20. CLAIMS PROCESSING

A. Claims Processing

APPLIES TO:

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

POLICY:

A. All Capitated Providers are delegated the responsibility of claims processing for non-capitated services and are subject to review by IEHP. IEHP provides oversight of the Capitated Providers by monitoring, reviewing, and measuring claims processing systems and dispute resolution mechanisms to ensure timely and accurate claims processing and dispute resolution.

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

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

D. Misdirected claims must be forwarded to the appropriate financially responsible entity within ten (10) working days of receipt.

E. Capitated Providers must pay or deny all initial clean or corrected claims for non-contracted Providers providing services to Medi-Cal Members within thirty (30) calendar days of receipt of the claim. Claims for contracted Providers must be paid or denied within forty-five (45) working days, or within other contractual timeframes.

F. Late payment of claims requires payment of interest penalties within five (5) working days of the claim payment date.

G. Overpayments or adjustments must be identified and written notification sent to Providers of Service within three hundred sixty-five (365) days of the date the original claim was paid. Providers of Service must either contest or pay the requested monies within thirty (30) working days of receipt of the notification of overpayment or adjustment.

H. All Capitated Providers must have a dispute resolution mechanism in place that allows Providers of Service to file a dispute within three hundred sixty-five (365) days of payment or denial. All disputes must be acknowledged within two (2) working days if received electronically and fifteen (15) working days if a paper dispute was received. All disputes must be resolved within forty-five (45) working days of receipt of the dispute as outlined in Policy 20A1, “Claim Processing - Provider Dispute Resolution Process - Initial Claims Dispute.”

I. All claims must be processed (paid or denied), and disclosures made in accordance with federal and state laws and regulations governing all IEHP Programs, plus all other applicable laws, regulations, and contractual stipulations pertaining to IEHP standards.

PROCEDURES:
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A. Claims Processing

A. Capitated Providers must have written procedures for claims processing that are available for review. In addition, Capitated Providers must disclose claims filing instructions, fee schedules and Provider dispute filing guidelines, via contract, written notification, Explanation of Benefits (EOB) or Remittance Advice (RA) at the time of payment, denial or adjustment, and/or via a website, as applicable. These written procedures and disclosures must comply with state, federal and IEHP contractual standards and requirements. Such disclosures must also be made available upon request to Providers of Service, IEHP, or a regulatory agency. For a sample of IEHP’s RA, (See Attachment, “IEHP Remittance Advice” in Section 20).

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

C. Contracted Providers of Service must be given no less than ninety (90) days from date of service and no greater than one (1) year from the date of service to submit an initial clean or corrected claim.

D. Non-contracted Medi-Cal Providers of service must submit initial clean or corrected claims within one hundred eighty (180) days after the month of service to be eligible for full reimbursement. Initial clean or corrected claims may be submitted up to one (1) year from the date of service, subject to the following reductions for any claims received after one hundred eighty (180) days:

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 submitted after one (1) year from the date of service can be denied;
4. Timely filing reductions are applied only to non-contracted Medi-Cal providers and on original received claims. They do not apply to subsequent adjustments.

E. Claims should be filed in accordance with the financially responsible Payor’s submission requirements. Claims involving IEHP as the Payor should be submitted to:

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

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

F. Initial clean or corrected claims submitted after the filing deadline can be denied unless substantiating documentation for good cause associated with the delay in billing or proof of timely filing is provided. Disputes filed by Providers of Service subsequent to the denial of
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A. Claims Processing

the claim for untimely filing must include proof of timely filing as defined below or other substantiating documentation of good cause for the delay in order to be reconsidered for payment. IEHP considers adequate proof of timely filing to be one or more of the following:

1. Claim determination letter or EOB/RA from IEHP or one of IEHP’s contracted Capitated Providers (See Attachment, “IEHP Remittance Advice” in Section 20).

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

3. Determination letter from other insurance carriers or other financially responsible entities such as 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.

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

G. Capitated Providers must have the systems in place and be able to identify and acknowledge the receipt of each claim, whether or not complete, and disclose the recorded date of receipt in the same manner as the claim was submitted.

1. If the claim was received electronically, acknowledgement must be provided within two (2) working days of receipt of the claim.

2. If the claim was a paper claim, acknowledgement must be provided within fifteen (15) working days of receipt of the claim.

H. Capitated Providers must redirect or deny claims that are not their financial responsibility within ten (10) working days, as follows:

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
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A. Claims Processing

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 as outlined in Policy 20H, “Claims and Provider Dispute Reporting.”

I. Complete (clean) claims are those claims and attachments or other documentation that include all reasonably relevant information necessary to determine Payor liability and in which no further information is required from the Provider of Service or a third party to develop the claim. To be considered a complete claim, the claim should be prepared in accordance with The National Uniform Billing Committee and The National Uniform Claim Committee standards and should include, but is not limited to the following information:

1. A complete paper claim form or EDI file that contains:
   a. A description of the service rendered using valid CPT, NDC, Diagnosis, HCPCS, ICD codes, and/or Revenue codes, the number of days or units for each service line, the place of service code and the type of service code and the charge for each listed service must be indicated;
   b. Member (patient) demographic information which must at a minimum include the Member’s last name and first name and date of birth;
   c. Provider of service name, address, National Provider Identifier (NPI) number and tax identification number;
   d. Valid date(s) of service;
   e. Billed Amount;
   f. Date and signature of person submitting claim or name of physician who rendered service(s); and
   g. Other documentation necessary in order to adjudicate the claim, such as medical or emergency room reports, claims itemization or detailed invoice, medical necessity documentation, other insurance payment information and referring Provider information (or copy of referral) as applicable.

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

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 check box letter or Remittance Advice. Requests related to an EDI claim will be sent in the form of an ANSI 277 return file to the submitter.

J. Claims received from contracted Providers must be appropriately paid or denied within forty-five (45) working days from receipt of a complete claim. Claims from non-contracted
20. CLAIMS PROCESSING

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providers rendering services to Medi-Cal Members must be paid or denied within thirty (30) calendar days of receipt.

1. This standard is based on the timeframe from the day after the date of receipt of the claim (e.g., date stamp) until the check or denial is mailed to the Provider of Service, regardless of when the check is dated.

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

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

K. Any claim, whether from a contracted or non-contracted Provider, that is not paid at billed charges must include an explanation of the adjustment (i.e., contract rate), language involving balance billing of the Member and the process for filing a dispute of the paid amount, on the EOB/RA (See Attachment, “IEHP Remittance Advice” in Section 20).

L. Reimbursement for services rendered to an IEHP Medi-Cal Member by a non-contracted Provider is as follows:

1. IEHP applies National Correct Coding Initiative (NCCI) edits for claims processed on or after March 28, 2011 with dates of service on or after October 1, 2010. NCCI edits consist of two types:
   a. Procedure-to-procedure (Column1/Column2) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons; and
   b. Medically Unlikely Edits (MUE), which are units of service edits, that define for each HCPCS/CPT code identified, the allowable number of units of service; units of service in excess of this value are not feasible for the procedure under normal conditions (e.g., claims for excision of more than one gall bladder or more than one appendix).

2. For outpatient services, the Fee for Service rates specified in the Medi-Cal schedule of reimbursement (RFO500); or

3. Inpatient Facility claims from private inpatient general acute care hospitals, California non-designated hospitals and out-of-state hospitals are paid using an all patient refined Diagnosis-Related Group (APR-DRG) payment methodology. Psychiatric hospitals and designated public hospitals are excluded from DRG reimbursement methodology. Claims submitted for these facilities follow the guidelines that were in place prior to implementation of the DRG model.
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4. For emergency services, the ER rate listed in the Medi-Cal schedule of reimbursement (RFO500).

5. 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.

6. Professional and ancillary services are paid at the corresponding Medi-Cal schedule of reimbursement (RFO500).

7. Federally Qualified Health Centers (FQHC) - FQHCs are paid an all-inclusive rate (AIR) for primary health services and qualified preventive health services. Beginning on or after October 1, 2014, FQHCs will transition to the FQHC prospective payment system (PPS) as required by Section 10501(i)(3)(B) of the Affordable Care Act.

8. 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.

9. American Indian Health Programs 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):

10. 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, as set forth in 42 USC 1395w-4(e)(6)(A)(ii).

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

M. An interest penalty must automatically be paid on any claim not paid within the required timeframe, beginning with the first calendar day after the forty-five (45) working day period. The forty-five (45) working day requirement for the payment of interest applies to both contracted and non-contracted providers. Failure to pay interest due automatically requires a $10.00 penalty to be paid in addition to any interest due.

1. Automatically means that interest due to the Provider of Service must be paid within five (5) working days of the payment of the claim or dispute resolution determination resulting in payment of additional monies, without the need for any reminder or request by the Provider of Service.

2. For claims not paid within the required timeframe, or that are identified as underpaid, interest must be paid for the period of the time that the payment is late or underpaid portion as follows:
   a. Non-emergency claims, including adjustments - 15% per annum, per claim; or
   b. Emergency service claims, including adjustments - the greater of $15 per claim for each twelve (12) month period or portion thereof, on a non-prorated basis; or 15% per annum.
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3. If the amount of interest due on an individual claim is less than $2.00 at the time the claim is paid, the interest on that claim or other such claims must be paid within ten (10) days of the close of the month in which the claim was paid.

4. Depending on the circumstances surrounding the claim or adjustment, interest methodology is as follows:
   a. Initial clean claims and corrected claims should calculate interest based on the period of the day after receipt to the date the payment is mailed. Interest accrues for each calendar day beyond forty-five (45) working days (if applicable).
   b. Claim adjustments due to a processing error should calculate interest based on the period of the day after receipt of the initial clean claim to the date the payment is mailed. Interest accrues for each calendar day beyond forty-five (45) working days (if applicable).
   c. Claim adjustments not involving a processing error should calculate interest based on the period of the day after receipt of the additional information that warranted the adjustment to the date the payment is mailed. Interest accrues for each calendar day beyond forty-five (45) working days (if applicable).

N. Any and all payments of interest must be listed separately on the EOB/RA to the Provider of Service (See Attachment, “IEHP Remittance Advice” in Section 20). Providers of Service that file a claim tracer or a corrected claim must identify the claim as such. Tracers should not be submitted prior to sixty (60) days from the date the claim was originally submitted to the financially responsible party.

O. California Children’s Services (CCS) claims or other claims in which there was potential responsibility for payment by another party, and subsequently denied by that party for non-coverage of service, termination of coverage or partial payment which is less than Medi-Cal rates, are considered timely if submitted within contract submission timelines for contracted Providers of Services, or one (1) year for non-contracted Medi-Cal Providers of Service from the date services were denied or partially paid, when accompanied by the notice of denial or partial payment. Claims submitted after the above noted timeframes from the date services were denied or partially paid can be denied.

P. Payment or notification of denial must be sent to the Provider of Service within forty-five (45) working days of the date a complete claim is received if a contracted Provider or thirty (30) calendar days if a non-contracted Provider, accompanied by an EOB or RA. The date of payment or notification of denial is the date the payment or notice is actually mailed to the Provider of Service.

Q. Any claim that is denied, adjusted or contested must include an accurate and clear written explanation of the actions taken. The Provider of Service and Member, when applicable, must
20. CLAIMS PROCESSING

A. Claims Processing

be appropriately notified if a claim is denied within forty-five (45) working days of receipt of a complete claim if contracted, or thirty (30) calendar days if non-contracted.

1. All denial notifications, including an EOB or RA, to the Provider of Service must include mandated language involving balance billing and the right to appeal the denial, including the process for filing a dispute. For a sample of IEHP’s RA and disclosure language (See Attachment, “IEHP Remittance Advice” in Section 20).

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

R. If a Capitated Provider determines that a claim has been overpaid, the Provider of Service must be notified in writing of the overpayment within three hundred sixty-five (365) days from the date the original claim was paid.

1. The written notice must clearly identify the claim, the name of the Member, the date of service and a clear explanation of the basis upon which the Capitated Provider believes the amount paid was in excess of the amount due, including interest and penalties.

