paid at PPS methodology.
5. End Stage Renal Disease Facilities are paid, for certain routine services, an amount called a composite rate. Composite rates are geographically adjusted to patient specific parameters.
6. Ambulance Services are paid based on the ambulance fee schedule.
7. Ambulatory Surgery Centers (ASC) are paid on a fee schedule comprised of wage adjusted payment groups. ASC payments have limits based on the hospital Order of Determination of Payment (OPD) rates.
8. Clinical Lab claims are generally based on the lab fee schedule.
9. Part B Drugs are mostly included in PPS reimbursement methodology or on cost but are based on a percentage of the Average Sales Price (ASP) methodology. If no ASP rate is available a specific procedure code, the Wholesale Acquisition Cost + 5% will be used.
10. Critical Access Hospitals (CAH) - Payment determination is based upon the billing hospital to submitting a copy of their most recent interim rate letter from their Medicare Fiscal Intermediary (FI).
11. Federally Qualified Health Centers (FQHC) - FQHCs are paid an all-inclusive rate (AIR) for primary health services and qualified preventive health services. Beginning on or after October 1, 2014, FQHCs will transition to the FQHC prospective payment system (PPS) as required by Section 10501(i)(3)(B) of the Affordable Care Act.[18]
12. 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.
13. For services provided on or after January 1, 2018, IEHP shall reimburse Indian Health Facilities (IHF) who provide Covered Services to Indian Enrollees, who are eligible to receive services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Facilities, and IEHP shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Facilities.[19]
14. 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 PPS rate.[20]
15. 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)".

[18] Coordinated Care Initiative (CCI) Three-Way Contract, Section - 2.10
[19] Ibid.
[20] 42 USC 1395w-4(e)(6)(A)(ii)

16. IEHP will not pay for an item or service with respect to any amount expended for which funds may not be used.[21]

J. If the Payer fails to pay a clean claim from a non-contracted Provider of Service within 30 calendar days after receipt, the Payer must pay interest at the rate used for such late payments.[22]

1. Interest rates are updated twice annually on January 1st and July 1st.
2. Interest accrues beginning on the first calendar day following 30 calendar days from the date of receipt until the date the check is mailed or electronically deposited into the Provider of Service's account.

K. Denial notification must be sent within timeframes stated in Procedure I for paying or denying a claim, accompanied by a paper or electronic Remittance Advice or Explanation of Benefits. The date of denial notification is the date the denial notice is mailed to the Provider of Service or Member.

1. Any claim that is denied must include an accurate and clear written explanation of the actions taken. Both the Provider of Service and Member must be notified of the denial.
2. All denial notifications and the Remittance Advice or Explanation of Benefits, to the Provider of Service must include mandated language and be properly formatted in accordance with Medicare specifications, See Attachments/ "Notice of Denial of Payment – English", "Notice of Denial of Payment – Spanish", "Notice of Denial of Payment – Chinese", and "Notice of Denial of Payment – Vietnamese" found on the IEHP website[23]. Accompanied with the Notice of Denial of Payment is a Non-Discrimination Tagline (See Attachment/"Non-Discrimination Tagline" found on the IEHP website[24]) which states Inland Empire Health Plan (IEHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. At a minimum, the denial notification must:
   a. Use approved notice language in a readable and understandable format;
   b. State the specific reason for the denial;
   c. Inform the Member of his or her right to reconsideration of the payment determination;
   d. For non-contracted provider claim denials, the standard appeal process, See Policy 20A1, "Claims Processing - Claims Appeals – Denied Claims. For non-contracted provider payment disputes, the standard payment dispute process, See Policy 20A2, "Claims Processing – Provider Payment Dispute Resolution"; and
   e. Comply with any other notice requirements specified by CMS/DHCS.

[21] Assisted Suicide Funding Restriction Act of 1997
[22] 42 CFR § 422.520
[23] https://www.iehp.org/en/providers/provider-resources?target=forms
[24] Ibid.

