20. CLAIMS PROCESSING

A. Claims Processing

APPLIES TO:

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

POLICY:

A. IEHP and its Capitated Providers must reimburse, contest, or deny all clean or corrected claims submitted by contracted and non-contracted Providers in accordance with this policy, unless the Plan and the contracted Provider have agreed in writing to an alternate payment schedule.[1]
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.[2]

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.[3] 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.[4]

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

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract
[2] Ibid
[3] California Health and Safety Code § 1371(a)(3)
[4] California Health and Safety Code § 1371(a)(3)

schedules and Provider dispute filing guidelines, via contract, written notification, - Explanation of Benefits (EOB), Remittance Advice (RA), or an Electronic Remittance Advice 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, .

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.[5]

1. If the claim was received electronically, acknowledgement must be provided within two (2) working days of receipt of the claim.[6]
2. If the claim was a paper claim, acknowledgement must be provided within 15 working days of receipt of the claim.[7]

D. Misdirected claims must be forwarded to the appropriate financially responsible entity within 10 working days of receipt. [8]

E. If a Capitated Provider determines that a claim has been overpaid, the Provider of Service must be notified in writing of the overpayment within 365 days from the date the original claim was paid.[9]

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 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 20H, "Provider Dispute Resolution Process – Initial Claims Disputes."

F. The claims processing systems for Capitated Providers must identify and track all claims and disputes by line of business and/or program, as well as claims related phone calls and inquiries, and be able to produce claims and dispute related reports as outlined in Policy 20G, "Claims and Provider Dispute Reporting."

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

G. All Capitated Providers must have a dispute resolution mechanism in place that allows Providers of Service to file a dispute within 365 days of payment or denial. All disputes must be acknowledged within two (2) working days if received electronically and 15 working days if a paper dispute was received. All disputes must be resolved within 45 working days of receipt of the dispute as outlined in Policy 20AH, "Provider Dispute Resolution Process - Initial Claims Dispute."[10]

H. 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

I. Contracted Providers of Service must be given at least 90 days from date of service to submit an initial clean or corrected claim. Non-contracted Medi-Cal providers of service have up to one (1) year from the date of service to submit an initial clean or corrected claim.[11]

J. Contracted Providers of Service must submit a claim (including any corrected claims) within the timely filing period specified in their Provider contract. A contracted Provider must allow a minimum of 90 days from the date of service to submit a claim.[12]

K. Non-contracted providers must submit a claim (including any corrected claims) within one (1) year from the date of service.[13] Non-contracted Medi-Cal providers of service must submit initial clean or corrected claims within 180 days after the month of service to be eligible for full reimbursement.

L. 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 4349
Rancho Cucamonga, CA 91729-4349

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

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

Claims Processing and Reimbursement

M. Capitated Providers must identify and acknowledge the receipt of all claims within two (2) working days if the claim was received electronically or within 15 working days if a paper claim was received.[14]

[10] Title 28 California Code of Regulations (CCR) § 1300.71
[11] Title 28 California Code of Regulations (CCR) § 1300.71
[12] Title 28 California Code of Regulations (CCR) § 1300.71
[13] Title 28 California Code of Regulations (CCR) § 1300.71
[14] Title 28 California Code of Regulations (CCR) § 1300.71

Initial clean or corrected claims may be submitted up to one (1) year from the date of service, subject to the following reductions for any claims received after one hundred 180 days:[15]

1. Claims received in the 7th through the 9th month, after the month of service, are subject to a payment reduction of 25%;
2. Claims received in the 10th through 12th month after the month of service are subject to a payment reduction of 50%;
3. Claims received beyond one (1) year from the date of service will be handled in accordance with Procedure N (below);
4. Timely filing reductions are applied only to non-contracted Medi-Cal providers and on original received claims. They do not apply to subsequent adjustments.

N. Initial clean or corrected claims received after the filing deadline will be denied unless substantiating documentation for good cause associated with the delay in billing or proof of timely filing is provided.[16] 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:

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 .
2. Copy of a written request for information or other written claim-related correspondence from IEHP or one of IEHP's Capitated Providers, dated and printed on letterhead or form letter with the date and letterhead clearly identified.
3. Determination letter from other insurance carriers or other financially responsible entities such as California Children's Services (CCS) or Medicare, dated and printed on letterhead, in which the date of determination is documented, that demonstrates the Provider originally presented the claim within the claims filing timelines permitted by law and/or written contractual agreement from the date of receipt of the determination.
4. Financial ledgers with multiple claim billings for the date of service in question, including name of the billed party (i.e., IEHP, Capitated Provider, Medicare, HMO, etc.).
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.

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

6. Other documentation that demonstrates good cause for the delay in being able to submit the claim timely.

O. 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.

   h. Medicare Providers billing for dual eligible (Medicare & Medi-Cal) Members are required to submit the NDCs for physician-administered drugs in order that this data can be crossed over to Medi-Cal. In addition to the NDC, the drug quantity must also be submitted on all dual eligible member claims as provided for by the National Uniform Claims Committee (NUCC).

2. Prior authorization documentation, such as an authorization number on the claim, a copy of the authorization form or referral form attached to the claim for services in which authorization is required.

3. If a paper or EDI claim is missing critical billing information, the claim will be rejected and a request for missing or invalid information will be sent to the submitter. Requests related to a paper claim submission will be sent in the form of a letter or Remittance Advice. Requests related to an EDI claim will be sent in the form of an ANSI 277 return file to the submitter.

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

1. Non-contracted provider claims - 90% within 30 calendar days, 99% within 90 calendar days, and 95% within 45 working days from receipt of the claim. [17,18]
2. Contracted Provider claims, 90% within 30 calendar days, 99% within 90 calendar days, and 95% within 45 working days from receipt of the claim, unless otherwise stated in the Provider contract.[19,20]

Q. 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 or denial is sent to the Provider of Service, regardless of when a check is dated.

The payment date used to meet timeliness standards is either the actual date a check is mailed, deposited into the Provider of Service's account, or transferred electronically. Proof of mailing must be maintained, including the date of mailing, the check number, and the check amount.

The date of receipt is the date the claim is first received by the financially responsible entity as indicated by its date stamp on the claim. In cases of a misdirected claim, the date of receipt is the date the claim is first received by the financially responsible entity. Claims with multiple date stamps should be deemed priority and processed immediately.

Late claim payment requires an additional payment of interest within five (5) working days of the claim payment date as described in section U below.[21]

R. Any claim, from a contracted or non-contracted Provider that is not paid at billed charges must include an explanation of the adjustment (e.g., contractual rate, non-covered service, included in other service, etc.), language prohibiting balance billing of the Member, and the process for filing a dispute of the paid, contested, or denied amount, on the Explanation of Benefits (EOB), Remittance Advice (RA) , or an Electronic Remittance Advice (X12 – 835 Health Care Claim Payment/Advice).