2. Providers of Service have thirty (30) working days from the receipt of the notice of the overpayment to contest or reimburse the overpayment.
   a. If a Provider of Service contests the request for overpayment, the Provider of Service must send a written notice to the Capitated Provider stating the reason why the Provider of Service believes the claim was not overpaid.
   b. The contested notice of overpayment must be tracked, resolved and reported as a Provider Dispute, in accordance with Policy 20A1, “Claims Processing - Provider Dispute Resolution Process – Initial Claims Disputes.”

S. Uncontested notices of overpayment can only be offset against a Provider of Service’s future reimbursement when the Provider requests the retraction, in writing; or the Provider fails to reimburse the monies due within thirty (30) working days and the Provider of Service’s contract allows for the offset. Any offsets must be clearly explained at the time of the offset via the EOB/RA or other written documentation, including identifying the specific overpayment(s). Capitated Providers must establish and maintain a Provider Dispute Resolution Mechanism for all Providers of Service that meets or exceeds the requirements outlined in Policies 16B1, “Dispute and Appeals Resolution for Providers - Initial” and 20A1, “Claims Processing - Dispute Resolution Process – Initial Claims Disputes.” In general, the Provider Dispute Resolution Mechanism must include the following:

1. Providers of Service have three hundred sixty-five (365) days from the date of the original payment, denial, adjustment or contest, or other last action on a claim (i.e., Provider inquiries), to dispute or appeal the claim decision.

2. All disputes must be acknowledged within two (2) working days of receipt, if received electronically, or within fifteen (15) working days if received via paper.
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A. Claims Processing

3. All disputes must be resolved within forty-five (45) working days after the date of receipt.

4. Any dispute resolved in favor of the disputing Provider and resulting in additional payment must include interest and penalties as outlined in Policy 20A1, “Claims Processing - Dispute Resolution Process – Initial Claims Disputes.” Any payment including interest must be made within five (5) working days of the date of the written determination.

5. Any dispute involving an issue of medical necessity or utilization review that is upheld by the Capitated Provider through the dispute mechanism may be submitted to IEHP for secondary review and resolution within sixty (60) working days of the determination date of the dispute from the Provider. Appeals must be submitted to IEHP in accordance with Policies 16B2, “Dispute and Appeals Resolution Process for Providers - Health Plan” and 20A2, “Claims Processing - Health Plan Claims Appeals” for appeals involving adjudication of claims or billing matters.

6. All Provider disputes must be reported to IEHP as outlined in Policy 20H, “Claims and Provider Dispute Reporting.” For reporting and monitoring purposes, issues resolved through arbitration are not considered a dispute and are not subject to the requirements noted above.

T. IEHP’s Provider Relations Team is available from 8:00am - 5:00pm PST, Monday through Friday at (909) 890-2054 or (866) 223-4347 to assist and answer any claim related inquiries.

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

U. The responsibility for a claim payment as outlined above continues until all claims have been paid or denied for services rendered during the period a Capitated Agreement existed.
20. CLAIMS PROCESSING

A. Claims Processing
   1. Provider Dispute Resolution Process - Initial Claims Disputes

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

POLICY:
A. “Providers” means any practitioner or professional person, acute care hospital organization, health facility, ancillary Provider, or other person or institution licensed by the State to deliver or furnish healthcare services directly to the Member.
B. Providers must submit all claims related disputes, including those involving claims payment or denial, billing, contracting or Utilization Management (UM)/medical necessity to the financially responsible Payor (contracted capitated Delegated IPAs, Hospitals or IEHP) for the initial dispute resolution process.
C. All disputes must be submitted to Payor within three hundred sixty-five (365) days of the last date of action on the claim requiring resolution.
D. Payors must identify and acknowledge the receipt of all disputes within two (2) working days if the dispute was received electronically or fifteen (15) working days of receipt of a written dispute.
E. Payors must resolve disputes and issue a written determination within forty-five (45) working days of receipt.
F. A Provider may submit a 2nd level appeal regarding the outcome of a Payor’s dispute resolution involving claims or billing to IEHP within six (6) months of receipt of the written dispute determination letter from the Payor.

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

1. Disputes are categorized as follows, for reporting, tracking and monitoring purposes:
   a. Claims/Billing – any formal written disagreement involving the payment, denial, adjustment or contesting of a claim, including overpayments, payment rates, billing issues or other claim reimbursement decisions.
   b. Denial of a claim for any reason including eligibility, benefits, untimely filing, etc. as outlined in Policy 20A, “Claims Processing”. 
20. CLAIMS PROCESSING

A. Claims Processing
   1. Provider Dispute Resolution Process - Initial Claims Disputes

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

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

2. Written claims and billing related disputes must be submitted to the Payor in accordance with the dispute filing guidelines issued by the Payor.

   a. For claims or billing disputes involving IEHP as the Payor, disputes must be sent to:

      IEHP Claims Appeal Resolution Unit
      P.O. Box 4319
      Rancho Cucamonga, CA 91729-4319

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

   c. Any dispute involving Primary Care Physician (PCP) Pay For Performance (P4P) reimbursements should be filed in accordance with Policy 19C, “Pay For Performance (P4P),”

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

4. If the dispute is not about a claim/billing, the written request must include a clear explanation of the issue and the Provider’s position, as outlined in Policy 16B1, “Dispute and Appeal Resolution Process for Providers - Initial”.

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

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

   2. If the dispute was received in paper form, acknowledgement must be provided within fifteen (15) working days of receipt of the dispute.

C. If a dispute is incomplete, or if the information is in the possession of the Provider and not readily accessible to the Payor, the Payor may send a written request for information (See Attachment, “Provider Dispute Request Additional Information Letter” in Section 20) that is necessary to resolve the dispute. The Provider has thirty (30) working days to resubmit an amended dispute with the missing information. If requested documentation is not received, a
20. CLAIMS PROCESSING

A. Claims Processing
   1. Provider Dispute Resolution Process - Initial Claims Disputes

A denial letter is issued (See Attachment, “Provider Dispute Denial – Requested Information Not Received Letter” in Section 20).

D. Payors must make every effort to investigate and take into consideration all information on file or received from the Provider and may further investigate and/or request additional information or discuss the issue with the involved Provider as needed to make a determination.

E. Payors must send a written notice of the resolution regardless of whether the dispute is upheld or overturned (See Attachments, “Provider Dispute Original Claims Determination Upheld Letter” and “Provider Dispute Payment Adjustment Made Letter” in Section 20), including pertinent facts and an explanation of the reason for the determination, within forty-five (45) working days of the receipt of the dispute. If the written determination results in payment to the disputing Provider, payment must be made within five (5) working days of the date of the written determination.

F. Determinations involving Medi-Cal claims made in favor of the disputing Provider that results in payment of additional monies is subject to interest penalties 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 per year or 15% per annum;
   c. Interest must be paid within five (5) working days of the determination to pay. Failure to pay interest automatically requires a $10.00 penalty, to be paid in addition to any interest due; and
   d. Interest is calculated on a calendar day basis.
   e. Interest begins with the first calendar day after the 45th working day from the original date of receipt of the first claim filed that is being disputed through the day the payment is mailed or electronically deposited.
   f. If the resolution of a Provider Dispute results in additional payment, IEHP will automatically include the appropriate interest amount if payment is not issued within the required timeframes.

2. If the determination is made to pay additional monies is based on information obtained subsequent to the initial adjudication decision, such as a request for retro-authorization or is made as a goodwill gesture, interest penalties are not due.

G. Providers that are dissatisfied with the resolution of any dispute not involving claims or billing
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A. Claims Processing
   1. Provider Dispute Resolution Process - Initial Claims Disputes

(i.e. capitation, contracts) may appeal to IEHP as outlined in Policy 16B2, “Dispute and Appeal Resolution Process for Providers - Health Plan Appeals.”

H. Providers that are dissatisfied with the initial resolution and written determination by the Payor that involves payment or denial decisions on adjudicated claims or billing, including denials for procedures, referrals or services may submit a written appeal of the Payor’s determination to IEHP by following the process outlined in Policy 20A2, “Claims Processing - Health Plan Claims Appeals.”

I. Providers that are not satisfied with the initial determination by the Payor, and the determination is related to medical necessity or utilization management, the Provider has the “de novo” right to appeal directly to IEHP within sixty (60) working days of receipt of the written determination by submitting a written request for review as outlined in Policies 16B2, “Dispute and Appeal Resolution Process for Providers - Health Plan” and 20A2, “Claims Processing - Health Plan Claims Appeals.”

J. Furthermore, Providers that are dissatisfied with the outcome of a dispute originally filed with the Payor that involves pre-service referral denials or modifications may submit an appeal to IEHP in accordance with Policy 16B3, “Dispute and Appeal Resolution Process for Providers - UM Decisions”.

K. No retaliation can be made against a Provider who submits a dispute in good faith.

L. 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.

M. Payors must track and report all disputes received and submit monthly summary reports to IEHP in accordance with Policy 20H, “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.
20. CLAIMS PROCESSING

A. Claims Processing
   2. Health Plan Claims Appeals

APPLIES TO:

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

POLICY:

A. “Provider of Service” means any Provider or professional person, acute care hospital organization, health facility, ancillary Provider, or other person or institution licensed by the State to deliver or furnish health care services directly to the Member.

B. Providers may submit a second level appeal to IEHP if they disagree with the written determination rendered by the financially responsible Payor (contracted capitated Delegated IPAs or Hospitals) 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.

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

D. IEHP will identify and acknowledge appeals within fifteen (15) working days of receipt.

E. IEHP reviews the appeal to determine the appropriateness of the denial/reduction and renders a decision within forty-five (45) working days of receipt of all necessary information.

PROCEDURES:

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

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

C. A Provider who has been denied payment for services or feels that the claim has been underpaid or who has other claims or billing related issues must first file a dispute with the responsible Payor as outlined in Policy 20A1, “Claims Processing - Provider Dispute Resolution Process - Initial Claims Disputes.”
20. CLAIMS PROCESSING

A. Claims Processing
   2. Health Plan Claims Appeals

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

E. Upon receipt of an appeal, IEHP will acknowledge by issuing a letter to the Provider within fifteen (15) working days (See Attachment, “Provider Appeal Acknowledgement Letter” in Section 20).

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

1. Appeals should be submitted to:

   IEHP – Claim Appeal Resolution Unit
   P.O. Box 4319
   Rancho Cucamonga, CA 91729-4319

2. The following information must be included with the written appeal, as applicable:

   a. Claim Appeal Cover Letter;
   b. Written Determination from the responsible Payor;
   c. Claim Form;
   d. Denial Letter/Explanations of Benefits;
   e. Transcribed Notes;
   f. Hardcopy Authorization if Prior Authorization Received;
   g. If Verbal Authorization Received:
      1) Services Authorized;
      2) Any Limitations to the Authorization;
      3) Name of Person Providing Verbal Authorization; and
      4) Date and Time Verbal Authorization Given.

      (Follow up calls for additional services require the same information.)
   h. Documentation proving an attempt was made to obtain authorization from the IPA/Hospital should indicate the phone number called, the date and time call was made, and whom the Provider spoke to, if applicable; and
   i. If the responsible entity denied the claim due to timeliness, evidence of timely billing or other documentation that substantiates good cause for the delay in billing, that includes but is not limited to the following, must be submitted with the appeal.

      1) Claim determination letter or Explanation of Benefits (EOB)/Remittance Advice (RA) from IEHP or one of IEHP’s contracted capitated Providers.
20. CLAIMS PROCESSING

A. Claims Processing

2. Health Plan Claims Appeals

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 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, 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.

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

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

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

H. If additional information is needed from the Payor, IEHP will request documentation from the Payor that has reduced payment or denied the services (See Attachment, “Provider 7-Day Payment Request” in Section 20). This documentation must be provided within the timeline outlined in the letter.

1. If the Payor fails to provide evidence of appropriate medical review, as applicable, the original adjudication decision is overturned based on procedural grounds. IEHP issues a letter indicating the Payor is financially liable for the claim in question (See Attachment, “7-Day Inappropriate Denial Letter” in Section 20). The Payor has seven (7) days to pay the claim, with appropriate interest and penalties, and provide evidence to IEHP that payment 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 payments, including capitation 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:
20. CLAIMS PROCESSING

A. Claims Processing

2. Health Plan Claims Appeals

1. Medical claims-related appeals are forwarded to the IEHP Medical Director. Medical claims-related appeals involve denials for non-authorized services, denials or down-coding of emergency services, UM/medical necessity decisions, etc.