3. The denial notification must incorporate appropriate denial reason language (see Attachment "ICE – Claim Denial Reason Guide –IEHP DualChoice" found on the IEHP website[25]).

L. Payer must establish processes to redirect a non-contracted provider appeal to IEHP within five (5) business days. IEHP's Provider Relations Team is available from 8:00am - 5:00pm, Monday through Friday at (909) 890-2054 to assist and answer any questions related to claims processing.

1. The responsibility for claims payment as outlined above continues until all claims have been paid or denied for services rendered during the timeframe an IPA Capitated Agreement existed.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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[25] https://www.iehp.org/en/providers/provider-resources?target=forms

20. CLAIMS PROCESSING

A. Claims Processing

1. Claim Appeals - Denied Claims

APPLIES TO:

A. This policy applies to Non-Contracted Providers (NCP).

POLICY:

A. This policy defines the process by which IEHP ensures that Non-Contracted Providers (NCP) have clear and reliable access to an Appeal process that meets the regulatory requirements established for Integrated Plans (Medicare and Medicaid) by the Centers for Medicare & Medicaid Services (CMS).

B. "Non-Contracted Provider" (NCP) 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 health care services and does not have a signed contract or letter of agreement to provide services directly to the Member IEHP.

C. Only Members or their authorized representative (including a Provider of Service filing on behalf of the Member), may initiate an appeal. NCP of services may file a payment appeal if they have furnished a covered service to a Member and complete a waiver of liability (WOL) statement indicating that they will not bill the Member regardless of the outcome of the case.

D. Appeals are requests for reconsideration of a claim denial and are required to be submitted to IEHP within 60 days of the denial notice.

E. An NCP is required to submit a signed WOL when submitted a reconsideration to IEHP.

F. IEHP will process all NCP claims payment disputes as Appeals that meets the regulatory requirements within 30 calendar days of receipt of the WOL as established by CMS for Integrated Health Plans CMS.

G. IEHP shall notify an NCP of the Appeal process:

1. In all RAs;

2. On the IEHP Website at www.IEHP.org; and

3. Upon request by the NCP.

H. IEHP will not review an Appeal from an NCP until IEHP receives a signed WOL. If IEHP does not receive the WOL by the end of the 30 calendar days, IEHP will issue a dismissal notice to the NCP.

I. IEHP Contracted Providers do not have the right to appeal. Contracted Providers need to follow the terms of their contract.

20. CLAIMS PROCESSING

A. Claims Processing

1. Claim Appeals - Denied Claims

PROCEDURES:

A. Organization Determinations include, but are not limited to the following situations:

1. A reopening, which leads to a fully or partially adverse determination.
2. Diagnosis code/DRG payment denials: an NCP submits a claim to IEHP. IEHP initially approves the claim, which is considered a favorable organization determination (pursuant to Title 42 Code of Federal Regulations (CFR), section 422.566(b)). IEHP later reopens and revises the favorable organization determination and denies the DRG code on the basis that a different DRG code should have been submitted and recoups funds;
3. Downcoding: IEHP approves coverage for inpatient services from a NCP, which is considered a favorable organization determination (pursuant to Title 42, CFR section 422.566(b)). IEHP later reopens and revises the favorable organization determination (e.g. retrospective review) and determines the Member should have received outpatient services; and
4. Bundling issues and disputed rate of payment: Pre- and post-pay bundling and global payment determinations. For example, denial of procedure codes – as mutually exclusive to another, or due to inclusion in a previously paid global surgical package.
5. Level of care or rate of payment details: Payment of a reduced fee schedule amount for a visit, but IEHP reimburses based on a lower level of care.

B. Appeals are related to the initial determination of a claim denial.

C. Members, their authorized representative or Providers of Service acting on behalf of a Member must submit all appeals in writing to IEHP within 60 calendar days from the date of a denial. The denial may be in the form of a written adverse determination from the Payer or an Explanation of Benefits (EOB) or Remittance Advice (RA). Justification and supporting documentation must be provided with the written appeal, as outlined in Procedure H below.