S. 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 two types:

a. Procedure-to-procedure (Column1/Column2) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons; and

b. Medically Unlikely Edits (MUE), which are units of service edits, that define for each HCPCS/CPT code identified, the allowable number of units of service; units of service in excess of this value are not feasible for the procedure under normal

[17] CA Health and Safety (Health & Saf.) Code § 1371(a)(1)
[18] California Welfare and Institutions Code (Welf. & Inst. Code), §14104.3 (3)
[19] CA Health and Safety (Health & Saf.) Code § 1371(a)(1)
[20] California Welfare and Institutions Code (Welf. & Inst. Code), §14104.3 (3)
[21] Title 28 California Code of Regulations (CCR) § 1300.71

conditions (e.g., claims for excision of more than one gall bladder or more than one appendix).

T. Reimbursement for services rendered to an IEHP Medi-Cal Member by a non-contracted provider are as follows:

1. For outpatient services, the Fee for Service rates specified in the Medi-Cal schedule of reimbursement (RFO500); or
2. Inpatient Facility claims from private inpatient general acute care hospitals, California non-designated hospitals and out-of-state hospitals are paid using an all-patient refined Diagnosis-Related Group (APR-DRG) payment methodology.

   Inpatient Facility claims resulting from an emergency admission, including Post-Stabilization Care Services are paid at an all-patient refined Diagnosis-Related Group (APR-DRG) payment methodology from private inpatient general acute care hospitals, California non-designated hospitals, and out-of-state hospitals.[22,23]

   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.
3. If a Member's IEHP coverage ends during an inpatient hospital stay, all services performed after their eligibility ends are not covered by IEHP.
4. For emergency services, the ER rate listed in the Medi-Cal schedule of reimbursement (RFO500).
5. If there are no CNMs, CNPs, or LNs in the Plan's network, IEHP and its' Capitated Providers will reimburse non-contracting CNMs, CNPs, or LNs for services provided to Members at no less than the applicable Medi-Cal FFS Rates. For hospitals, the requirements of Emergency Services and Post-Stabilization Care Services, if applicable, apply. For Free Standing Birthing Centers, IEHP or its' Capitated Providers must reimburse non-contracting Free Standing Birthing Centers at no less than the applicable Medi-Cal FFS Rate. If an appropriately licensed non-contracting Free Standing Birthing Center is used, IEHP or its' Capitated Providers also must pay the Center's facility fee.
6. For Family Planning claims, the family planning rates listed for the procedure codes and diagnosis billed as outlined in Senate Bill 94, effective January 1, 2008.
7. Professional and ancillary services are paid at the corresponding Medi-Cal schedule of reimbursement in effect at the time services were performed.
8. Federally Qualified Health Centers (FQHC) - FQHCs are paid at the FQHC prospective payment system (PPS) for primary health services and qualified preventive health

[22] 42 CFR 438.114(e), 442.11(c)(2), and 442.214

[23] Exhibit A Attachment III Section 3.3 Provider Compensation Arrangements, Subsection 3.3.16 Emergency Services

services.

If FQHC and RHC services are not available in-network or within the Plan's service area, IEHP will reimburse non-contracting FQHCs and RHCs for Covered Services provided to Members at a level and amount of payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a Provider which is not a FQHC or RHC.

9. Rural Health Clinic (RHC) - RHC's are paid the lesser of the provider specific AIR or a national per-visit limit. The AIR is determined for each center based on historical costs.
10. American Indian Health Providers are paid based on the applicable IHS provider type designation as listed below:[24]
    a. IHS-MOA Clinic Providers, whether contracted or not, are paid the applicable encounter rate published annually in the Federal Register by the Indian Health Service (IHS) the Office of Management and Budget (OMB) encounter rate for covered services provided to Indian enrollees who are eligible to receive services from such providers.[25]
    b. Effective January 1st, 2021, IHS-MOA clinic providers that elect to participate in Medi-Cal as Tribal FQHCs are paid DHCS's Alternate Payment Methodology (APM) rates as follows for each visit:[26]
        1) For Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, irrespective of Medicare Part D coverage, the required payment is the difference between the "APM Rate (Excluding Medicare)" and 80 percent of the Medicare FQHC prospective payment system rate.[27]
        2) For Medi-Cal beneficiaries that do not have Medicare Coverage or have Medicare Part A only, irrespective of Medicare Part D coverage, the required payment is the "APM Rate (Excluding Medicare)."[28]
        3) APM rates will be effective for a calendar year and may have a retroactive effective date. Tribal FQHCs will be paid the most current applicable payments during the calendar year for which the rate applies and as an interim rate in a subsequent calendar year if an updated APM has not been published. Interim payments are reconciled to the applicable updated rate for the specific calendar year in accordance with contractual prompt payment requirements.[29] Tribal FQHCs must be reimbursed at the applicable APM rate for up to a maximum of three visits per day, per Member, in any combination of different visits in the

[24] DHCS APL 21-008
[25] 42 CFR § 438.14(b)(2)
[26] DHCS APL 21-008
[27] DHCS APL 21-008
[28] DHCS APL 21-008
[29] DHCS APL 21-008

following visit categories: medical, mental health, and ambulatory. For example, Tribal FQHCs can be reimbursed for:[30]

- A combination of three (3) different medical visits with a Primary Care Provider (PCP), Nurse Practitioner, and a Specialist;
- A combination of three (3) different mental health visits with a Psychiatrist, Psychologist, and a licensed clinical social worker;
- A combination of three (3) different ambulatory visits for audiology, physical therapy, and optometry services.
- Certain covered services will continue to be reimbursed outside the APM, including Non-Medical Transportation, Non-Emergency Medical Transportation and Pharmacy.[31]

c. Non-Medical Transportation provided by an Indian Health Center or Tribal FQC is payable separately from the OMB rates. Contracted Providers are paid at their respective contracted rates. Non-Contracted providers are paid at the prevailing Medi-Cal Fee Schedule amount.

d. 90% of IHS claims must be paid, contested, or denied within 30 calendar days, 99% within 90 calendar days, and 95% within 45 working days from receipt of the claim.[32]

11. For Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, the required payment is the difference between the "Outpatient Per Visit Rate (Excluding Medicare)" listed in the Federal Register and 80 percent of the Medicare FQHC prospective payment system (PPS) rate.[33]

12. For Medi-Cal beneficiaries that do not have Medicare Coverage or have Medicare Part A only, the required payment is the "Outpatient Per Visit Rate (Excluding Medicare)".