2. Medical disputes involving current patient care are resolved in accordance with Policy 16B3, “Dispute and Appeal Resolution Process for Providers - UM Decisions” and the immediacy of the situation.

K. IEHP conducts a review of the appeal and renders a decision within ten (10) days. A written determination of the decision is sent to the appealing party within forty-five (45) working days of receipt of the appeal (See Attachment, “Provider Dispute Original Claims Determination Upheld Letters” in Section 20).

1. If the reduced payment or denial is upheld, the appealing party and Payor are notified in writing of the decision and no further action is taken by IEHP (See Attachment, “Provider Dispute Original Claims Determination Upheld Letter” in Section 20).

2. If the reduced payment or denial is overturned, the Payor is notified in writing, via certified mail, of their financial obligation with a copy sent to the appealing Provider. IEHP instructs the Payor to pay the claim, including interest and penalties as applicable, within seven (7) days (See Attachment, ”7-Day Inappropriate Denial Letter” in Section 20). Interest must be paid as outlined in Policy 20A1, “Claims Processing - Provider Dispute Resolution Process – Initial Claims Disputes.”

a. If Payor fails to respond to an IEHP inquiry, a demand letter will be issued requiring proof of payment within the timeline outlined in the 7-Day Non-Response letter (See Attachment, “7-Day Non-Response Letter” in Section 20). If evidence is not provided of claim payment, IEHP will pay the claim on the Payor’s behalf and deducts the payment from the next capitation payment.

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

1. For outpatient services the 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.

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. For emergency services, the Emergency Room (ER) rate listed in the Medi-Cal schedule of reimbursement (RFO500).
20. CLAIMS PROCESSING

A. Claims Processing
   2. Health Plan Claims Appeals

M. If the Provider is still not satisfied with the outcome of the health plan appeal determination, the Provider may request IEHP Chief Executive Officer (CEO) reviews the appeal. Appeals for IEHP CEO must be received within thirty (30) days of receipt of the decision concerning the health plan level appeal. IEHP will acknowledge receipt by issuing a letter to the Provider within fifteen (15) working days. If the decision on the health plan appeal by IEHP CEO determines the Payor is not financially responsible, and if IEHP paid the claim on their behalf, the payment deduction from capitation is reversed.
20. CLAIMS PROCESSING

B. Billing of IEHP Members

APPLIES TO:

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

POLICY:

A. Under the Knox-Keene Act, Health and Safety Code 1379 of the State of California, it is illegal to bill an HMO Member for whom services were provided, except for non-benefit items or non-covered services.

B. According to State and Federal regulations, it is illegal to bill a Medi-Cal Member for covered medical services. It is also illegal to bill a Member a co-payment amount for any reason or purpose under Medi-Cal managed care.

C. Providers and practitioners are not allowed and must not bill Medi-Cal Members or attempt collection against a Medi-Cal Member as indicated above.

D. IEHP monitors Providers to ensure compliance with these regulations.

PROCEDURES:

A. When IEHP is notified by a Member stating they are being billed for medical services, IEHP determines the Member’s responsibility for the services rendered. If it is determined that the services are the responsibility of the Member, the Member is advised accordingly. If it is determined that the services billed are not the responsibility of the Member, IEHP obtains all pertinent information regarding the bill and records it into a tracking database. Additionally, IEHP instructs the Member to submit the received bill to IEHP for further research and action.

1. IEHP allows fourteen (14) days for the Member to submit the bill. If the bill is not received within fourteen (14) days, the Member is contacted and another additional seven (7) days is provided to submit the information. If no response is received following the second attempt, IEHP closes the case.

B. When IEHP receives the Member’s bill, IEHP reviews the information logged and verifies eligibility, responsible Payor, benefits and the Member’s Primary Care Physician (PCP). If the bill received is not a complete itemized claim, IEHP requests any additional information needed for claims processing via a Provider phone call.

C. When required documents for covered services are received, IEHP identifies the financially responsible Payor and issues a 7-Day letter (See Attachment “Provider 7-Day Payment Request” in Section 20).

D. If the Payor fails to respond within the seven (7) days period, or if the response received is inappropriate, IEHP will pay the claim and deduct an equivalent amount from the next scheduled Delegated IPA Capitation payment, if the Delegated IPA is the responsible payor, as outlined in Policy 20C, “Claims Deduction From Capitation - 7 Days Letter.” If IEHP agrees with the Delegated IPA decision, IEHP will inform the provider of the upheld decision.
20. CLAIMS PROCESSING

B. Billing of IEHP Members

(See Attachment, “Provider Dispute Original Claims Determination Upheld Letter” in Section 20).

E. If IEHP is the responsible Payor, a letter to the Provider of Service with a notice to cease and desist from billing the Member for covered services is sent (See Attachment, “Non-Cooperative 1st Letter – Medi-Cal” in Section 20). This letter instructs the Provider of Service to resolve the matter directly with IEHP.

1. Covered services are outlined [http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp](http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp) and also include any forms required by IEHP that must be completed by the Provider pertaining to payment, authorization or reporting of services. Examples of forms that are considered covered services, and for which Members cannot be charged for completing them, include, but are not limited to:
   a. Referrals (e.g., WIC referral forms, referrals for specialty services, etc.);
   b. Assessments, surveys or questionnaires (e.g., Lead testing questionnaire, perinatal assessment forms, etc.); and
   c. Prescriptions.

2. If the Provider of Service is a participating practitioner, the responsible Payor must intervene and contact the Provider to ensure that the billing of the assigned Member is discontinued.

3. If the claim is a balance bill, IEHP sends a letter to the Provider of Service (See Attachment, “Balance Bill – Out of State Provider” in Section 20) with a copy to the Member and Delegated IPA/hospital, stating that the Member cannot be balanced billed (See Attachment, “Balance Bill – Medi-Cal Member” in Section 20).

F. If the Provider of Service continues to charge a Member in violation of this policy after being notified to stop, or sends the Member’s account to a collections agency, IEHP reserves the right to inform the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS) or other regulatory agencies of the violation. In addition, the billing of Members is in violation of the IEHP Agreement and IEHP takes all necessary actions, up to and including termination of the Agreement, to ensure that such actions cease.

G. In addition, if the services provided are deemed medically necessary and the Member was sent to collections, IEHP reserves the right to pay the Provider of Service and reduce the responsible Provider’s next monthly capitation check, as applicable.
20. CLAIMS PROCESSING

B. Billing of IEHP Members

REFERENCE:

20. CLAIMS PROCESSING

C. Claims Deduction From Capitation – 7-Day Letter

APPLIES TO:

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

POLICY:

A. Payor must appropriately pay or deny complete claims for contracted Providers of Service within forty-five (45) working days from original receipt. Non-contracted providers of service must be paid within thirty (30) calendar days. This standard is based on the timeframe from the initial receipt of the claim (date stamped) until the check or denial letter is mailed to the Provider of Service.

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

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

PROCEDURES:

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

B. IEHP’s 7-Day letter process is available to Providers of Service under the following circumstances:
   1. A Provider of Service notifies IEHP that no status has been provided on claims submitted to the appropriate Payor for over forty-five (45) working days (approximately sixty (60) calendar days); or
   2. IEHP identifies a claim that has not been paid within the claims processing timeframes above.

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

D. As outlined in Policy 20A2, “Claim Processing - Health Plan Claims Appeals” Providers of Service should submit documentation demonstrating an attempt to obtain payment from the Payor. Documentation should include:
20. CLAIMS PROCESSING

C. Claims Deduction From Capitation – 7-Day Letter

1. A Clean Claim (See Attachment “CMS 1500 Form” and “UB04 Inpatient & Outpatient Form” in Section 20);
2. Appeal Cover Letter from Provider;
3. Written Determination from the responsible Payor;
4. EOB from the responsible entity;
5. Denial Letter/Explanation of Benefits;
6. Medical Records;
7. Claim Tracers;
8. Transcribed Notes;
9. Hardcopy authorization if prior authorization received;
10. Phone Logs;
11. Authorization received:
   a. Services authorized;
   b. Any limitations to the authorization;
   c. Name of person providing verbal authorization; and
   d. Date and time verbal authorization given.
   (Follow up calls for additional services require the same information.)
12. Or any other necessary information that supports the appropriateness of services rendered.

E. Upon receipt of the claim, IEHP verifies Member eligibility on the date of service, and ensures that the claim was sent to the appropriate Payor. If the Member is not eligible with IEHP for the date of service, the request is rejected and a denial letter is issued to the Provider of Service explaining the reason for the rejection. If the claim was sent to the incorrect Payor, IEHP returns the claim to the Provider of Service advising them to re-bill the correct Payor.

F. IEHP sends a secure email or mails a certified 7-Day letter (See Attachment, “7-Day Inappropriate Denial Letter” in Section 20) to the Provider (See Attachment, “Provider 7-Day Payment Request” in Section 20). The 7-Day letter includes a copy of the claim and requests information on the status of the claim, which must be completed by the Provider and returned to IEHP within seven (7) days from the sent date.

G. Payor must respond to IEHP with the following claim information:
   1. The date the claim was originally received;
   2. If it was paid or denied;
   3. The date paid or denied;
20. CLAIMS PROCESSING

C. Claims Deduction From Capitation –7-Day Letter

4. The amount paid;
5. The check number of payment; and/or
6. The reason for the denial.

7. 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).

8. 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. For outpatient services the 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.

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.

9. Claims capitation deductions are outlined on a detail report, sent with the capitation payment (See Attachment, “Capitation Payment Deduction” in Section 20).

10. 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

11. If Payor fails to respond to an IEHP inquiry, a demand letter will be issued requiring proof of payment within the timeline outlined in (See Attachment, “7-Day Non-Response Letter” in Section 20) 7-Day Non-Response letter.
20. CLAIMS PROCESSING

C. Claims Deduction From Capitation –7-Day Letter
20. CLAIMS PROCESSING

D. Claims and Compliance Audits

APPLIES TO:

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

POLICY:

A. IEHP provides oversight of claims processing by Capitated Providers 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 Capitated Providers annually or as necessary.

C. Audits include on-site review and evaluation of specific claims, disputes, adjustments, reports, personnel, written policies and procedures and 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 Capitated Providers are required to cure any deficiencies in their systems in order to bring them into contractual and regulatory compliance.

E. Capitated Providers can submit a rebuttal to dispute the result of an audit through the IEHP Rebuttal process by submitting a written rebuttal to IEHP as outlined in the IEHP Audit Guide.

PROCEDURES:

A. IEHP provides comprehensive oversight of Capitated Providers’ delegated 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 Capitated Providers.

B. Audits ensure Capitated Providers:

1. Are paying and denying claims and resolving Provider disputes in accordance with regulatory and contractual requirements.

2. Have adequate system protocols in place to log, acknowledge, track, monitor and appropriately adjudicate or resolve all claims and disputes received; follow-up and reporting meet IEHP requirements, and that these systems are operating as designed and do not result in unfair payment patterns.

3. Claims processing systems are adequate to meet the terms of the IEHP contract as well as regulatory requirements.

4. Have contracts in place with subcontracted Providers that meet regulatory requirements as they pertain to claims processing and dispute resolution.
20. **CLAIMS PROCESSING**

   **D. Claims and Compliance Audits**

5. Are financially viable and are 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 Capitated Providers 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 trends for possible indicators of potential or emerging patterns of unfair payment practices or inability to perform delegated functions.

D. Capitated Providers must submit the following monthly and quarterly reports to IEHP within specified timeframes, in a format designated by IEHP, as outlined in the IEHP Audit Guide.

1. By the 15th of each month, capitated Providers 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 and is outlined in Policy 20H, “Claims and Provider Dispute Reporting.”

2. By the 30th of the month following the end of the quarter, for the previous quarter, Capitated Providers must submit information regarding disputes and adjustments. The reports due, as outlined in Policy 20H, “Claims and Provider Dispute Reporting,” are:
   a. Quarterly Provider Dispute Resolution (PDR) Report;
   b. Quarterly Provider Dispute by Type/Volume Report;
   c. Quarterly Adjustments Summary Report; and

3. Capitated Providers 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 20H, “Claims and Provider Dispute Reporting.”