D. IEHP may accept a request for reconsideration of an appeal filed after 60 calendar days if the Member, the Member's authorized representative or NCPs of service submits a written request for an extension of the timeframe for good cause.

Examples of circumstances where good cause may exist include (but are not limited to) the following situations:

1. The Member did not personally receive the adverse organization determination notice, or he/she received it late
2. The Member was seriously ill, which prevented a timely appeal
3. There was a death or serious illness in the Member's immediate family
4. An accident caused important records to be destroyed

5. Documentation was difficult to locate within the time limits
6. The Member had incorrect or incomplete information concerning the reconsideration process
7. The Member lacked the capacity to understand the timeframe for filing a request for reconsideration

E. NCPs or suppliers of service may file a payment appeal if they have furnished a covered service to a Member and complete a waiver of liability statement indicating they will not bill the Member regardless of the outcome of the case (See Attachment/"Medicare Waiver of Liability Statement" found on the IEHP website[1]).

F. NCP appeals and signed waiver of liability must be submitted to IEHP in accordance with the appeal process guidelines to:

IEHP Medicare CMC Appeals and Resolution Unit
P.O. Box 40
Rancho Cucamonga, CA 91729

G. Written appeals must include:

1. The IEHP DualChoice (HMO D-SNP) health insurance claim number and Member identification number.
2. Specific service(s) and/or item(s) for which reconsideration is being requested including the date(s) of service.
3. The name and signature of the party or the representative of the party filing the appeal.
4. A clear explanation of why the appealing party disagrees with Payer's initial determination and expected outcome.
5. Signed Waiver of Liability Form.
6. Any supporting documentation the appealing party wants to be considered, including the claim and the original payment determination.

H. If the NCP fails to submit a signed WOL form after two (2) attempts by IEHP, the NCP will be notified that IEHP has dismissed their Appeal due to lack of the WOL, no sooner than 30 calendar days from the receipt of the request. The Notice of Dismissal of Appeal Request shall inform the NCP of the process and the right to request a review of the dismissal by the Independent Review Entity (IRE).

I. Failure to respond to the request for a WOL and/or submit a written request for an extension of the submission timeframe for good cause will result in a dismissal of the appeal. A dismissal

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

letter (See Attachment/"Notice of Dismissal of Appeal Request" found on the IEHP website[2]) will be sent to the Provider of Service following 30 calendar days after receiving the request for reconsideration.

J. IEHP will commence review of the Appeal upon receipt of the signed WOL form or letter of good cause, as applicable, and the review shall be completed within 30 calendar days of that the receipt date.

K. Upon completion of review of the Appeal, IEHP shall send a resolution letter to the NCP informing the NCP of the review decision within 30 calendar days of receipt of the signed WOL form.

1. The information must be forwarded to the IRE within five (5) calendar days of the determination or within 30 calendar days of receipt of the appeal from the appealing party, whichever occurs first.
2. The IRE will make a decision on the payment appeal in accordance with CMS contracted timeframes.
3. The IRE may request additional information, and upon receipt of such request, IEHP and/or the Payer must make every effort to provide the requested information within the timeframe specified by the IRE.
4. If the IRE upholds the original adverse determination, the IRE will notify the Member and other parties to the appeal in writing of such decision following CMS guidelines.
5. If the IRE reverses or partially reverses the original adverse determination, the IRE notifies the Payer and the payer in turn must notify the appealing party of the decision.
6. If payment is required as a result of the IRE, the IRE notifies the Payer of the requirement to pay the claim. Payment must be issued within 30 calendar days of receipt of the decision by the IRE. No interest is due on favorable payment determinations made by the IRE.

L. Failure of IEHP to provide the NCP with a decision within the 30 calendar day period constitutes an adverse decision and IEHP shall forward the Appeal to the IRE for review.

M. An Appeal decision which upholds in whole, or in part, the initial denial shall be forwarded to the IRE for review.

N. At any point in the process, the appealing party may bypass IEHP and submit an appeal directly to Maximus, the CMS Independent Review Entity (IRE). Additionally, any party to the appeal may withdraw the appeal at any point in the appeal process.