U. IEHP and its Capitated Providers must automatically pay interest (in addition to the claim payment) on any clean and complete claim not paid within 45 working days, beginning with the first calendar day after the 45 working day period. The 45 working day requirement for the payment of interest applies to both contracted and non-contracted Providers. Failure to automatically pay interest due requires a $10.00 penalty to be paid to the Provider in addition to any interest due.[34,35]

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

[30] DHCS APL 21-008
[31] DHCS APL 21-008
[32] 42 CFR § 438.14(b)(2)
[33] Title 42 United States Code (U.S.C) § 1395w-4(e)(6)(A)(ii)
[34] CA Health & Saf. Code § 1371(a)(2)
[35] 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.[36]

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 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 10 days of the close of the month in which the claim was paid.[37]
4. Depending on the circumstances surrounding the claim or adjustment, interest methodology[38] is as follows:
   a. Initial clean claims and corrected claims should calculate interest based on the period of the day after receipt to the date payment is issued. Interest accrues for each calendar day beyond 45 working days (if applicable).
   b. Claim adjustments due to a processing error should calculate interest based on the period of the day after receipt of the initial clean claim to the date the payment is mailed. Interest accrues for each calendar day beyond 45 working days (if applicable).
   c. Claim adjustments not involving a processing error should calculate interest based on the period of the day after receipt of the additional information that warranted the adjustment to the date the payment is mailed. Interest accrues for each calendar day beyond 45 working days (if applicable).
   d. Overpayments or adjustments must be identified and written notification sent to Providers of Service within 365 days of the date the original claim was paid. Providers of Service must either contest or pay the requested monies within 30 working days of receipt of the notification of overpayment or adjustment.[39]

Notification Requirements

V. 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

[36] Title 28 California Code of Regulations (CCR) § 1300.71
[37] Title 28 California Code of Regulations (CCR) § 1300.71
[38] Title 28 California Code of Regulations (CCR) § 1300.71
[39] Title 28 California Code of Regulations (CCR) § 1300.71

shall be either contested or denied in writing within the timeframes set forth in Section P 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.[40]

W. 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.[41]

X. Members do not need notification of a denial when services are paid at a lower level than billed (e.g. ED services that have been down coded resulting in payment of the triage fee only), there is no Member liability, or the denial is Provider specific, such as duplicate claims.

Y. 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. 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 60 days from the date the claim was originally submitted to the financially responsible party.

Another Payor's Financial Responsibility

Z. Capitated Providers must redirect or deny claims that are not their financial responsibility within 10 working days, as follows:[42]

1. Claims in which the Capitated Provider has an affiliated network relationship with the financially responsible Payor, including both emergency and non-emergency service claims must be forwarded to the financially responsible entity. This includes IEHP as the health plan when the health plan is the financially responsible Payor.
2. If the Member cannot be identified or the financially responsible entity is not affiliated with the Capitated Provider's network, the claim should be denied and/or returned to the Provider of Service advising the billing Provider to verify eligibility assignment and to bill the appropriate responsible party.
3. All forwarded and denied misdirected claims must be tracked and reported, See Policy 20G, "Claims and Provider Dispute Reporting."

AA. California Children's Services (CCS) claims or other claims in which there was potential responsibility for payment by another party, and subsequently denied by that party for non-coverage of service, termination of coverage or partial payment which is less than Medi-Cal rates, are considered timely if submitted within contract submission timelines for contracted Providers of Services, or one (1) year for non-contracted Medi-Cal Providers of Service from the date services were denied or partially paid[43], when

[40] Title 28 California Code of Regulations (CCR) § 1300.71
[41] CA Welfare and Institutions Code § 14019.4
[42] Title 28 California Code of Regulations (CCR) § 1300.71
[43] Title 28 California Code of Regulations (CCR) § 1300.71

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

Provider Dispute Resolution

BB. Uncontested notices of overpayment can only be offset against a Provider of Service's future reimbursement when the Provider requests the retraction, in writing; or the Provider fails to reimburse the monies due within 30 working days and the Provider of Service's contract allows for the offset. Any offsets must be clearly explained at the time of the offset via the Explanation of Benefits (EOB), Remittance Advice (RA), or an Electronic Remittance Advice or other written documentation, including identifying the specific overpayment(s). Capitated Providers must establish and maintain a Provider Dispute Resolution Mechanism for all Providers of Service that meets or exceeds the requirements, See Policies 16C1, "Dispute and Appeals Resolution for Providers - Initial" and 20AH, "Dispute Resolution Process – Initial Claims Disputes." In general, the Provider Dispute Resolution Mechanism must include the following:

1. Providers of Service have 365 days from the date of the original payment, denial, adjustment or contest, or other last action on a claim (i.e., Provider inquiries), to dispute or appeal the claim decision.
2. All disputes must be acknowledged within two (2) working days of receipt, if received electronically, or within 15 working days if received via paper.
3. All disputes must be resolved within 45 working days after the date of receipt.
4. Any dispute resolved in favor of the disputing Provider and resulting in additional payment must include interest and penalties, See Policy 20H, "Dispute Resolution Process – Initial Claims Disputes." Any payment including interest must be made within five (5) working days of the date of the written determination.
5. Any dispute involving an issue of medical necessity or utilization review that is upheld by the Capitated Provider through the dispute mechanism may be submitted to IEHP for secondary review and resolution within 60 working days of the determination date of the dispute from the Provider. Appeals must be submitted to IEHP, See Policies 162, "Dispute and Appeals Resolution Process for Providers - Health Plan" and 20H1, "Provider Dispute Resolution - Health Plan Claims Appeals" for appeals involving adjudication of claims or billing matters.
6. All Provider disputes must be reported to IEHP, See Policy 20G, "Claims and Provider Dispute Reporting." For reporting and monitoring purposes, issues resolved through arbitration are not considered a dispute and are not subject to the requirements noted above.

CC. IEHP's Provider Relations Team is available from 8:00am - 5:00pm PST, Monday through Friday at (909) 890-2054 or (866) 223-4347 to assist and answer any claim related inquiries.

Contracted Providers where IEHP is the Payor may also verify claim status on IEHP's website at www.iehp.org.

20. CLAIMS PROCESSING

A. Claims Processing

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

B. Billing of IEHP Members

APPLIES TO:

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

POLICY:

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

PROCEDURES:

A. Providers who accept an IEHP Medi-Cal Member as a patient shall accept payment from IEHP, its health network or medical group as payment in full for Medi-Cal covered services.

B. Providers are prohibited from billing a Medi-Cal Member for services including, but not limited to:

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

C. Provider may bill a Member only for services not covered by Medi-Cal, 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.
   3. The rendering Provider is not registered with Medi-Cal.

D. Providers 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. Providers 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, its health network, or medical group.

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

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 16.A, "Member Grievance Resolution Process."