4. IEHP reserves the right to request additional reports as deemed necessary.

5. Failure to submit required reports that include all required information in a complete and accurate manner in IEHP’s required format, within the indicated timeframes, may result in the Capitated Provider being subjected to a focused audit and negatively impact the Capitated Provider’s contract renewal terms.

E. IEHP audits the claims processing system of each Capitated Provider 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
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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 required 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 possible payment practices that 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 capitated Providers in writing at least ninety (90) days in advance of the scheduled audit. The notice is explicit in the timeframe being audited, its request for documents and access to Provider staff. For Focused Audits, IEHP reserves the right to give a minimum of three (3) working days prior notice.

1. Routine Audits include off-site and on-site review.

2. Approximately sixty (60) days prior to the scheduled audit, Capitated Providers must submit the following detailed reports, covering the audit period, to IEHP for review and selection of claims:
   a. Paid Claims (including identification of emergency and family planning claims);
   b. Denied Claims (including identification of emergency and family planning claims);
   c. Closed Overpayments;
   d. Post-Payment Adjustments;
   e. Resolved Disputed Claims;
   f. Interest Paid Claims; and
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3. In addition, the following reports must be provided at the time of the audit for on-site claims selection and/or review. IEHP also reserves the right to request additional reports and/or documents as deemed necessary.

   a. Received Claims (including identification of emergency service claims, separately subtotalled).
   b. Pended Claims (including identification of emergency service claims, separately subtotalled).
   c. Open Claims (including identification of emergency service claims, separately subtotalled).
   d. Log or report of Redirected Claims.
   e. Signed Check Mailing/Attestation or Log.

4. Refer to the IEHP Audit Guide for a detailed description of each report and required reporting elements as well as the pre-audit notification and audit preparation requirements.

G. IEHP randomly selects claims to audit. The number of claims selected varies depending on the type and scope of the audit and the Provider’s total claim volume, and generally covers a twelve (12) month period. For specific information on the number of claims selected by volume, please refer to the IEHP Audit Guide.

   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 and Denied Claims;
      b. Emergency Services claims (paid);
      c. Non-contracted family planning claims, (paid and denied);
      d. Disputed claims;
      e. Post-Payment Adjustments;
      f. Interest Paid on late paying, adjusted or disputed claims;
      g. Overpayment Refund Requests (refunded, retracted or disputed); and
      h. Pended claims.

   2. The random claim selections will be forwarded to capitated Providers thirty (30) days prior to the scheduled audit. For concurrent audits involving more than one (1) entity, IEHP will allow five (5) additional days per additional entity.

   3. IEHP performs the claims review noted above off-site. One (1) day, usually the last day
20. CLAIMS PROCESSING

D. Claims and Compliance Audits

of the scheduled audit, IEHP will perform an on-site visit.

4. At the time of the on-site visit, IEHP will review current received, open and pend reports (as of the date of the audit), as well as a log of redirected claims, and may select additional claims for review.

5. IEHP also randomly selects Provider contracts for review.

6. IEHP reserves the right to request additional claims, reports or other documents on-site for review.

7. For verification and focused audits, the number or type of claims selected for review depends on the nature and issue of the deficiencies identified and may or may not be randomly selected.

H. One (1) week before the scheduled first day of the audit, Capitated Providers are required to send to IEHP specific supporting documentation for the selected claims or disputes to review. In addition, a signed Checklist must be included with the audit documentation attesting to the completeness of the data provided. Please refer to the Audit Guide for a detailed list of the audit documentation for each type of claim reviewed. Note: If any of the required documentation outlined in the Audit Guide is not available at the time of the audit and cannot be provided upon demand, the claim or dispute will be deemed non-compliant.

I. The audit consists of a review of three (3) areas: timeliness, appropriateness and systems. Within each area are a number of measures that must be met in order to fully pass an audit, including regulatory standards pertaining to the processing of claims or dispute resolutions. Each measure is considered a scorable element of the audit under the area assessed. In general, the measures reviewed include those outlined below. Please refer to the Audit Guide for a more comprehensive outline of each element and the relevant measures.

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. Refer to the IEHP Audit Guide (under timeliness) for the specifics of each element and related measures (i.e., 90% of non-contracted provider claims must be paid within thirty (30) days).

   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 in order to validate the date of receipt. In general, IEHP allows a ninety (90) days lag for non-contracted providers and one hundred eighty (180) days for
D. Claims and Compliance Audits

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. In order to confirm mailed date, IEHP tracks the timeframe between the check date and the date the check is presented for payment by the Provider of Service. The current standard allows for a twenty (20) day period between the check date and for the funds (e.g., claim check) to clear. This timeframe allows for variances in the mail delivery system and individual office practices for billing and handling accounts receivable.

e. Signed proof of mailing of checks must be maintained (check mailing/attestation). IEHP reserves the right to request and review the check mailing/attestation log (or other proof of mailing) as part of any audit to confirm mailing dates and/or to research check clearing patterns.

2. Appropriateness

a. Appropriateness measures include elements pertaining to 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 as a result of a review of claims selected for an audit are considered non-compliant. If an adjustment is made as a result of routine operational activities, such as a Provider inquiry, the adjustment is compliant. If a selected claim is adjusted during the period between the time the audit confirmation letter is received and the date of the audit due to routine activities, proof must be provided to support the adjustment, such as claim notes or a fax. Otherwise, that adjustment will be considered non-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
20. CLAIMS PROCESSING

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is mailed to the Provider of Service on the adjusted payment.

3. Systems
   a. The Systems portion of the audit includes both scored and non-scored elements.
   b. The scored elements are those measures that assess 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.
   c. The non-scored elements pertain to an assessment of the Capitated Provider’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 Provider compliance including periodic capitated Provider reporting to IEHP; and a physical walk-through of the claims department before and/or after the audit.

J. IEHP may conduct a preliminary verbal exit interview with the Capitated Provider at the end of the audit to discuss preliminary results, areas of concern, need for and timing of corrective actions to rectify noted system deficiencies and the timeframe for the next audit.

K. During the course of or subsequent to the audit, if IEHP suspects fraud, the claims auditor submits his/her findings to IEHP’s Compliance Department.

Capitated Providers must meet all measurements (elements) under each area, as outlined in the IEHP Audit Guide in order to pass the audit. The overall score assigned to the audit, which is used for performance evaluation purposes, is based on the total number of elements met as a percent of the total number of elements measured.

1. A passing score is assigned when all of the elements are met.
2. A conditional pass is assigned when claims compliance is 95% or higher, but all elements were not met (up to four (4) elements not met).
3. A non-compliant score is assigned when claims compliance is between 80% and 94% or five to eight (5 to 8) elements were not met. Repeatedly missing one (1) or more of the same elements over the course of two (2) consecutive audits will result in non-compliance.
4. A failing score is assigned when any of the following occur:
   a. Nine (9) or more elements are missed;
20. CLAIMS PROCESSING

D. Claims and Compliance Audits

b. Less than 80% of the claims are compliant;
c. Any suspected illegal, fraudulent or abusive practices or violation of regulatory requirements that could result in sanctionable actions by a regulatory agency is identified during the audit; or
d. Repeated non-compliance with one (1) or more of the same element over the course of three (3) or more consecutive audits. In this situation, a failing score will continue to be assigned until such time as a passing score has been achieved.

5. Failure of the audit will require the capitated Provider to submit a Corrective Action Plan (CAP).

6. For more specific information on the actual scoring of the audit, the elements within each area noted below and actions taken for non-compliance or failure, please refer to the IEHP Audit Guide.

L. Within thirty (30) days of the last day of the audit (usually the on-site visit), IEHP sends a preliminary audit report to the capitated Provider documenting the outcome of the audit, findings and recommended corrective actions. Capitated Providers have two (2) weeks to review the preliminary report and notify IEHP if the capitated Provider disagrees with any of the findings listed in the report through a formal rebuttal. For specific details of the rebuttal process, please refer to the IEHP Audit Guide.

M. Within fifteen (15) days of receipt of the capitated Provider’s response to the preliminary report, IEHP sends a Final Findings Report and Corrective Action Plan Request (CAPR).

N. The CAPR lists IEHP’s findings with respect to deficiencies, along with specific recommendations to bring the capitated Provider into contractual compliance. Capitated Providers are required to respond in writing to the CAPR by submitting a CAP within the timeframe specified by IEHP, generally thirty (30) days from the date of the Final Findings Report. The CAP should discuss in detail how the Capitated Provider has modified its claims processing system to address the findings of the CAPR. If the CAP caused changes to the Provider’s written policies and procedures and work flow charts, copies of this information must be submitted along with the CAP.

O. IEHP evaluates and issues a letter of acceptance or rejection of submitted CAPs within thirty (30) days of receipt.

1. If the CAP is accepted, IEHP issues a letter of acceptance.

2. If a CAP is rejected, the reasons, along with recommendations as to how the CAP should be changed, are included in the rejection letter.

3. Capitated Providers must submit a revised CAP within fifteen (15) days after the IEHP rejection letter is issued. IEHP evaluates the revised CAP within fifteen (15) days of receipt.
   a. If acceptable, an acceptance letter is issued.
20. CLAIMS PROCESSING

D. Claims and Compliance Audits

b. If rejected, the matter is referred to IEHP’s Delegation Oversight Committee.

P. Failure to provide an adequate CAP within required timeframes is deemed as a contractual breach and may result in the Capitated Provider being sanctioned and subjected up to a 2% reduction of their monthly capitation payment or possible contract termination until such time as an acceptable CAP is received. Untimely or inadequate CAPs may also impact the Capitated Provider’s contract renewal terms.

Q. CAP verification audits are performed whenever a Capitated Provider fails an annual or focused claims audit and/or to verify implementation of corrective actions for non-compliant audits.

1. The number and type of claims selected for a CAP verification audit may vary depending on the nature and scope of the deficiencies noted during the annual or focused audit.

2. Capitated Providers failing the verification audit may be subjected to a 2% monthly capitation deduction, weekly monitoring or possible contract termination.

3. Capitated Providers passing their CAP verification audit will be scheduled for their next annual audit approximately six (6) months from the date of the last CAP verification audit and every twelve (12) months thereafter.

R. Capitated Providers passing their annual audit are scheduled for the next annual audit approximately twelve (12) months from the date of the last audit and every twelve (12) months thereafter; subject to the focused or verification audit provisions noted herein.

S. Capitated Providers that receive an audit score that results 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 scores. 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 Capitated Provider is responsible for paying the outside auditors fees.

REFERENCE:

A. Section 1300.75.4.2 of Title 28 California Code of Regulations of the Knox Keene Act.
20. CLAIMS PROCESSING

E. Disputes Between Contracted Relationships

APPLIES TO:

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

POLICY:

A. Delegated IPAs, PCPs and/or IEHP are responsible for authorizing medical care.
B. The IEHP IPA capitated Agreement binds the Delegated 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 Delegated 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 Delegated 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 a Delegated IPA representative that is in breach of the above policy, the following may occur:

1. Hospital/IEHP reviews its incoming claims and identifies Delegated 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 Delegated IPA for payment with a denial letter explaining the reasons for the denial. If denied by the Hospital a copy of the denial letter, claim, records, and all supporting documentation should also be sent to IEHP at the following address:

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

E. Disputes Between Contracted Relationships

4. Hospitals may send the practitioner a letter informing them that the claim has been forwarded to the Delegated IPA for payment; however, a denial should not be sent to the practitioner.

5. The Delegated IPA must pay the claim for these hospital services unless the Delegated IPA feels the services provided were emergent or that the service was justified. In the event of the latter the Delegated IPA should submit the claim with the appropriate supporting documentation to IEHP at the above address with a letter of appeal explaining their position. The appeal must be submitted to IEHP within three hundred sixty-five (365) days of the denial or payment.

6. IEHP will follow the procedures outlined in Policy 20A2, “Claims Processing - Health Plan Claims Appeals,” in determining the appropriateness of the appeal and whose financial responsibility it is to pay the claim.