O. No retaliation can be made against a Member or Provider of Service who submits an appeal in good faith.

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

P. Copies of all appeals and related documentation must be retained for at least 10 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.

Q. Payers must track and report all appeals received in accordance with Policy 20.F, "Claims and Payment Appeals Reporting" and Policy 21.B, "CMS Medicare Part C Reporting Requirements."

R. IEHP tracks, trends and analyzes appeals data, taking into account information from all other sources, including Payers, and presents such information to the IEHP Governing Board with recommendations for intervention, as appropriate.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	July 1, 2012	
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20. CLAIMS PROCESSING

A. Claims Processing
2. Provider Payment Dispute Resolution

APPLIES TO:

A. This policy applies to all Providers of Service that render services to IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Financially responsible Payors must establish and maintain a process that addresses the receipt, handling and disposition of a payment dispute in accordance with applicable statutes, regulations and contractual requirements.

B. Non-contracted providers or suppliers of service may file a payment dispute. All Provider Payment Dispute Resolutions (PDR) must be submitted to the Payor 120 days from the initial determination.

C. If a decision to overturn is made, the payment must be issued at the time of determination and include any applicable interest payment calculated from the initial received date of the claim.

D. PDRs are requests for reconsideration of an adverse payment decision or denial by the Payor that affects the care rendered to a Member. Grievances are separate and distinct from disputes and the disputes process. Upon receipt of a complaint or grievance, the Payor must inform the Member whether the case is subject to IEHP's grievance or appeals/reconsideration process. If a case clearly has components of both a grievance and an appeal, the Provider must process as parallel cases to the extent possible.

PROCEDURES:

A. 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 payment disputes and are handled in accordance with Policy 20C, "Claims Deduction From Capitation – 7 Days Letter."

B. PDRs relate to the initial determination of a payment decision and are primarily requests for additional payment by a non-contracted provider only.

1. Any dispute involving contracted Primary Care Provider (PCP) or Pay For Performance (P4P) reimbursements should be filed in accordance with the guidelines provided in Policies 19.C1, "Pay For Performance (P4P) – Medicare DualChoice Annual Visit" and 19.C2, "Pay For Performance (P4P) – Medicare P4P IEHP Direct Program."

2. Any appeal involving a determination unrelated to a claim should be filed in accordance with the guidelines provided in Policy 16.C1, "Grievance and Appeal Resolution Process for Providers – Initial."

3. Grievances and appeals are separate and distinct. If the documentation submitted is considered to be a grievance, Payors must resolve it in accordance with their grievance

policies and procedures as outlined in Policy 16.C1, "Grievance and Appeal Resolution Process for Providers - Initial" or 16.A, "Member Grievance Resolution Process."

C. Non-contracted providers of service must submit all payment disputes in writing to the Payor within 120 calendar days from the initial determination date of the denial notice or other adverse payment determination from the Payor. The denial is in the form of a written adverse determination from the Payor. Justification and supporting documentation must be provided with the written dispute, as outlined in Procedure F below.

1. If a Provider or supplier has failed to establish a good cause for late filing of a Provider dispute, the Payor may dismiss the Provider dispute as untimely filed. The Payor's notification must explain the reason for dismissal and that the Provider or supplier has up to 180 calendar days from the date of the notification to provide additional documentation for good cause.
2. If Provider or supplier submits evidence within 180 calendar days of dismissal that supports a finding of good cause for late filing then the Payor makes a favorable good cause determination and issues a redetermination.
3. If the Payor does not find good cause, the dismissal remains in effect and Payor issues a letter explaining that good cause has not been established.

D. Payors may accept a PDR request filed after 120 calendar days if the non-contracted provider of service submits a written request for an extension of the timeframe for good cause.