G. 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 Providers who have been delegated to pay claims for IEHP Medi-Cal Members.

POLICY:

A. Payor must appropriately pay or deny complete claims for contracted Providers of Service within 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's claims processing standards as indicated above, IEHP may elect to pay these claims on behalf of the Payor by deducting such payments from the Payor's next monthly capitation check.

C. The 7-Day letter process is an escalation mechanism for Providers who have submitted a claim to an IPA and have not received a response within the regulatory timeframes.

PROCEDURES:

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

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

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

   2. IEHP identifies a claim that has not been paid within the claims processing timeframes above.

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

D. As outlined in Policy 20.H.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. 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 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 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 with the following claim information:

1. The date the claim was originally received
2. If the claim was paid or denied

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

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 confirms financial responsibility prior to 7-day notification).
2. Member Not Eligible (IEHP confirms eligibility prior to 7-day notification).
3. Not Authorized (it is inappropriate to deny a claim due to "No Authorization" as medical review must be performed prior to denial).

I. Once IEHP receives all necessary documentation, the appeal undergoes review. Medical and non-medical claims-related appeals are resolved separately:

1. Medical claims-related appeals are forwarded to the IEHP Medical Director. Medical claims-related appeals involve denials for non-authorized services, denials or down-coding of emergency services, utilization management (UM)/medical necessity decisions, etc.
2. Medical appeals involving current patient care are resolved in accordance with Policy 16B3, "Dispute and Appeal Resolution Process for Providers - UM Decisions" and the immediacy of the situation.

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

1. Outpatient services are paid the rates specified in the Medi-Cal schedule of reimbursement (RFO500).
2. Inpatient Facility claims from private inpatient general acute care hospitals, California non-designated hospitals and out-of-state hospitals are paid using an All Patient Refined Diagnosis-Related Group (APR-DRG) payment methodology.
3. Psychiatric hospitals and designated public hospitals are excluded from DRG reimbursement methodology. Claims submitted for these facilities follow the guidelines that were in place prior to implementation of the DRG model.

K. If Payor fails to respond to an IEHP 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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[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 Medi-Cal Delegates.

POLICY:

A. IEHP provides oversight of claims processing by Delegates through monitoring, reviewing, and measuring claims payments and denial processes, Provider dispute mechanisms and assessing for demonstrable and unjust payment patterns on an on-going basis.

B. IEHP audits all Delegates annually or as necessary.

C. Audits may include on-site review and evaluation of specific claims, disputes, adjustments, reports, personnel, written policies and procedures, contracts, management involvement and oversight, claims processing systems and functions, dispute resolution mechanism and regulatory and contractual compliance. These audits are conducted in accordance with IEHP standards and state and federal requirements.

D. Audited Delegates are required to cure any deficiencies in their systems to bring them into contractual and regulatory compliance.

E. Delegates can submit a rebuttal to dispute the result of an audit through the IEHP Rebuttal process by submitting a written rebuttal to IEHP using the IEHP Rebuttal Form included with the Preliminary Report.

***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 20G, "Claims and Provider Dispute Reporting."
2. Delegates must also submit to IEHP by the 15th of each month detailed reports for the previous month's activity. The required reports, See Policy 20G, "Claims and Provider Dispute Reporting," are:
    a. Paid Claims
    b. Denied Claims
    c. Provider Dispute Resolution (PDR)
    d. Redirected Claims
3. By the 30th of the month following the end of the quarter, for the previous quarter, Delegates must submit information regarding disputes. 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. Delegates must also submit to IEHP by November 30th of each year, an Annual Claims Payment and Provider Dispute Report (Annual Report) for the reporting period covering October 1st through September 30th, as outlined in Policy 20G, "Claims and Provider Dispute Reporting."
5. IEHP reserves the right to request additional reports as deemed necessary.
6. Failure to submit required reports that include all required information in a complete and accurate manner in IEHP's required format, within the indicated timeframes, may result

in the Delegate being subjected to a focused audit and negatively impacting the Delegate's contract renewal terms.

E. IEHP audits the claims processing system of each Delegate on an annual basis. Audits may be conducted more frequently (Focused Audits) if circumstances arise that in the judgment of IEHP management requires closer scrutiny including but not limited to the following circumstances:

1. Failure to meet IEHP Financial Viability Standards.
2. Non-compliance with monthly and quarterly self-reporting requirements to IEHP or to California Department of Managed Health Care (DMHC) under SB260, or discovery during an audit or through other means, deficiencies that were not self- reported.
3. Excessive claims appeals that are overturned by IEHP for denial of payment or underpayment.
4. Excessive number of insufficient or inappropriate responses to 7-day letters that result in payment by IEHP to the Provider of Service that is deducted from capitation.
5. Excessive claims grievances, Provider disputes, Provider inquiries or other information received by IEHP from subcontracted entities or other outside sources.
6. Failure to submit accurate and completed reports to IEHP within specified timeframes.
7. Failure to meet claims payment standards, dispute resolution standards and other indicators and measures based on IEHP review of periodic reports and other internally and externally available information.
8. Identification of potential or emerging unfair payment patterns or other indicators of payment practices that possibly pose undue risk to IEHP and/or its Members or Providers based on claims inquiries, grievances and appeals, IEHP review of periodic reports, contracts or other internally or externally available information.
9. Failure to cooperate with IEHP in report resolution, issue resolution or other matters with respect to determination of compliance with IEHP requirements.
10. Change in claims processing system.
11. Change in management oversight, including Management Services Organization (MSO).

F. IEHP notifies Delegates in writing at least six (6) weeks in advance of the scheduled audit.

The notice is explicit in the timeframe being audited, the request for reports, documents, and access to Delegate staff. For Focused Audits, IEHP reserves the right to give a minimum of three (3) working days prior notice.

1. Routine Audits 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. Family Planning claims
    d. Disputed claims
    e. Post-Payment Adjustments

f. Interest Paid on late paying, adjusted or disputed claims

g. Overpayment Recovery Requests (refunded, retracted, or disputed).

h. Redirected claims.

2. The claim selections will be forwarded to Delegates one (1) hour prior to the start of the scheduled audit.

3. IEHP performs the claims review noted above via webinar and is scheduled for three (3) days. IEHP may also schedule a one (1) day on-site visit.

4. At the time of the onsite visit, IEHP will review current received, open and pend reports (as of the date of the audit), 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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20. CLAIMS PROCESSING

E. Disputes Between Contracted Relationships

APPLIES TO:

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

POLICY:

A. IPAs and/or IEHP are responsible for authorizing medical care.

B. The IEHP IPA capitated agreement binds the IPA and its Physicians to use the designated assigned Hospital as the exclusive Provider for all hospital services, as applicable.