7. Payment will be issued by the responsible party as outlined in Policy 20A2, “Claims Processing - Health Plan Claims Appeals.”
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. IEHP should rely on the Medi-Cal eligibility record for cost avoidance and post payment recoveries.³

D. 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 meets the requirement for billing IEHP directly.⁴

E. If IEHP is made aware of OHC from sources other than the Medi-Cal eligibility record, IEHP may use OHC information for the claim containing the OHC information. IEHP must report the OHC to DHCS within 10 calendar days of discovery.⁵

F. 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.⁶

G. California Children’s Services (CCS) is the sole responsible payer if a Medi-Cal Member utilizes services for CCS eligible conditions.⁷

DEFINITIONS:

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

PROCEDURES:

State Programs

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¹ Department of Health Care Services (DHCS) All Plan Letter (APL) 20-010, “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

A. Unless otherwise indicated, if a Medi-Cal Member has OHC excluding tort liability of a third party (refer to Policy 19E, “Third Party Liability” for third party liability information), 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.8

B. IEHP coordinates benefits with both other health insurance carriers and Medicare. Exceptions include both claims where the Provider is paid under an IEHP capitation agreement and claims for services that meet the requirement for billing Medi-Cal directly.9

C. 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.10

D. 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.11

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

F. Medi-Cal 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.12

G. Medi-Cal Members with only Medicare Part B coverage have an annual deductible. There is also a coinsurance requirement of 20% of the Medicare allowable amount for most services.13

H. 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 has a contracted rate, the contracted rate will be used as the base rate for COB comparison.14

8 Ibid.
9 Ibid.
10 Ibid.
11 Medi-Cal Program and Eligibility (medi-cal.gov.ca).
12 CMS.GOV Centers for Medicare & Medicaid Services 2020 Medicare Parts A & B Premiums and Deductibles.
13 Ibid.
14 APL 20-010.
20. CLAIMS PROCESSING

F. Coordination of Benefits
20. CLAIMS PROCESSING

G. Claims and Provider Dispute Reporting

APPLIES TO:

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

POLICY:

A. IEHP provides oversight of claims processing by Capitated Providers through monitoring of Capitated Providers’ 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, capitated Providers 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 Provider being subjected to a focused audit which may negatively impact the Provider’s contract renewal terms and may lead to contract termination or conversion.

PROCEDURES:

A. Capitated Providers’ claims processing systems must be able to identify, track and report all claims and Provider disputes, by line of business and produce the following ad hoc reports as outlined in the IEHP Audit Guide, Section I, “Performance Monitoring.”

1. Received Claims – all claims received for a specified period regardless of status.

2. Paid Claims – all claims paid for services rendered to Members.

3. Denied Claims – all claims denied for services rendered to Members. (Note: IEHP considers denied claims to be all claims adjudicated in which the total dollars paid is $0.00. This includes all claims denied for non-contracted and Contracted Providers, such as duplicates or non-authorized services, as well as those in which the Member may be liable).

4. Pended/Contested Claims – claims pended and/or contested for development or in which a determination to pay or deny cannot be made without further information. Examples include claims forwarded for medical review, contested claims and written requests for additional information sent.

5. Claims Inventory – all claims received and open (i.e. received, however a check or denial has not been issued), whether or not entered 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.
20. CLAIMS PROCESSING

G. Claims and Provider Dispute Reporting

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.


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 or not entered 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 disputes 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 Capitated Providers 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 and/or designated format as delineated in the IEHP Audit Guide.

C. By the 15th of each month, Capitated Providers must submit to IEHP the Monthly Claims Timeliness Summary Report (MTR) for the previous month’s activity, as outlined in the Audit Guide.
20. CLAIMS PROCESSING

G. Claims and Provider Dispute Reporting

1. Each line of business should be separately tracked and reported.
2. 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.
3. Refer to the Audit Guide for detailed specifications for each report and additional monthly reporting requirements and information.

D. On a quarterly basis, Capitated Providers must submit reports for disputes and adjustments for review and evaluation as outlined below.

1. The required reports are:
   a. Quarterly Provider Dispute Resolution (PDR);
   b. Statement of Deficiencies;
   c. Adjustment Summary Report; and
   d. Resolved Disputes by Type/Volume.
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 10/1/18 through 12/31/18 would be due January 30, 2019) and must be signed by the designated principal officer.
3. Refer to the Audit Guide for detailed specifications for each report and additional quarterly reporting requirements and information.

E. On an annual basis, Capitated Providers 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 Capitated Provider for all lines of business combined.

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.
2. Refer to the Audit Guide for detailed specifications for each report and additional annual reporting requirements and information.

F. As outlined in Policy 20D, “Claims and Compliance Audits,” as well as the Audit Guide, Capitated Providers must also generate the following reports for the designated audit period, for review and claims selection (detailed specifications are outlined in the Audit Guide):

1. Paid Claims Report, including separate identification of emergency service claims and family planning claims (see the Audit Guide for definitions of emergency services and family planning claims).
20. CLAIMS PROCESSING

G. Claims and Provider Dispute Reporting

2. Denied Claims Report, including separate identification of emergency service and family planning claims.
5. Resolved Disputed 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 last ninety (90) days of the audit period, regardless of status).
10. Log or report of Redirected Claims.
11. Claims Inquiry/Customer Call Log (covering last ninety (90) days of the audit period), including reason for the call and outcome.
12. Signed Check Mailing/Attestation or Log (covering all checks issued for IEHP Members during the audit period), including check number, check amount and date mailed.

G. As outlined in the Audit Guide, 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); or a
3. Focused audit.

H. Failure to submit fully completed and accurate reports within mandated timeframes, using IEHP specific templates and formats or to submit amended reports as applicable and/or refusal to cooperate in the identification or resolution of identified issues, concerns, patterns or trends, is considered a breach of contractual requirements and may subject the Capitated Provider 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 Capitated Providers as outlined above and in the IEHP Audit Guide, is evaluated annually as part of
20. CLAIMS PROCESSING

G. Claims and Provider Dispute Reporting

IEHP’s Performance Evaluation Tool and contract renewal process. Failure to submit complete accurate reports within the specified timeframes may impact contract renewal terms.
## 20. CLAIMS PROCESSING

### Attachments

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>POLICY CROSS REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-Day Non-Response Letter</td>
<td>20A2, 20C</td>
</tr>
<tr>
<td>7-Day Inappropriate Denial Letter</td>
<td>20A2, 20C</td>
</tr>
<tr>
<td>Balance Bill - Medi-Cal Member</td>
<td>20B</td>
</tr>
<tr>
<td>Balance Bill – Out of State Provider</td>
<td>20B</td>
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<tr>
<td>Capitation Payment Deduction</td>
<td>20A2, 20C</td>
</tr>
<tr>
<td>CMS 1500 Form</td>
<td>20C</td>
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<td>IEHP Remittance Advice</td>
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<td>Non-Cooperative 1st Letter - Medi-Cal</td>
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<td>Provider 7-Day Payment Request</td>
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<td>Provider Appeal Acknowledgement Letter</td>
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<td>Provider Dispute Denial – Late Submission</td>
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<td>Provider Dispute Denial - Requested Information Not Received Letter</td>
<td>20A1</td>
</tr>
<tr>
<td>Provider Dispute Original Claim Determination Upheld Letter</td>
<td>20A1, 20A2</td>
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<tr>
<td>Provider Dispute Payment Adjustment Made Letter</td>
<td>20A1</td>
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<tr>
<td>Provider Dispute Request Additional Information Letter</td>
<td>20A1</td>
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<tr>
<td>UB04 Inpatient Form</td>
<td>20C</td>
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<tr>
<td>UB04 Outpatient Form</td>
<td>20C</td>
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</table>
{{(Date)}}

{{(Provider Name)}}
{{(Address)}}
{{(City, State Zip)}}

Dear Claims Manager:

Inland Empire Health Plan (IEHP) Claims Department received the enclosed claim from the provider of service. The provider has requested a review of the initial processing of this claim. After reviewing, this process has been found to be inappropriate.

<Letter Comments>

<table>
<thead>
<tr>
<th>Claim Number:</th>
<th>Date Paid:</th>
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<tbody>
<tr>
<td>Member Name:</td>
<td>Amount Paid:</td>
</tr>
<tr>
<td>IEHP ID:</td>
<td>Check Number:</td>
</tr>
<tr>
<td>Pt. Acct. No.:</td>
<td>Date Mailed:</td>
</tr>
<tr>
<td>Date of Service:</td>
<td>Signed:</td>
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<td>Amount Billed:</td>
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</table>

**Person Responding:**

**Phone:**

Comments:

Please complete this form and return it to the IEHP Claims Department. You may mail to Inland Empire Health Plan, Attention Claims Department. P.O. Box 4319, Rancho Cucamonga, CA 91729-4319 or Fax to: 909-890-5747.

Payment is due within seven (7) calendar days. If you fail to provide proof of payment within seven (7) calendar days, the claim will be subject to capitation deduction from your next capitation payment. If you have any questions, or concerns, please contact the IEHP Provider Relations Team at (909) 890-2054 or (866) 223-4347.

Sincerely,

Claims Appeal Resolution Specialist
Inland Empire Health Plan
Secure E-mail Template Demand for Payment

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

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

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

<table>
<thead>
<tr>
<th>Member Name</th>
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<tbody>
<tr>
<td>DOB</td>
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<tr>
<td>IEHP MEMBER ID</td>
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<tr>
<td>IEHP Claim Number</td>
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<tr>
<td>Provider of Service</td>
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<td>Tax ID</td>
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<td>Date of Service</td>
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<td>Amount Billed</td>
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<tr>
<td>Patient Account No.</td>
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</table>

Sincerely,

Claim Resolution Specialist
Inland Empire Health Plan
<Insert Processor Initials>
Secure E-mail Template notice of CAP deduction

From:
To:
Cc:
Subject: Notice of CAP deduction, <Insert Claim Numbers>

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

<table>
<thead>
<tr>
<th>Member Name</th>
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<tbody>
<tr>
<td>DOB</td>
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<tr>
<td>IEHP MEMBER ID</td>
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</tr>
<tr>
<td>Claim Number</td>
<td></td>
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<tr>
<td>Provider of Service</td>
<td></td>
</tr>
<tr>
<td>Tax ID</td>
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<tr>
<td>Date of Service</td>
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<tr>
<td>Amount Billed</td>
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<tr>
<td>Patient Account No.</td>
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<tr>
<td>Notification Date</td>
<td></td>
</tr>
<tr>
<td>CAP Deduction Amount</td>
<td></td>
</tr>
<tr>
<td>Process Date Date</td>
<td></td>
</tr>
</tbody>
</table>

Sincerely,

Claim Resolution Specialist  
Inland Empire Health Plan  
<Insert Processor Initials>
{(Date)}

{(Provider Name)}
Attention: Billing Department
{(Address)}
{(City, State Zip)}
{(Phone)}

Dear Claims Manager:

Inland Empire Health Plan’s (IEHP) Claims Department previously requested information from you regarding the below referenced claim. IEHP has not received the required proof of payment within the 7 days timeframe in accordance with IEHP Policy 20A2. The policy indicates, “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 payments, including capitation due to the Provider”.

As a result, IEHP will deduct the amount listed below from your next monthly Capitation Payment.

<table>
<thead>
<tr>
<th>Claim Number:</th>
<th>Date Of Service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Name:</td>
<td>Provider:</td>
</tr>
<tr>
<td>IEHP ID:</td>
<td>Date Paid:</td>
</tr>
<tr>
<td>Pt. Acct. No.:</td>
<td>Amount Paid:</td>
</tr>
</tbody>
</table>

If you have any questions, please contact the IEHP Provider Relations Team at (909) 890-2054 or (866) 223-4347 or fax information to (909) 890-5747.