E. Written disputes must be submitted to the Payor in accordance with the PDR process guidelines issued by the Payor.

1. For PDRs involving IEHP as the Payor, disputes must be sent to:

IEHP Medicare CMC Appeals
P.O. Box 40
Rancho Cucamonga, CA 91729-4319

2. Written payment disputes to the Payor must include:
   a. IEHP DualChoice (HMO D-SNP) health insurance claim number and Member identification number.
   b. Specific service(s) and/or item(s) for which reconsideration is being requested including the date(s) of service.
   c. The name and signature of the party or the representative of the party filing the dispute.
   d. A clear explanation of why the party disagrees with Payor's initial determination and should include any supporting documentation the appealing party wants to be considered with the dispute.
3. If supporting documentation is not available or the Payor does not have enough

information to make a determination on the PDR, the Payor may send a request for additional information to the Provider of Service. If the Provider of Service fails to provide requested information within seven (7) calendar days of the request, the Payor must make a determination on the information available.

F. Payors must send written notice of the resolution, including pertinent facts and an explanation of the reason for the determination, within 30 calendar days of the receipt of the PDR. The notification must be sent to appealing party.

1. Written notification of affirmative (uphold) determinations, whether in whole or in part, must be written in a manner easily understood by the Provider of Service and include:

   a. A clear statement indicating the extent to which the redetermination is favorable or unfavorable.

   b. A summary of the facts, including, as appropriate, a summary of the clinical or scientific evidence used in making the redetermination.

   c. A summary of the rationale for the redetermination in clear, understandable language.

   d. The procedures for obtaining additional information concerning determinations, such as specific provisions of the policy, manual or regulation used in making the determination.

   e. Any other requirements specified by CMS.

G. If the written determination results in payment, payment must be made within 30 calendar days of receipt of the PDR, which is concurrent with the written determination. Interest must be paid for non-contracted providers if the original claim was underpaid in error.

H. If the determination is to affirm or uphold the initial payment determination, the Payor must send a written determination to the appealing party informing them of the decision.

I. If IEHP receives an initial payment dispute directly for which another Payor is financially responsible, IEHP will forward the dispute to the Payor for resolution, as applicable and notify the involved parties.

J. Members or Providers of Service not satisfied with the initial determination by the Payor where the determination is related to medical necessity, utilization management or pre-service referral denials or modifications may submit a written dispute to IEHP within 60 calendar days, for review as outlined in Policy 16.C1, "Grievance and Appeal Resolution Process for Providers – Initial."

K. No retaliation can be made against a Member or Provider of Service who submits an appeal in good faith.

L. Copies of all PDRs and related documentation must be retained for at least 10 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.

M. Payors must track and report all PDRs received in accordance with Policy 20.F, "Claims and Payment Appeal Reporting."

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	July 1, 2012	
Revision Effective Date:	January 1, 2023	

20.CLAIMS PROCESSING

B. Billing of IEHP Members

APPLIES TO:

A. This policy applies to all DualChoice (HMO D-SNP) Providers.

POLICY:

A. A Provider, as defined in this policy, must not submit claims to or demand or otherwise collect reimbursement from a an IEHP DualChoice (HMO D-SNP) beneficiary, or from other persons on behalf of the beneficiary, for any service included in the IEHP DualChoice (HMO D-SNP) program's scope of benefits.

PROCEDURES:

A. Providers who accept an IEHP DualChoice (HMO D-SNP) Member as a patient shall accept payment from IEHP, its health network or medical group as payment in full for DualChoice (HMO D-SNP) covered services.

B. Providers are prohibited from billing a DualChoice (HMO D-SNP) Member for services including, but not limited to:

1. DualChoice (HMO D-SNP) covered services (inclusive of both Medicare and
2. Medi-Cal benefits).
3. Covered services once the Member meets his or her share of cost requirements.
4. Pended, contested, or disputed claims.
5. Fees for missed, broken, cancelled or same day appointments.
6. Copayments, coinsurance, deductible or other cost sharing required under a
7. Member's other health coverage.
8. Fees for completing paperwork related to the delivery of care.

C. Provider may bill a Member only for non-covered services (not covered by Medicare or Medi-Cal) DualChoice (HMO D-SNP) 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.