C. In the event that a particular service is not available at the assigned Hospital the IPA must coordinate with the Hospital, if capitated, or IEHP for per diem contracted Hospitals, to provide care for the Member at a mutually agreed upon facility.

D. In the event of an emergency, the IPA must inform the Hospital, if capitated or IEHP for per diem contracted Hospitals that care is being rendered at another facility.

E. Members cannot be transferred when Member refuses to be transferred.

PROCEDURES:

A. In the event an authorization for hospital services is provided by an IPA representative that is in breach of the above policy, the following may occur:

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

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

4. Hospitals may send the Provider a letter informing them that the claim has been forwarded to the IPA for payment; however, a denial should not be sent to the Provider.
5. The IPA must pay the claim for these hospital services unless the IPA feels the services provided were emergent or that the service was justified. In the event of the latter the IPA should submit the claim with the appropriate supporting documentation to IEHP at the above address with a letter of appeal explaining their position. The appeal must be submitted to IEHP within 365 days of the denial or payment.
6. IEHP will follow the procedures outlined in Policy 20H1, "Provider Dispute Resolution - Health Plan Claims Appeals," in determining the appropriateness of the appeal and whose financial responsibility it is to pay the claim.
7. Payment will be issued by the responsible party as outlined in Policy 20H1, "Provider Dispute Resolution Process - Health Plan Claims Appeals."

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20. CLAIMS PROCESSING

F. Coordination of Benefits

APPLIES TO:

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

POLICY:

A. State law requires Medi-Cal to be the payer of last resort for services which there is a responsible third party, including Medicare.[1]

B. Medi-Cal Members with Other Health Coverage (OHC) must utilize their OHC for covered services prior to accessing their Medi-Cal benefits.[2]

C. Cost avoidance is the practice of requiring Providers to bill liable third parties prior to seeking payment from IEHP.

D. IEHP should rely on the Medi-Cal eligibility record for cost avoidance and post payment recoveries. See policy 14A3, "Review Procedures – Other Health Coverage."[3]

E. If IEHP becomes aware of OHC from sources other than the Medi-Cal eligibility record, IEHP may use this OHC information, but must report the OHC to the Department of Health Care Services (DHCS) within 10 calendar days of discovery.[4]

F. IEHP must report new OHC information not found on the Medi-Cal eligibility record or OHC information that is different from what is found on the Medi-Cal eligibility record to DHCS within ten (10) calendar days of discovery.[5]

G. Beginning April 1, 2021, IEHP must include OHC information in its notification to the Provider when a claim is denied due to the presence of OHC. OHC information includes, but is not limited to, the name of the OHC, Provider, the policy number and contact or billing information. Prior to April 1, 2021, IEHP may direct Providers to access the necessary Member OHC information utilizing the Automated Eligibility Verification System at (800) 427-1295 or the Medi-Cal online eligibility portal. Information regarding OHC carriers can be found in the Health and Human Services Open Data Portal.[6]

H. IEHP does not process claims for a Member whose Medi-Cal eligibility record indicates OHC, other than a code of A or N, unless the Provider presents proof that all sources of payment have been exhausted, or the provided services meet the requirement for billing IEHP directly.[7]

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-002, "Cost Avoidance & Post-Payment For Other Heath Coverage"
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Ibid.

20. CLAIMS PROCESSING

F. Coordination of Benefits

I. IEHP and its Delegates are responsible for identifying Payers that are primary to Medi-Cal and must coordinate benefits for Members in accordance with state and federal law.[8]

J. California Children's Services (CCS) is the sole responsible payer if a Medi-Cal Member utilizes services for CCS eligible conditions.[9]

K. If OHC is discovered retroactively or the Member had an OHC indicator of 'A' on their Medi-Cal eligibility record at the time of service, IEHP and its Delegates must engage in post payment recovery.

1. Post payment recovery must be initiated within 12 months from the date of payment of a service.
2. IEHP is required to submit detailed claim information regarding OHC recoveries to DHCS no later than the 15th of every month.
3. IEHP and its Delegates are entitled to retain all monies recovered within 12 months from the date of payment.
4. If a re-payment plan with a Provider is established within 12 months, but the recoupment extends beyond 12 months from the date of service, IEHP and its Delegate will retain the recovered money.
5. If a recovery is received after twelve 12 months from the date of payment and no re-payment plan was initiated with the Provider prior to, IEHP must remit payment to DHCS.

DEFINITIONS:

A. Cost Avoidance - The practice of requiring Providers to bill liable third parties prior to seeking payment from IEHP.

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

PROCEDURES:

State Programs

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

[8] DHCS APL 21-002
[9] Ibid.
[10] Ibid.

B. IEHP coordinates benefits with other health insurance carriers, including Medicare. Exceptions include claims where the Provider is reimbursed under an IEHP capitation agreement and claims for services that meet the requirement for billing Medi-Cal directly.[11]

C. The following is a partial list of insurance that is not considered to be OHC:

1. Personal injury and/or medical payment covered under automobile insurance
2. Life insurance
3. Workers' compensation
4. Homeowners insurance
5. Umbrella insurance
6. Accident insurance
7. Income replacement insurance (e.g., Aflac)

D. Other Health Coverage (OHC) Cost-Sharing Providers are prohibited from billing Medi-Cal recipients, or individuals active on their behalf, for any amounts other than the Medi-Cal copayment or Share of Cost (SOC). Therefore, if the recipient's OHC requires a copayment, coinsurance, deductible or other cost-sharing, the Provider is not permitted to bill the recipient. If the Provider bills the OHC and the OHC denies or reduces payment because of its cost-sharing requirements, the Provider may then bill IEHP.[12]

E. When coordinating benefits, IEHP will reimburse Providers up to the Medi-Cal allowable or the Provider's contract amount (if applicable) minus any payment(s) the Provider has received from the Member's primary insurance. Payment will not exceed the Member's OHC cost sharing amount or the Medicare deductible and coinsurance amount.[13]

F. If IEHP receives a claim for a Member containing evidence of primary OHC coverage and IEHP has no record of the OHC coverage, IEHP will process the claim as the secondary payer and notify DHCS of the other coverage within 10 calendar days of discovery.

G. When a claim is denied due to the presence of OHC, IEHP provides OHC information to the outgoing paper and electronic remittance advices (as applicable) to the Provider.