Sincerely,

Claims Appeal Resolution Specialist
Inland Empire Health Plan

cc: Provider of Services
Secure E•mail Template Demand
for Payment

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

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

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

<table>
<thead>
<tr>
<th>Member Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>IEHP MEMBER ID</td>
<td></td>
</tr>
<tr>
<td>IEHP Claim Number</td>
<td></td>
</tr>
<tr>
<td>Provider of Service</td>
<td></td>
</tr>
<tr>
<td>Tax ID</td>
<td></td>
</tr>
<tr>
<td>Date of Service</td>
<td></td>
</tr>
<tr>
<td>Amount Billed</td>
<td></td>
</tr>
<tr>
<td>Patient Account No.</td>
<td></td>
</tr>
</tbody>
</table>

Sincerely,

Claim Resolution Specialist
Inland Empire Health Plan
<Insert Processor Initials>
Secure E-mail Template notice of CAP deduction

From:
To:
Cc:
Subject: Notice of CAP deduction, <Insert Claim Numbers>

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

<table>
<thead>
<tr>
<th>Member Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>IEHP MEMBER ID</td>
<td></td>
</tr>
<tr>
<td>Claim Number</td>
<td></td>
</tr>
<tr>
<td>Provider of Service</td>
<td></td>
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<tr>
<td>Tax ID</td>
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<tr>
<td>Date of Service</td>
<td></td>
</tr>
<tr>
<td>Amount Billed</td>
<td></td>
</tr>
<tr>
<td>Patient Account No.</td>
<td></td>
</tr>
<tr>
<td>Notification Date</td>
<td></td>
</tr>
<tr>
<td>CAP Deduction Amount</td>
<td></td>
</tr>
<tr>
<td>Process Date Date</td>
<td></td>
</tr>
</tbody>
</table>

Sincerely,

Claim Resolution Specialist
Inland Empire Health Plan
<Insert Processor Initials>
Attachment 20 - Balance Bill – Medi-Cal Member

{(Date)}

Via Certified Mail:
Due:

{(Provider Name)}
{(Address)}
{(City, State Zip)}

Re: Balance billing of IEHP Medi-Cal Member {(Member Name)}

Acct# {Number} Identification #: {(IEHP ID #)}
Claim# {Number} Claim Receipt Date: {(Date)}
DOS: {(Date)} Dollar Amount: {( $ )}

To Whom It May Concern:

It has come to the attention of Inland Empire Health Plan ("IEHP") that {(Provider Name)} has been improperly pursuing collection actions against the above-captioned Medi-Cal beneficiary who is enrolled with IEHP. Such collection actions may have included sending bills to and calling the Medi-Cal beneficiary with demands to pay the outstanding balance, and referrals to a collection agency.

Please be advised that the California Supreme Court has made it clear such practices as they relate to Medi-Cal beneficiaries are strictly prohibited under both federal and state laws:

“Even though Medicaid payments are typically lower than the amounts normally charged by providers for their services (see McAmis v. Wallace (W.D.Va. 1997) 980 F.Supp. 181, 182), “[a] State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual” (42 C.F.R. § 447.15, italics added). FN8 Section 1396a(a)(25)(C) of title 42 United States Code Service then provides “that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service” except under specific circumstances and in limited amounts defined by the statute. FN9 (Italics added; see also 42 C.F.R. § 447.20(a.).) FN10

“To comply with these federal requirements, Medi-Cal has imposed certain limitations on provider reimbursement. Under section 14019.3, subdivision (c), “[u]pon presentation of the Medi-Cal card or other proof of eligibility, the provider shall submit a Medi-Cal claim for reimbursement ....” "Any provider of health care services who obtains a label or copy from the
Medi-Cal card or other proof of eligibility ... shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or any person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services.” (§ 14019.4, subd. (a).)

This prohibition against the balance billing of Medi-Cal beneficiaries applies irrespective of whether the services are emergent or non-emergent.

It is also noted that such actions would be in violation of the Provider’s conditions of participation in the Medi-Cal program:

“Beneficiary Billing. Provider agrees that it shall not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program’s scope of benefits in addition to a claim submitted to the Medi-Cal program for that service, except to: (1) collect payments due under a contractual or legal entitlement pursuant to Welfare and Institutions Code, Section 14000(b); (2) bill a long-term care patient for the amount of his/her liability; and, (3) collect a co-payment pursuant to Welfare and Institutions Code, Sections 14134 and 14134.1.

As you may know, violation of state laws prohibiting the balance billing of Medi-Cal beneficiaries constitutes grounds for suspension from the Medi-Cal program.

Based on the foregoing, you are hereby requested to immediately (a) cease and desist from any balance billing or collection activities as it relates to IEHP’s Medi-Cal Members; (b) return to IEHP’s Medi-Cal Members any monies collected from such Members; and (c) reverse any negative credit reporting made against any such Members.

Thank you for your anticipated cooperation.

Sincerely,

Claims Appeal Resolution Specialist
Inland Empire Health Plan

---

2 Id. at 813 (emphasis added). Also see Title 22, Calif. Code of Regulations, § 51002(a).
3 For emergent services, the prohibition against balance billing is also set forth in Title 28, Calif. Code of Regulations, § 1300.71.39(a).
4 California Department of Health Services, Medi-Cal Provider Agreement, DHS 6208 (1/06) (“DHS Provider Agreement”), sec. 20 (emphasis in original).
5 See Calif. Welf. & Inst. Code, sec. 14123(a); DHS Provider Agreement, sec. 25(b)(1).
{(Date)}

{(Provider Name)}
{(Address)}
{(City, State Zip)}

Attn: Billing Department

Member Name: Acct #: {(Number)}
ID No.: Balance {( $ )}
Date of Service:

To Whom It May Concern:

It has come to the attention of Inland Empire Health Plan (IEHP) that you are “balance billing” an IEHP Member for services rendered at your facility. Moreover, the Member(s) in some cases have been sent to collections.

IEHP is a Medi-Cal Managed Care Plan contracted with the California Department of Health Care Services (DHCS) to administer the federal Medicaid program in California to certain recipients. Therefore, IEHP pays according to DHCS payment schedule. While your facility is located outside the state of California, your State Statues as well as the Code of Federal Regulations Title 42 – govern the payments you must accept for treating a Medicaid recipient.

In the case above, you have been reimbursed from IEHP the correct amount per our contract with DHCS, which in turn is the amount your state requires us to pay. Should you persist in leaving our Member in collections or “balance bill” the Member for services IEHP has already paid for, IEHP will have no choice but to seek action against you.

IEHP will contact your State Department of Health Care Services, the Federal Office of Inspector General and the Center for Medicaid and Medicare Services. In doing so, you jeopardize sanction, as well as, potential loss of recognition as a Medicaid Provider.

Thank you for your attention and quick resolution to this matter. If you have any further questions, please contact IEHP at (909) 890-2054 or (866) 223-4347.

Sincerely,

Claims Appeal Resolution Specialist
Inland Empire Health Plan

MB02/Diamond Initials
## Capitation Payment Deduction

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<th>MEMBER LAST NAME</th>
<th>MEMBER FIRST NAME</th>
<th>DATE OF SERVICE</th>
<th>IEHP ID</th>
<th>CLAIM#</th>
<th>CODE BILLED</th>
<th>MOD</th>
<th>QTY</th>
<th>AMOUNT BILLED</th>
<th>AMOUNT PAID</th>
<th>EOB CODE</th>
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**Total Deductions for:**

**Report Date:** 10/12/2007
Please print or type

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<th>Group Health Plan</th>
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<th>2. Patient's Name</th>
<th>Last Name, First Name, Middle Initial</th>
<th>3. Patient's Birth Date</th>
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<th>YY</th>
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<th>4. Insured's Name</th>
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<th>5. Patient's Address</th>
<th>Na., Street</th>
<th>6. Patient Relationship to Insured</th>
<th>Spouse</th>
<th>Child</th>
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<th>CITY</th>
<th>STATE</th>
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<th>TELEPHONE (Include Area Code)</th>
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<th>Last Name, First Name, Middle Initial</th>
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<th>10. Is patient's condition related to:</th>
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<th>11. Insured's Policy Group or FECA Number</th>
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<th>a. Employment</th>
<th>Current or Previous</th>
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<th>12. Patient's or authorized person's signature</th>
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<th>13. Other insured's policy group or FECA number</th>
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<th>14. Date of current illness, injury, or pregnancy (LMP)</th>
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<th>15. Other Date</th>
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<th>16. Dates patient unable to work in current occupation</th>
<th>From</th>
<th>MM</th>
<th>DD</th>
<th>YY</th>
<th>To</th>
<th>MM</th>
<th>DD</th>
<th>YY</th>
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<table>
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<tr>
<th>17a. Name of Referring Provider or Other Source</th>
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<th>17b. NPI</th>
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</table>

<table>
<thead>
<tr>
<th>18. Hospitalization dates related to current services</th>
<th>From</th>
<th>MM</th>
<th>DD</th>
<th>YY</th>
<th>To</th>
<th>MM</th>
<th>DD</th>
<th>YY</th>
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</table>

<table>
<thead>
<tr>
<th>19. Additional Claim Information (Designated by NUCC)</th>
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</table>

<table>
<thead>
<tr>
<th>20. Outside lab?</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>21. Diagnosis or nature of illness or injury</th>
<th>ICD-10 code</th>
</tr>
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</table>

|------------------------|-------------------|

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<thead>
<tr>
<th>23. Prior Authorization Number</th>
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<table>
<thead>
<tr>
<th>24. A. Date(s) of Service</th>
<th>MM</th>
<th>DD</th>
<th>YY</th>
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</table>

<table>
<thead>
<tr>
<th>B. Place of Service</th>
<th>E</th>
<th>G</th>
<th>S</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>C. Services or Supplies</th>
<th>Explained Unusual Circumstances</th>
<th>GTPHC/CPCS</th>
<th>Modifier</th>
<th>Diagnosis Pointer</th>
</tr>
</thead>
</table>

|--------------------------|---------------------------|

<table>
<thead>
<tr>
<th>27. Accept Assessment?</th>
<th>Y</th>
<th>N</th>
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</thead>
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<table>
<thead>
<tr>
<th>28. Total Charge</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>29. Amount Paid</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>30. Indiv. for NUCC Use</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>31. Signature of physician or supplier including degrees or credentials (I certify that the statements on the reverse apply to this bill and are made a part hereof)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>32. Service Facility Location Information</th>
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</table>

<table>
<thead>
<tr>
<th>33. Billing Provider Info &amp; PHA</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NPI</th>
<th>NPI</th>
</tr>
</thead>
</table>

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

Approved OMB-0938-1197 Form 1500 (02-12)
BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

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

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient’s signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided is true, accurate and complete. In the case of a Medicare provider, it is also true, accurate and complete. The patient’s signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker’s compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See §42 CFR 411.24(a); if item 18 is completed, the patient’s signature authorizes release of the information to the health plan or agency shown.

In Medicare or TRICARE participation cases, the patient is responsible for payment of the Medicare or TRICARE fiscal intermediary. If the fiscal intermediary is not the Medicare carrier or TRICARE carrier unless the patient is responsible for the deductible, coinsurance and non-covered services. In the event the patient is responsible for the deductible, coinsurance and non-covered services, the services are billed directly to the patient.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the payment of fee as authorized by the Black Lung Act as amended.

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

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

For services to be considered "incident to" a physician’s professional services, 1) they must be rendered under the physician’s direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician’s offices, and 4) the services of non-physicians must be included on the physician’s bills.