D. 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 16.A, "Member Grievance Resolution Process."

E. IEHP will take disciplinary action against contracted and non-contracted Providers that continue to inappropriately bill IEHP Members including but 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.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

20. CLAIMS PROCESSING

C. Claims Deduction From Capitation - 7-Day Letter

APPLIES TO:

A. This policy applies to all IEHP Capitated Providers who have been delegated to pay claims for IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Payors must pay clean claims for non-contracted providers rendering services to IEHP DualChoice (HMO D-SNP) Members within 30 calendar days of receipt of the claim. All other claims must be paid or denied within 60 calendar days of receipt. Calendar day timeframes include all holidays and weekends.

B. In the event the Payor fails to meet IEHP's claims processing standards as indicated above, IEHP may elect to pay these claims on behalf of the Payor by deducting such payment from the Payor's next monthly capitation check.

C. The 7-Day letter process is available for unpaid, underpaid and/or non-response to claims inquiries for up to one (1) year and 60 days following the date of service.

PROCEDURE:

A. The 7-Day letter is a tool used by IEHP to facilitate inquiries from Providers of Service related to claims issues involving alleged non-payment, underpayment or denial from the payor.

B. IEHP's 7-Day letter process is available for unpaid, underpaid and/or non-response to claims inquiries as follows:

   1. A Provider, supplier, or member notifies IEHP that no status has been provided on a claim submitted to the financially responsible payor that exceeds the timelines outlined in Policy A above.

C. Providers of service may avail themselves to the 7-Day letter process for up to one (1) year and 60 days after the date of service.

D. As outlined in Policy 20.A2, "Claim Process – Health Plan Claims Appeals" Providers of service must submit the 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. Providers are required to submit the following documents:

   1. A Clean Claim (See Attachments/"CMS 1500 Form" and "UB04 Inpatient & Outpatient Form" found on the IEHP website[1])
   2. Appeal Cover Letter from Provider
   3. Written Determination from the responsible Payor

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

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. Date and time verbal authorization given
    b. Diagnosis code(s) authorized
    c. Services authorized and associated coding
    d. Start date and end date of authorization
    e. Authorized provider or facility

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

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" found on the IEHP website[2]). 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. Providers must respond to all requested items on the 7-Day Letter request.

H. The following are examples of unacceptable responses to the 7-day letter:
1. Not Payor's Delegated 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).

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

20. CLAIMS PROCESSING

C. Claims Deduction From Capitation - 7-Day Letter

I. 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 Deduction" found on the IEHP website[3]).”

J. Claims capitation deductions are outlined on a detail report that is sent with the capitation payment.

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

20. CLAIMS PROCESSING

D. Claims and Compliance Audits

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Delegates.

POLICY:

A. IEHP provides oversight of claims processing by Delegates through monitoring, reviewing, and measuring claims payments and denial processes, Provider payment disputes and appeals 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, Provider payment disputes, adjustments, overpayment reports, personnel, written policies and procedures, contracts, management involvement and oversight, claims processing systems and functions, appeal processes 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 in order to bring them into 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 Delegates' monthly and quarterly reporting to IEHP.

B. Audits ensure:

1. Delegates are paying and denying claims and resolving Provider payment disputes in accordance with regulatory and contractual requirements.
2. Delegates have adequate system protocols in place to log, track, acknowledge, 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' policies and procedures are adequate to meet regulatory and contractual requirements and that such policies and procedures reflect actual operations.
5. Delegates' contracts with subcontracted Delegates include mandatory language pertaining to claims processing, appeals and other requirements outlined in state and

federal regulations.

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, in a format designated by IEHP.

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 is outlined in Policy 20F, "Claims and Payment Appeal Reporting".
2. By the 15th of each month Delegates must submit to IEHP a Payment Organization Determinations and Reconsiderations report for the previous month's activity, as outlined in Policy 20F, "Claims and Payment Appeal Reporting."
3. By the 30th of the month following the end of the quarter, for the previous quarter, Delegates must submit to IEHP the Quarterly Provider Payment Dispute Resolution Report. The report contains information regarding disputes and adjustments and is as outlined in Policy 20F, "Claims and Payment Appeal Reporting."
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 impact 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 discovery during an audit or through other means.
3. Excessive claims appeals that are overturned by IEHP.
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 and appeals, 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 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 the Delegate 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 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 a Payment Organization Determinations and Reconsiderations report covering the audit period, to IEHP for review and selection of claims.