H. Providers of Service retain any monies collected through COB, in addition to any capitation received.

I. Members with Medicare Part A coverage have a Hospital inpatient deductible for each benefit period. There is also a specified daily coinsurance per day for each benefit period sixty-one (61) days and beyond.[14]

[11] DHCS APL 21-002
[12] Ibid.
[13] Medi-Cal Program and Eligibility (medi-cal.gov.ca)
[14] CMS.GOV Centers for Medicare & Medicaid Services 2020 Medicare Parts A & B Premiums and Deductibles

J. Members with Medicare Part B coverage have an annual deductible. There is also a coinsurance requirement of 20% of the Medicare allowable amount for most services.[15]

K. When IEHP is coordinating benefits between Medicare or an OHC, Medicare or the OHC is primary and Medi-Cal rates shall be used as the basis of coordination of benefits up to the maximum allowed by Medi-Cal fee-for-service. If the Medi-Cal maximum allowed is less than or equal to the Medicare or OHC reimbursement, then there will be no additional IEHP payment. If a Provider of Service is contracted, the contract may require that the contracted rate be used as the base rate for COB comparison.[16]

L. When OHC overpayments are identified, IEHP and its Delegates will initiate post payment recovery within 12 months from the date of payment.

M. Delegates must submit to IEHP a detailed post payment recovery report of OHC recoveries by the 5th of every month via IEHP's Secure File Transfer Protocol (SFTP) utilizing the template provided by IEHP.

N. Delegates must remit to IEHP all recovered OHC monies that are thirteen (13) months or older from the date of payment of a service by the 5th of every month and IEHP will send the payments to DHCS.

a. To remit payment by mail, payment must be sent to:

Inland Empire Health Plan

Attn: Accounts Receivable

P.O. Box 1800

Rancho Cucamonga, CA 91729-1800

b. To remit payment electronically, payment must be sent to:

MUFG Union Bank, N.A.

1980 Saturn Street

Monterey Park, CA 91755

Routing Number: 122000496

Account Number: 2740019794

Beneficiary: IEHP-Concentration account

O. Delegates must submit to IEHP a report of all recovered OHC monies that are 13 months or older from the date of payment of a service by the 5th of every month via IEHP's SFTP utilizing the template provided by IEHP.

[15] DHCS APL 21-002
[16] Ibid.

20. CLAIMS PROCESSING

F. Coordination of Benefits

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

20. CLAIMS PROCESSING

G. Claims and Provider Dispute Reporting

APPLIES TO:

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

POLICY:

A. IEHP provides oversight of claims processing by Delegates through monitoring of the Delegate's claims payments and denial processes, Provider dispute mechanisms and assessing for demonstrable and unjust payment patterns on an on-going basis.

B. As part of the monitoring process and to comply with state and federal regulatory requirements, Delegates are required to submit Claims Payment and Dispute Mechanism Reports to IEHP.

C. Failure to submit required reports within the indicated timeframes may result in the Delegate being subjected to a focused audit which may negatively impact the Delegate's contract renewal terms and may lead to contract termination or conversion.

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, quarterly, and annual reports to self-report compliance with contractual and regulatory standards pertaining to claims and dispute processing. Each report must be submitted in IEHP's required format, using IEHP provided templates.

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, "Medi-Cal Universe Layout Instructions" in Section 20 for detailed specifications of each report.

E. On a quarterly basis, Delegates must submit reports for disputes for review and evaluation as outlined below.

1. The required reports are:
   a. Quarterly Provider Dispute Resolution (PDR).
   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. On an annual basis, Delegates must submit an Annual Claims Payment and Provider Dispute Mechanism Report (Annual Report) to IEHP summarizing the disposition of all claims and Provider disputes received by the Delegate.

1. The Annual Report must be submitted to IEHP no later than November 30th of each year, for the reporting period covering October 1 through September 30 and must be signed by the Designated Principal Officer attesting to the accuracy and validity of the reported information.

G. As outlined in Policy 20D, "Claims and Compliance Audits," Delegates must also generate the following reports for the designated audit period, for review and claims selection (detailed specifications (See Attachment, "Medi-Cal Universe Layout Instructions" found on the IEHP website[1]).

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

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

4. Adjustments Report.
5. Resolved Disputed Claims Report.
6. Interest Paid Claims Report.
7. Pended Claims Report (covering all unresolved pended claims on day of audit), including identification of the pend reason as well as identification and count of emergency claims and non-emergency services claims.
8. Claims Inventory Report (covering all open claims on day of audit), including separate identification and count of emergency claims.
9. Claims Received Report (covering all claims received in the audit period, regardless of status).
10. Redirected Claims Report.
11. Claims Inquiry/Customer Call Log (covering the audit period), including reason for the call and outcome.
12. Signed Check Mailing/Attestation or Log (covering all checks issued for IEHP Members during the audit period), including check number, check amount and date mailed.

H. IEHP reviews all reports for on-going monitoring of compliance with regulatory and contractual requirements, as well as to identify possible trends or patterns that may be indicators, alone or in conjunction with other information obtained by IEHP (i.e., Provider inquiries), of potential unfair payment practices or other issues that may trigger out-of-cycle corrective actions. Such action includes but is not limited to:

1. Increased reporting and monitoring.
2. Submission of a Corrective Action Plan (CAP).
3. Focused audit.

I. Failure to submit fully completed and accurate reports within mandated timeframes, using IEHP specific templates and formats or to submit amended reports as applicable and/or refusal to cooperate in the identification or resolution of identified issues, concerns, patterns or trends, is considered a breach of contractual requirements and may subject the Delegate to a focused audit, initiation of contract termination and/or other actions as deemed appropriate by IEHP.

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

20. CLAIMS PROCESSING

G. Claims and Provider Dispute Reporting

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	February 1, 2004	
Revision Effective Date:	January 1, 2024	

20. CLAIMS PROCESSING

H. Provider Dispute Resolution Process - Initial Claims Disputes

APPLIES TO:

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

POLICY:

A. Providers must submit all claims related disputes, including those involving claims payment or denial, billing, contracting or Utilization Management (UM)/medical necessity to the financially responsible Payor (contracted capitated IPAs, Hospitals or IEHP) for the initial dispute resolution process.

B. All disputes must be submitted to Payor within three hundred sixty-five (365) days of the last date of action on the claim requiring resolution.[1]

C. Payors must identify and acknowledge the receipt of all disputes within two (2) working days if the dispute was received electronically or 15 working days of receipt of a written dispute.[2]

D. Payors must resolve disputes and issue a written determination within 45 working days of receipt.[3]

E. A Provider may submit a 2nd level appeal regarding the outcome of a Payor's dispute resolution involving claims or billing to IEHP within six (6) months of receipt of the written dispute determination letter from the Payor.

F. Providers are not required to submit a copy of the original claim submission when submitting a claim payment dispute.

PROCEDURE:

A. Providers must submit all disputes, including those involving claims payment or denial, contracting issues, or those involving UM/medical necessity, in writing to the Payor within 365 calendar days from 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. For reporting, tracking, and monitoring purposes, disputes are categorized as follows:

    a. Claims/Billing – any formal written disagreement involving the payment, denial, adjustment or contesting of a claim, including overpayments, payment rates, billing issues or other claim reimbursement decisions.