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

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

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

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

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

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

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


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

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

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction. It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1122B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

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

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

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

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

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

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0906-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates(s) or suggestions for improving this form, please write to this office: CMS, 75XX Security Boulevard, Attn: PPA Reports Clearance Officer, Mail Stop CA-28-06, Baltimore, Maryland 21244-1850. This address is for comments and/or questions only, DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.
## Remittance Advice Sample - MediTrac

### Inland Empire Health Plan

**Remittance Advice**

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<thead>
<tr>
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<th>Provider Name</th>
<th>Net Paid</th>
<th>T</th>
<th>Adjust</th>
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<td>RENDRING PROVIDER NAME</td>
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<td>03/14/2018 02/27/2018 02/27/2018</td>
<td>71275</td>
<td>706.00</td>
<td>217.96</td>
<td>706.00</td>
</tr>
<tr>
<td>Patient Acct. #</td>
<td>12345678901</td>
<td></td>
<td></td>
<td>217.96</td>
<td></td>
<td>706.00</td>
</tr>
<tr>
<td>123456785123000</td>
<td>Medi-Cal</td>
<td>MEMBER NAME B</td>
<td>RENDRING PROVIDER NAME</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>00000377741</td>
<td>0108</td>
<td>03/03/2018 02/20/2018 02/20/2018</td>
<td>70466</td>
<td>26.00</td>
<td>62.50</td>
<td>26.00</td>
</tr>
<tr>
<td>Patient Acct. #</td>
<td>12345678901</td>
<td></td>
<td></td>
<td>26.00</td>
<td>62.50</td>
<td>26.00</td>
</tr>
<tr>
<td>0000037741</td>
<td>0208</td>
<td>03/02/2018 02/20/2018 02/20/2018</td>
<td>70450</td>
<td>123.00</td>
<td>26.12</td>
<td>123.00</td>
</tr>
<tr>
<td>Patient Acct. #</td>
<td>12345678901</td>
<td></td>
<td></td>
<td>123.00</td>
<td>26.12</td>
<td>123.00</td>
</tr>
<tr>
<td>423456785123000</td>
<td>Medi-Cal</td>
<td>MEMBER NAME C</td>
<td>RENDRING PROVIDER NAME</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>00000170665</td>
<td>0103</td>
<td>03/08/2018 02/25/2018 02/25/2018</td>
<td>74176</td>
<td>258.00</td>
<td>72.24</td>
<td>258.00</td>
</tr>
<tr>
<td>Patient Acct. #</td>
<td>12345678901</td>
<td></td>
<td></td>
<td>258.00</td>
<td>72.24</td>
<td>258.00</td>
</tr>
<tr>
<td>00000170665</td>
<td>0103</td>
<td>03/08/2018 02/25/2018 02/25/2018</td>
<td>74176</td>
<td>258.00</td>
<td>72.24</td>
<td>258.00</td>
</tr>
</tbody>
</table>
{(Date)}
{(Provider Name)}
{(Address)}
{(City, State, Zip Code)}

Attn: Billing Office Manager

Member Name:
ID No.:
Date of Service:
Acct #:

To Whom It May Concern:

It has come to the attention of Inland Empire Health Plan that you are billing the above referenced Member for medical services rendered on {(Date)}. Our records indicate that this member was an active Medi-Cal beneficiary on this date. The State of California makes it unlawful to bill eligible Medi-Cal beneficiaries for covered medical services.

Title 22, Section 51002, of the California Code of Regulations states:

“A provider of service under the Medi-Cal program shall not submit to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program’s scope of benefits in addition to a claim submitted to the Medi-Cal program for that service…”

The Member has been billed inappropriately. The provider of service must not bill the patient or attempt collection against the patient. If there is any issue with the bill, you must address it with IEHP directly, not the Member. IEHP has made several attempts to obtain the information necessary to resolve this issue.

If a provider of medical services knowingly bills an eligible Medi-Cal beneficiary in an attempt to collect monies for covered services other than from the responsible Medi-Cal program, this activity constitutes fraud. Therefore, if any further collection activity is attempted against this Member, IEHP will have no other recourse but to report this activity to the Medi-Cal Fraud Division and to the Center for Medicaid and Medicare. If you have turned the Member over to a collection agency please remove them immediately. In addition, the Member’s delinquent status must be removed from all credit bureaus where this item has been reported. If you feel that you have received this letter in error or should you have any questions, please contact us at (909) 890-2054 or (866) 223-4347.

Thank you for your attention and quick resolution to this matter.

Sincerely,

Claims Appeal Resolution Specialist
Inland Empire Health Plan
Due Date: <Date>

<Provider Name>
<Provider Address>
<Provider City, State & Zip Code>
<Provider Phone>

Dear Claims Manager:

Please provide payment or denial information for the claim listed below. Attached is a copy of the original claim for your review. Return this fully completed letter within seven (7) calendar days to: IEHP Claims Appeal Resolution Unit, P.O. Box 4319, Rancho Cucamonga, CA. 91729-4319 or fax to: 909-890-5747.

Incomplete responses or responses received after Seven (7) calendar days will be subject to capitation deduction from your next monthly capitation payment.

1. Your response must indicate whether claim is paid or denied.
2. Pending, No Auth, and Not Eligible are inappropriate responses. IEHP has verified the Member's eligibility.
3. If denial letter is being issued as a result of this inquiry, a copy of the letter must accompany your response.
4. Provide written documentation (EOB, Auth Limitations, TANN Log, etc.) to substantiate your responses.

<table>
<thead>
<tr>
<th>IEHP Completes</th>
<th>Payer Completes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Number:</td>
<td>Original Date Rec’d:</td>
</tr>
<tr>
<td>Member Name:</td>
<td>Date Paid:</td>
</tr>
<tr>
<td>IEHP ID:</td>
<td>Amount Paid:</td>
</tr>
<tr>
<td>Pt. Acct. No.:</td>
<td>Check Number:</td>
</tr>
<tr>
<td>Date Of Service:</td>
<td>Date Denial Sent:</td>
</tr>
<tr>
<td>Amount Billed:</td>
<td>Denial Reason:</td>
</tr>
<tr>
<td>IEHP Note:</td>
<td>Person Responding and Phone#:</td>
</tr>
</tbody>
</table>

Payer Notes:

DENIAL REASONS (Please check all that apply)

- [ ] Services not covered under member's plan
- [ ] No authorization
- [ ] Not medically necessary
- [ ] Untimely submission

- [ ] IPA Retro Review
- [ ] Prior authorization on file
- [ ] Medical records previously requested not received
- [ ] Incorrect billing

- [ ] Services exceeds benefit limit
- [ ] Required medical records for review
- [ ] Paid contract rate

Please contact the IEHP Provider Relations Team at (909) 890-2054 or (866) 223-4347 if you have any further questions or concerns.

Sincerely,

Claims Appeal Resolution Specialist
Inland Empire Health Plan
Secure E•mail Template Demand for Payment

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

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

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

<table>
<thead>
<tr>
<th>Member Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>IEHP MEMBER ID</td>
<td></td>
</tr>
<tr>
<td>IEHP Claim Number</td>
<td></td>
</tr>
<tr>
<td>Provider of Service</td>
<td></td>
</tr>
<tr>
<td>Tax ID</td>
<td></td>
</tr>
<tr>
<td>Date of Service</td>
<td></td>
</tr>
<tr>
<td>Amount Billed</td>
<td></td>
</tr>
<tr>
<td>Patient Account No.</td>
<td></td>
</tr>
</tbody>
</table>

Sincerely,

Claim Resolution Specialist
Inland Empire Health Plan
<Insert Processor Initials>
Secure E-mail Template notice of CAP deduction

From: 
To: 
Cc: 
Subject: Notice of CAP deduction, <Insert Claim Numbers>

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

<table>
<thead>
<tr>
<th>Member Name</th>
<th>DOB</th>
<th>IEHP MEMBER ID</th>
<th>Claim Number</th>
<th>Provider of Service</th>
<th>Tax ID</th>
<th>Date of Service</th>
<th>Amount Billed</th>
<th>Patient Account No.</th>
<th>Notification Date</th>
<th>CAP Deduction Amount</th>
<th>Process Date Date</th>
</tr>
</thead>
</table>

Sincerely,

Claim Resolution Specialist
Inland Empire Health Plan
<Insert Processor Initials>
<Date>

<Provider Name>
<Provider Address>
<Provider City, State, Zip>

Member Name: <Member Name>
Member ID Number: <Member Id #>
Patient Acct #: <Member Acct #>
Date of Service: <Date of Service>
IEHP Claim Number: <Claim #>

Dear Billing Department:

Inland Empire Health Plan (IEHP) has received your Appeal on the above referenced claim on <Date>. You will be notified of the decision made within forty-five (45) working days from the day that IEHP received the Appeal.

While IEHP considers and reviews your Appeal, we ask that you do not bill IEHP Members.

If you have any questions or need further assistance please feel free to call the IEHP IEHP Provider Relations Team at (909) 890-2054 or (866) 223-4347.

Sincerely,

Claims Appeal Resolution Specialist
Inland Empire Health Plan
CLAIMS DISPUTE RESOLUTION
Late Submission

Date:

Provider Name: Member Name:
Attention: Billing Department Date of Service:
Provider Address: Total Billed Amount:
Provider City, State Zip: Claim #:
PDR Date Received:
IEHP ID #:
Patient Account #:

Dear Provider:

Inland Empire Health Plan (IEHP) Claims Department received a claim dispute regarding the claim referenced above. Our deadline for filing a dispute is three hundred sixty-five (365) days following claim payment or recent action.

Please be advised that Inland Empire Health Plan did not receive this dispute within the three hundred sixty-five (365)-day timeframe. The initial claim decision is therefore upheld and your dispute is closed.

If you require further information regarding the resolution of this dispute, please contact the IEHP Provider Relations Team at (909) 890-2054 or (866) 223-4347 or fax your request to (909) 890-5747. Please use the claim number to reference the claim.

Sincerely,

Claim Appeals Resolution Specialist
Inland Empire Health Plan
DISPUTE CLOSURE LETTER FOR NON RECEIPT
OF ADDITIONAL INFORMATION

Date:  
Provider Name:  
Attention: Billing Department  
Member Name:  
Date of Service:  
Provider Address:  
Total Billed Amount:  
Provider City, State Zip:  
Claim #:  
PDR Date Received:  
IEHP ID #:  
Patient Account #:  

Dear Provider:

Inland Empire Health Plan (IEHP) received a claim dispute regarding the claim referenced above. The additional information indicated below was requested in order to resolve and make a determination on your claim dispute:

- [INSERT WHAT HAD BEEN REQUESTED FROM D05 LETTER]

Please be advised that Inland Empire Health Plan did not receive the additional information within thirty (30) working days. The initial claim decision is therefore upheld and your dispute is closed.

If you require additional information regarding this dispute, please contact the IEHP Provider Relations Team at (909) 890-2054 or (866) 223-4347 or fax information to (909) 890-5747. Please use the claim number to reference the claim.

Sincerely,

Claim Appeals Resolution Specialist  
Inland Empire Health Plan
CLAIMS DISPUTE RESOLUTION
Original Claim Determination Upheld

Date:

Provider Name: Member Name:
Attention: Billing Department Date of Service:
Provider Address: Total Billed Amount:
Provider City, State Zip: Claim #:
PDR Date Received: IEHP ID #:
Patient Account #: 

Dear Provider:

Inland Empire Health Plan (IEHP) received a claim dispute regarding the claim referenced above. Upon careful review of this dispute, we have determined that the initial claim decision is being upheld for the following reason(s):

- The claim is the financial responsibility of the member’s IPA.
- The member was not eligible at the time medical services were rendered.
- The medical services received are not a covered benefit under the health plan.
- Contracted rate paid and no additional amount is due.
- No invoice received.
- Medical services were not authorized.
- Member has other primary insurance.
- Additional information requested was never received.
- Additional information requested was never received.
- Insufficient proof of timely filing and follow up activity submitted.
- Provider of service is members assigned PCP and is included in the PCP’s capitation.
- Please submit a corrected claim with valid Medicare codes.
- Please submit a corrected claim with valid Medi-Cal codes.
- Other:

This dispute process is now closed, but if you require additional information regarding the resolution of this dispute, please contact the IEHP Provider Relations Team at (909) 890-2054 or (866) 223-4347 or fax information to (909) 890-5747. Please use the claim number to reference the claim.

Sincerely,

Claim Appeals Resolution Specialist
Inland Empire Health Plan
CLAIMS DISPUTE RESOLUTION  
Adjustment/Payment Made

Date:

Provider Name:  Member Name:  
Attention:  Billing Department  Date of Service:  
Provider Address:  Total Billed Amount:  
Provider City, State Zip:  Claim #:  
PDR Date Received:  IEHP ID #:  
Patient Account #:  

Dear Provider:

Inland Empire Health Plan (IEHP) received a claim dispute regarding the claim referenced above. Upon careful review of this dispute, we have determined that the initial claim decision is being overturned and payment will be made.

Payment in the amount of $________ is made for the following service(s):

Either list line items or a description of service must be given for reason for payment.

Payment may include applicable interest or penalties due.