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

1. Pended Claims (those pended for development)
2. Open Claims
3. Report or Log of Redirected Claims
4. Received Claims
5. Signed Check Mailing/Attestation or Log
6. Customer Service Inquiry/Call Log
7. IEHP also reserves the right to request additional reports and/or documents as deemed necessary.

H. 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 is as follows:
   a. Paid Non-Contracted Provider Clean Claims
   b. Paid Non-Contracted Provider Unclean Claims

c. Denied Non-Contracted Provider Claims

2. The claims 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 two (2) days. IEHP may also schedule a one (1) day on-site visit.
4. At the time of the on-site 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.

I. One (1) 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 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.

J. 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 Provider payment disputes.

K. 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.

L. If IEHP suspects fraud during the course of or subsequent to the audit, the findings are submitted to IEHP's Compliance Department.

M. 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 an IPA fails to produce an accurate universe within three (3) attempts.

N. 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 the Delegate disagrees with any of the findings listed in the report through the formal rebuttal process.

O. 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.

P. 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).

Q. 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 necessitates changes to the Delegate's written policies and procedures or workflow charts, copies of this information must be submitted along with the CAP.

R. 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. The Delegate must submit a revised CAP within 15days 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.

S. 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.

T. CAP verification audits are performed to verify the implementation of the Delegate's corrective action plan 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 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 12 months thereafter.

U. 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.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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20. CLAIMS PROCESSING

E. Coordination of Benefits

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Coordination of Benefits (COB) is the procedure to determine the order of payment responsibility when a Member is covered by more than one (1) health plan or insurer.

B. COB is applied in accordance with state and federal law governing COB, including the Order of Determination of Payment (OPD).

C. IEHP and its Delegates are responsible for identifying Payers that are primary to IEHP and must coordinate benefits for Members in accordance with state and federal law.

D. IEHP and its Providers must make reasonable efforts to appropriately determine payment of claims for covered services rendered to any Member who is fully or partially covered for the same service under any other state or federal program or some other entitlement such as a private group or indemnification program.

E. Medicare may be the secondary payer under Centers for Medicare and Medicaid Services (CMS) Medicare Secondary Payer requirements.

PROCEDURES:

A. IEHP pays Primary Care Providers capitation rates, as outlined in the IEHP Capitated Agreement for all Members assigned to them, regardless of other insurance coverage.

B. Unless otherwise indicated, if a Member has both Medicare and Medi-Cal, the claim is processed with Medicare as the primary and Medi-Cal as the secondary coverage.

C. If the Member has other health coverage in addition to Medicare and Medi-Cal, Medicare may be secondary based on CMS's COB rules and Medi-Cal may be tertiary.

D. If the Member has other primary health care coverage, the claim is adjudicated up to the lesser of the Medicare allowable amount or the primary payer's allowable amount. If the services are not covered by the primary payer, the Provider of Service must submit such claims with a denial letter or explanation of benefits from the primary health coverage.

E. The COB claim determination period is based on the period of time the Member is enrolled with IEHP. If the Member is not enrolled with IEHP on the date of service, COB is not applicable.

F. IEHP has the right to obtain and release COB information and may do so without the Member's or Authorized Representative's consent. Members must provide an insurer with any information needed to make COB determinations and to pay claims.

G. IEHP is the secondary payer under the below conditions listed:

   1. Items or services rendered to the Member are covered under a Workers' Compensation law or plan of the United States or state, or other tort liability such as homeowner's

liability insurance, malpractice insurance, product liability insurance or general casualty insurance.