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

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

See Policy 20.A, "Claims Processing."

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

d. UM/Medical Necessity – any formal written disagreement concerning the need, level or intensity of health care services provided to Members.

2. Claim disputes must be submitted in writing to the Payor in accordance with the dispute filing guidelines issued by the Payor.

   a. For claim disputes involving IEHP as the Payor, disputes must be sent to:

   IEHP Provider Claims Resolution and Recovery Unit
   P.O. Box 4319
   Rancho Cucamonga, CA 91729-4319

   b. IEHP Provider dispute forms are available upon request and are also available on IEHP's website at www.iehp.org.

   c. Submission of a Dispute:

      1) A Dispute must contain the following:

         a) Provider Dispute Resolution (PDR) Form or Dispute Letter and supporting documents.

         b) Provider name and Provider Identification Number (PIN).

         c) Contact Information.

         d) Claim number assigned to the original claim that is being disputed.

         e) Clear description of the disputed item.

         f) Date of Service.

         g) Clear explanation of the basis upon which the Provider believes the action is incorrect.

         h) If the Dispute involved a bundled group of multiple claims that are substantially similar, identification of the original claim number; and

         i) If the Compliant involves a dispute involving a Member or group of Members, the name(s) and identification number(s) and Claim numbers (if applicable) of the Member(s), a clear explanation of the disputed item(s), includes the date(s) of service, and the Providers position on the issue(s).

3. Emergency and/or Post Stabilization services rendered by a non-contracted Provider must be submitted to the Payor in accordance with the dispute filing guidelines.

   a. If the non-contracted Provider disagrees with the Payor's dispute determination the dispute may be submitted for resolution to:

Department of Health Care Services
Office of Administrative Hearings and Appeals
3831 North Freeway Blvd. Suite 200
Sacramento, CA 95834

b. If the Department of Health Care Services (DHCS) determines the Emergency Services and/or Post Stabilization is reimbursable the Payor will reimburse the non-contracted Provider within 30 calendar days of the DHCS determination and provide proof of reimbursement to DHCS.

4. Any dispute involving Primary Care Provider (PCP) or Pay For Performance (P4P) reimbursements should be filed in accordance with Policy 19.C, "Pay For Performance (P4P)." 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.

5. A Provider that has furnished Covered Services to a Member for which a Delegate is financially responsible, or is dissatisfied with any aspect of a Delegates program, shall file a Dispute with that Delegate prior to filing a dispute with IEHP within 365 calendar days after a Delegates action, or in the case of inaction, within 365 calendar days after the Delegates action, or in the case of inaction, within 365 calendar days after the time for contesting or denying claims has expired.

6. If the dispute is not about a claim/billing, the written request must include a clear explanation of the issue and the Provider's position, See Policy 16.C1, "Dispute and Appeal Resolution Process for Providers – Initial."

B. Payors must identify and acknowledge in writing the receipt of each dispute, whether complete or not, and disclose the recorded date of 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

2. If the dispute was received in paper form, acknowledgement must be provided within 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.2, the dispute is rejected, and a written statement is issued to the Provider indicating 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

[5] 28 CCR § 1300.71.38

required to make the dispute complete.

D. Providers that include a new or corrected claim attached have their Provider Dispute rejected, and a written determination letter issued advising the Provider the new or corrected claims have been forwarded to the correct IEHP department for processing.

E. 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.

F. 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 45 working days of receipt of the dispute. If the written determination results in payment to the disputing Provider, payment must be made within five (5) working days of the date of the written determination.[6]

G. Determinations involving Medi-Cal claims made in favor of the disputing Provider that result in payment of additional monies are subject to interest penalties[7] as follows:

1. If the determination is made to pay additional monies based on information originally provided and/or available at the time the claim was first presented to the financially responsible Payor for adjudication, or a result of a processing error, interest penalties are due as follows:

    a. Claims not involving emergency services, including adjustments - 15% per annum.

    b. Claims involving emergency services, including adjustments - the greater of $15.00 or 15% per annum.

    c. Interest must be paid within five (5) working days of the determination to pay.

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

    e. Interest is calculated on a calendar day basis.

    f. Interest begins with the first calendar day after the 45th working day from the original date of receipt of the first claim filed that is being disputed through the day the payment is mailed or electronically deposited.

    g. If the resolution of a Provider Dispute results in additional payment, IEHP will automatically include the appropriate interest amount if payment is not issued within the required timeframes.

2. If the determination to pay additional monies is based on information obtained subsequent to the initial adjudication decision, such as a request for retro-authorization or is made as

[6] 28 CCR § 1300.71.38
[7] Ibid.

a goodwill gesture, interest penalties are not due.

H. Providers that are dissatisfied with the resolution of any dispute not involving claims or billing (i.e. capitation, contracts) may appeal to IEHP See Policy 16.C2, "Dispute and Appeal Resolution Process for Providers - Health Plan Appeals."

I. Providers that are dissatisfied with the initial resolution and written determination by the Payor that involves payment or denial decisions on adjudicated claims or billing, including denials for procedures, referrals or services may submit a written appeal of the Payor's determination to IEHP by following the process See Policy 20.H1, "Provider Dispute Resolution Process - Health Plan Claims Appeals."

J. 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 60 working days of receipt of the written determination by submitting a written request for review See Policies 16.C2, "Dispute and Appeal Resolution Process for Providers - Health Plan" and 20.H1, "Provider Dispute Resolution Process - Health Plan Claims Appeals.[8]"

K. Furthermore, Providers that are dissatisfied with the outcome of a dispute originally filed with the Payor that involves pre-service referral denials or modifications may submit an appeal to IEHP See Policy 16.C2, "Dispute and Appeal Resolution Process for Providers – Health Plan."

L. If disputes require IEHP or its IPA to change contracting arrangements with their network Providers and/or Subcontractors that are deemed significant, IEHP or its IPAs must meet notification and reporting requirements as outlined in APL 21-003.

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

N. 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]

O. Payors must track and report all disputes received and submit monthly summary reports to IEHP in accordance with Policy 20.G, "Claims and Provider Dispute Reporting." A principal officer of the entity must be assigned responsibility for the Dispute Resolution Process and sign as to the validity and accuracy of all dispute related reporting.[11]

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

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	August 1, 2005	
Revision Effective Date:	January 1, 2024	

20. CLAIMS PROCESSING

H. Provider Dispute Resolution
1. Health Plan Claims Appeals

APPLIES TO:

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

POLICY:

A. Providers may submit a second level appeal to IEHP if they disagree with the written determination rendered by the financially responsible Payor for any dispute involving payment, denial, adjustment or contesting of a claim, including overpayments, payment rates, billing issues or other claim reimbursement decisions that they deem were unfairly upheld or underpaid.