2. Members are over the age of 65 and are covered by an employer group health plan as an employee or a spouse for an employer group with 20 or more employees.
3. Members covered under an employer group health plan because they are eligible for or entitled to benefits on the basis of end-stage renal disease (ESRD) during a period of up to 30 months if Medicare was not the proper primary payer for the Member on the basis of age or disability at the time the Member became eligible or entitled to Medicare on the basis of ESRD.
4. Members under age 65 entitled to Medicare on the basis of disability and are covered under a large group health plan (100 or more employees) on the basis of their own employment status or the current employment status of a family member.
5. If the Member is covered both as a dependent under the spouse's group health plan and as a non-dependent under another plan, such as a retiree plan, the group plan would pay first, Medicare would be second and the retiree plan third.

H. Medicare Secondary Payer rules supersede other federal and state law governing the coordination of benefits.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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20. CLAIMS PROCESSING

F. Claims and Payment Appeal Reporting

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Delegates.

POLICY:

A. IEHP provides oversight of claims processing by Delegates through monitoring of the Delegate's claims payments and denial processes, Provider payment dispute processes 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 and Payment Dispute 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 payment 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 whether denied in part or whole. This includes all claims denied for non-contracted and contracted Providers, as well as those in which the Member may be liable).
4. Pended Claims– all claims pended for development or in which a determination to pay or deny cannot be made without further information. Examples include claims forwarded for medical review or when additional information has been requested from external sources (i.e., Provider of Service, Member, etc.) in order to finalize the claim.
5. Claims Inventory – all claims received and open that have not been issued a payment or denial, whether or not entered in the claims system.
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 an adjustment has been made due to internal discovery, disputes or appeals, 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 Payment Disputes – all disputes received where the Provider is disputing an underpayment.
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 Payer or denied to the Provider of Service, whether or not entered in the claims system.
12. Emergency Services Claims – all claims received involving emergency services, regardless of outcome.
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. Check Mailing/Attestation – an accounting of all checks mailed per check run whether scheduled or not.

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 and/or designated format.

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. Each report must be reviewed and include a signed attestation as to the accuracy and validity of the report by a Designated Principal Officer.

D. Delegates must also submit to IEHP by the 15th of each month a Payment Organization Determinations and Reconsiderations report for the previous month's activity, (See Attachment/"Part C Organization Determinations, Appeals, and Grievances (ODAG) found on the IEHP website[1]").

E. On a quarterly basis, Delegates must submit a Quarterly Provider Payment Dispute Resolution Report. The report is due to IEHP by the 30th of the month following the end of the quarter (i.e., the quarterly report for the period 10/1/23 through 12/31/23 would be due on January 30, 2024).

F. As outlined in Policy 20D, "Claims and Compliance Audits", Delegates must also generate a universal report of paid and denied claims at the time of each annual audit, for claims selection and/or review, (See Attachment/"Part C Organization Determinations, Appeals, and Grievances (ODAG) found on the IEHP website[2]").

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

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

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.

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20. CLAIMS PROCESSING

G. Third-Party Liability

APPLIES TO:

A. This policy applies to all IEHP DualChoice HMO (D-SNP) Delegates.

POLICY:

A. Delegates may make claim for recovery for the value of covered services rendered to an IEHP DualChoice Member when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance, including Workers' Compensation awards and Uninsured Motorists coverage.

PROCEDURES:

A. After the claim has been paid and the Payor becomes aware of a claim involving Third Party Liability (TPL), the Payor may pursue recovery of any monies paid in accordance with the case and applicable law.

B. The Payor of a claim involving TPL must notify the primary insurance Payor and/or attorney through a formal lien letter of an intent to recover monies paid. Additionally, the Payor must provide an itemization of all related claims with the notification.

   1. Itemization should include the following information:
      a. Member First and Last Name
      b. Social Security Number
      c. Date of Birth
      d. Date of Injury
      e. Claim Numbers
      f. Dates of Service
      g. Amount Billed
      h. Amount Paid
      i. Current Procedural Terminology (CPT)/Revenue Code
      j. Modifier
      k. Diagnosis Code
      l. Provider of Service

C. The Payor may follow-up every 30 days from the date of the initial correspondence until resolution is complete.

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