B. Second level appeals to IEHP involving claims or billing must be submitted in writing within six (6) months from the date of determination of the dispute received from the Payor. Appeals received beyond this timeframe are denied. Justification and supporting documentation must be provided with the written appeal. IEHP reviews Provider appeals as an intermediary between the payor and the Provider 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.

PROCEDURES:

A. Claim appeals relate to the initial determination of a dispute by the Payor involving the original adjudication decision of a claim or billing issue and are primarily complaints concerning reduced payment or denial of services that were not resolved to the satisfaction of the appealing Provider.

B. Inquiries regarding the status of a claim, or requests for intervention by IEHP on behalf of the billing Provider in an attempt to get an initial adjudication decision (payment or denial) made on a claim by the Payor, are not considered disputes or appeals and are handled in accordance with Policy 20.C, "Claims Deduction From Capitation – 7-Day Letter."

C. A Provider who has been denied payment for services or feels that the claim has been underpaid or who has other claims or billing related issues must first file a dispute with the responsible Payor as outlined in Policy 20.H, "Provider Dispute Resolution Process – Initial Claims Disputes."

D. If IEHP receives an initial claim or billing dispute directly from a Provider, IEHP will forward the claim or billing dispute to the Payor for resolution as applicable and notify the Provider.

E. Upon receipt of an appeal, IEHP will acknowledge by issuing a letter to the Provider within 15 working days (See Attachment/"Acknowledgement Letter" found on the IEHP website[1]).

F. Providers that disagree with the written determination of the dispute by the Payor may appeal to IEHP in writing within six (6) months of the date of the written determination.

1. Appeals should be submitted to:

IEHP – Provider Claims Resolution and Recovery Unit
P.O. Box 4319
Rancho Cucamonga, CA 91729-4319

2. The following information must be included with the written appeal, as applicable:
   a. Claim Appeal Cover Letter.
   b. Written Determination from the responsible Payor.
   c. Claim Form.
   d. Denial Letter/Explanation of Benefits.
   e. Transcribed Notes.
   f. Hardcopy Authorization if Prior Authorization Received.
   g. If Verbal Authorization Received:
      1) Name, title, phone, and fax number of the staff member providing the verbal authorization.
      2) Date and time verbal authorization given.
      3) Diagnosis code(s).
      4) Services authorized and associated code(s).
      5) Start and end date of authorization.
      6) Authorization number.

      (Follow up calls for additional services require the same information.)
   h. Documentation proving an attempt was made to obtain authorization from the IPA/Hospital should indicate the phone number called, the date and time the 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] https://www.iehp.org/en/providers/provider-resources?target=forms

1) Claim determination letter or Explanation of Benefits (EOB)/Remittance Advice (RA) from IEHP or one of IEHP's contracted Delegates.

2) Copy of a written request for information or other written claim-related correspondence from IEHP or one of IEHP's Delegates, dated and printed on letterhead or form letter with the date and letterhead clearly identified.

3) Determination letter from other insurance carriers or other financially responsible entities, such as California Children's Services (CCS) or Medicare, dated and printed on letterhead, in which the date of determination and date of receipt is documented, that demonstrates the Provider presented the claim within the claims filing timelines permitted by law and/or written contractual agreement from the date of receipt of the determination.

4) Financial ledgers with multiple claim billings for that day, including name of the billed party (i.e., IEHP, Delegate, Medicare, HMO, etc.).

5) Computer generated claim transaction history that includes the billing history of the claim and history of timely and consistent follow-up attempts made to the original billed entity within the timely filing guidelines permitted by law and/or written contractual agreement. Detailed history should include billing dates and/or ledgers that show follow-up dates, contact names, time of calls (if applicable) and/or address to which the claim was sent.

6) Other documentation that demonstrates good cause for the delay in being able to submit the claim timely.

j. Any other information to assist IEHP in validating the appropriateness of services rendered.

G. If the appealing party does not provide the above required documentation, the appeal will be closed and returned to the Provider indicating the missing information.

H. If additional information is needed from the Payor, IEHP will request documentation from the Payor that has reduced payment or denied the services. This documentation must be provided within the timeline outlined in the letter.

1. If the Payor fails to provide evidence of appropriate medical review, as applicable, the original adjudication decision is overturned based on procedural grounds. IEHP issues a letter indicating the Payor is financially liable for the claim in question. The Payor has seven (7) days to pay the claim, with appropriate interest and penalties, and provide evidence to IEHP that payment was made. If the Payor does not pay or provide evidence that the claim was paid then IEHP pays the claim on the Payor's behalf and deducts the payment from future capitation payments, due to the Provider.

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

J. Medical and non-medical claims-related appeals are resolved separately:

1. Medical claims-related appeals are forwarded to the IEHP Medical Director. Medical claims-related appeals involve denials for non-authorized services, denials or down-coding of emergency services, UM/medical necessity decisions, etc.
2. Medical disputes involving current patient care are resolved in accordance with Policy 16.B3, "Dispute and Appeal Resolution Process for Providers - UM Decisions" and the immediacy of the situation.

K. IEHP conducts a review of the appeal and renders a decision within 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 .
2. If the reduced payment or denial is overturned, the Payor is notified in writing, of their financial obligation. IEHP instructs the Payor to pay the claim, including interest and penalties as applicable, within seven (7) calendar days (See Attachment, "Demand for Payment Letter" in Section 20). Interest must be paid Policy 20.H, "Provider Dispute Resolution Process – Initial Claims Disputes."
    a. If Payor fails to respond to an IEHP inquiry, a demand letter will be issued requiring proof of payment within the timeline outlined in the Notice of CAP Deduction letter . If evidence is not provided of claim payment, IEHP will pay the claim on the Payor's behalf and deduct the payment from the next capitation payment.

L. If, after seven (7) calendar days, the Payor has not paid the claim, IEHP pays the claim on the Payor's behalf and deducts the payment from future capitation payments due to the Payor, as follows:

1. For outpatient services the rates specified in the Medi-Cal schedule of reimbursement; or
2. Inpatient Facility claims from private inpatient general Acute Care Hospitals, California non-designated hospitals and out-of-state hospitals are paid using an All Patient Refined Diagnosis-Related Group (APR-DRG) payment methodology.
3. Psychiatric Hospitals and designated public Hospitals are excluded from DRG reimbursement methodology. Claims submitted for these facilities follow the guidelines that were in place prior to implementation of the DRG model.
4. For emergency services, the Emergency Room (ER) rate listed in the Medi-Cal schedule of reimbursement.

20. CLAIMS PROCESSING

H. Provider Dispute Resolution
1. Health Plan Claims Appeals

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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