If you require further information regarding the resolution of this dispute, please contact the IEHP Provider Relations Team at (909) 890-2054 or (866)-223-4347 or fax information to (909) 890-5747.

Sincerely,

Claim Appeals Resolution Specialist  
Inland Empire Health Plan
D05 - SINGLE DISPUTE ACKNOWLEDGEMENT LETTER
WITH REQUEST FOR ADDITIONAL INFORMATION

Date:

Provider Name:  Member Name:
Attention: Billing Department  Date of Service:
Provider Address:  Total Billed Amount:
Provider City, State Zip:  Claim #:
PDR Date Received:  IEHP ID #:
Patient Account #:

Dear Provider:

Inland Empire Health Plan (IEHP) received a claim dispute regarding the claim referenced above; however, additional information is required in order that we may review and give a resolution of the dispute. Please provide us with the information indicated below within thirty (30) working days:

- List specific item of information needed for dispute

Upon receipt of all information necessary to determine the outcome of the dispute, IEHP has forty-five (45) working days to review and resolve the dispute. Please submit the above requested information and a copy of this letter to the following address:

IEHP, Claim Appeals Resolution Unit
P.O. Box 4319
Rancho Cucamonga, CA  91729-4319
or fax information to:
(909) 890-5747

If you require additional information please contact the IEHP Provider Relations Team at (909) 890-2054 or (866) 223-4347. Please use the claim number to reference the claim.

Sincerely,

Claim Appeals Resolution Specialist
Inland Empire Health Plan
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 PATIENT NAME</td>
<td>a</td>
</tr>
<tr>
<td>9 PATIENT ADDRESS</td>
<td>a</td>
</tr>
<tr>
<td>10 BIRTHDATE</td>
<td>c, d, e</td>
</tr>
<tr>
<td>11 SEX</td>
<td></td>
</tr>
<tr>
<td>12 DATE</td>
<td></td>
</tr>
<tr>
<td>13 HR</td>
<td></td>
</tr>
<tr>
<td>14 Type</td>
<td>15 SRC</td>
</tr>
<tr>
<td>17 STAT</td>
<td>18</td>
</tr>
<tr>
<td>39 VALUE CODES</td>
<td>40 AMOUNT</td>
</tr>
<tr>
<td>44 HCPCS / RATE / HIPPS CODE</td>
<td>45 SERV. DATE</td>
</tr>
<tr>
<td>49</td>
<td></td>
</tr>
<tr>
<td>50 PAYER NAME</td>
<td>51 HEALTH PLAN ID</td>
</tr>
<tr>
<td>63 TREATMENT AUTHORIZATION CODES</td>
<td>64 DOCUMENT CONTROL NUMBER</td>
</tr>
<tr>
<td>66 PATIENT ADDRESS</td>
<td>67</td>
</tr>
<tr>
<td>69 TYPE OF BILL</td>
<td>70</td>
</tr>
<tr>
<td>72</td>
<td>73</td>
</tr>
<tr>
<td>74 PRINCIPAL PROCEDURE CODE</td>
<td>75 OTHER PROFESSIONAL CODE</td>
</tr>
<tr>
<td>76 ATTENDING NPI</td>
<td>77 OPERATING NPI</td>
</tr>
<tr>
<td>78 OTHER NPI</td>
<td>79 OTHER NPI</td>
</tr>
<tr>
<td>80 REMARKS</td>
<td>a</td>
</tr>
<tr>
<td>81</td>
<td>82</td>
</tr>
</tbody>
</table>

**Attachment 20 - UB04 Inpatient Form**
<table>
<thead>
<tr>
<th>FIELD</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-28</td>
<td>CONDITION CODES - This field is required if applicable. The condition codes indicate any conditions/events relating to this bill that may affect processing. This field is required if applicable.</td>
</tr>
<tr>
<td>31-34</td>
<td>OCCURRENCE CODE AND DATES - This field is required if applicable. The occurrence code indicates a significant event relating to this bill that may affect processing. This field is required if applicable.</td>
</tr>
<tr>
<td>35-36</td>
<td>OCCURRENCE SPAN - This field is required if applicable. The occurrence span code identifies an event that relates to the payment of the claim. This field is required if applicable.</td>
</tr>
<tr>
<td>38</td>
<td>The name and address of the party responsible for the bill. This field is required if applicable.</td>
</tr>
<tr>
<td>39-41</td>
<td>VALUE CODES AND AMOUNTS The Value Code refers to a code to relate amounts or values to identify data elements necessary to process the claim as qualified by the payer organization.</td>
</tr>
<tr>
<td>43</td>
<td>DESCRIPTION Please fill in the standard abbreviated description of the related revenue code included on this bill. The NDC Code is required in this field when billing for injectables, drugs and family planning pharmaceuticals.</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/RATE/HIPPS CODE - This field is required if applicable. HCPCS or Healthcare Common Procedure Coding. The accommodation rate for inpatient bills. HIPPS or Health Insurance Prospective Payment System.</td>
</tr>
<tr>
<td>48</td>
<td>NON-COVERED CHARGES - This field is required if applicable. This field reflects the non-covered charges for the destination payer as it pertains to the related revenue code.</td>
</tr>
<tr>
<td>51</td>
<td>HEALTH PLAN ID - This field is required if applicable. A-C This is the alphanumeric identifier used by the health plan to identify itself.</td>
</tr>
<tr>
<td>54</td>
<td>PRIOR PAYMENTS - This field is required if applicable. This field should reflect any payment from the health plan for this bill.</td>
</tr>
<tr>
<td>55</td>
<td>EST. AMOUNT DUE This field should reflect the estimate how much is due from the payer (estimate less prior payments).</td>
</tr>
<tr>
<td>57</td>
<td>OTHER / PRV ID The Provider Medicare ID is required when billing for services rendered to a DualChoice Member or if reimbursement is based on Medicare rates.</td>
</tr>
<tr>
<td>61-62</td>
<td>GROUP NAME / INSURANCE GROUP NUMBER This is the group/plan name through which the insurance is provided to the insured along with the control number/code assigned by the carrier to identify the group under which the individual is covered.</td>
</tr>
<tr>
<td>63</td>
<td>TREATMENT AUTHORIZATION CODES An indicator that designates the treatment indicated on this bill has been authorized by the payer.</td>
</tr>
<tr>
<td>65</td>
<td>EMPLOYER NAME - The name of the insured’s employer.</td>
</tr>
<tr>
<td>67</td>
<td>OTHER DIAGNOSIS CODE - This field is required when applicable A-Q Other conditions that coexist or develop during the patient’s treatment.</td>
</tr>
<tr>
<td>70</td>
<td>PATIENT REASON DX - This field is required when applicable Is this an unscheduled outpatient visit? If so, please fill in the ICD code that reflects the patient’s reason for visit at the time of outpatient registration.</td>
</tr>
<tr>
<td>71</td>
<td>PPS CODE - This field is required when applicable. Fill in the Prospective Payment System code for the applicable claim type.</td>
</tr>
<tr>
<td>72</td>
<td>ECI - This field is required when applicable A-C Was the cause for treatment due to injury or poisoning? If so please enter the ECI which is the External Cause of Injury. This is indicated by an ICD code.</td>
</tr>
<tr>
<td>74</td>
<td>PRINCIPAL PROCEDURE - This field is required when applicable A-E This field should indicate the ICD code that identifies the inpatient principal procedure performed at the claim level during the period.</td>
</tr>
<tr>
<td>77-79</td>
<td>OPERATING / OTHER - This field is required for surgery This field should be filled with the individual who has primary responsibility for performing the surgical procedure(s). Utilize fields 78-79 for other provider names and identifiers.</td>
</tr>
<tr>
<td>80</td>
<td>REMARKS - This field is required when applicable This area may be used to capture any additional information needed to adjudicate the claim.</td>
</tr>
<tr>
<td>FIELD</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
</tr>
<tr>
<td>12</td>
<td>ADMISSION DATE</td>
</tr>
<tr>
<td></td>
<td>Admission/Start of Care Date Required for Inpatient and Home Health. Enter the date admitted for inpatient care, or the date of the outpatient service.</td>
</tr>
<tr>
<td>13</td>
<td>ADMISSION HR -</td>
</tr>
<tr>
<td></td>
<td>This field is required if applicable. Enter the hour during which the patient was admitted for inpatient or outpatient care. This field is required if applicable.</td>
</tr>
<tr>
<td>16</td>
<td>DHR -</td>
</tr>
<tr>
<td></td>
<td>This field is required if applicable. DHR refers to the code indicating the discharge hour of the patient from inpatient care. This field is required if applicable.</td>
</tr>
<tr>
<td>18-28</td>
<td>CONDITION CODES -</td>
</tr>
<tr>
<td></td>
<td>This field is required if applicable. The condition codes indicate any conditions/events relating to this bill that may affect processing. This field is required if applicable.</td>
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<td>OCCURRENCE CODE AND DATES -</td>
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<td></td>
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<td>38</td>
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<td>VALUE CODES AND AMOUNTS</td>
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<tr>
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<td>48</td>
<td>non-covered charges -</td>
</tr>
<tr>
<td></td>
<td>This field reflects the non-covered charges for the destination payer as it pertains to the related revenue code.</td>
</tr>
<tr>
<td>51</td>
<td>HEALTH PLAN ID -</td>
</tr>
<tr>
<td></td>
<td>This is the alphanumeric identifier used by the health plan to identify itself.</td>
</tr>
<tr>
<td>54</td>
<td>PRIOR PAYMENTS -</td>
</tr>
<tr>
<td></td>
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<td>55</td>
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<td>61-62</td>
<td>GROUP NAME / INSURANCE GROUP NUMBER</td>
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<tr>
<td></td>
<td>This is the group/plan name through which the insurance is provided to the insured along with the control number/code assigned by the carrier to identify the group under which the individual is covered.</td>
</tr>
<tr>
<td>63</td>
<td>TREATMENT AUTHORIZATION CODES</td>
</tr>
<tr>
<td></td>
<td>An indicator that designates the treatment indicated on this bill has been authorized by the payer.</td>
</tr>
<tr>
<td>65</td>
<td>EMPLOYER NAME</td>
</tr>
<tr>
<td></td>
<td>The name of the insured’s employer.</td>
</tr>
<tr>
<td>67</td>
<td>OTHER DIAGNOSIS CODE -</td>
</tr>
<tr>
<td></td>
<td>Other conditions that coexist or develop during the patient’s treatment.</td>
</tr>
<tr>
<td>69</td>
<td>ADMIT DX -</td>
</tr>
<tr>
<td></td>
<td>Required on inpatient. Required on outpatient if applicable. The Admitting Diagnosis Code (ICD) which describes the patient’s diagnosis at the time of admission.</td>
</tr>
<tr>
<td>70</td>
<td>PATIENT REASON DX -</td>
</tr>
<tr>
<td></td>
<td>This field is required when applicable. Is this an unscheduled outpatient visit? If so, please fill in the ICD code that reflects the patient’s reason for visit at the time of outpatient registration.</td>
</tr>
<tr>
<td>71</td>
<td>PPS CODE -</td>
</tr>
<tr>
<td></td>
<td>This field is required when applicable. Fill in the Prospective Payment System code for the applicable claim type.</td>
</tr>
<tr>
<td>72</td>
<td>ECI -</td>
</tr>
<tr>
<td></td>
<td>This field is required when applicable. Was the cause for treatment due to injury or poisoning? If so please enter the ECI which is the External Cause of Injury. This is indicated by an ICD code.</td>
</tr>
<tr>
<td>74</td>
<td>PRINCIPAL PROCEDURE -</td>
</tr>
<tr>
<td></td>
<td>This field is required when applicable. This field should indicate the ICD code that identifies the inpatient principal procedure performed at the claim level during the period.</td>
</tr>
<tr>
<td>77-79</td>
<td>OPERATING/OTHER -</td>
</tr>
<tr>
<td></td>
<td>This field is required for surgery. This field should be filled with the individual who has primary responsibility for performing the surgical procedure(s). Utilize fields 78-79 for other provider names and identifiers.</td>
</tr>
<tr>
<td>80</td>
<td>REMARKS -</td>
</tr>
<tr>
<td></td>
<td>This field is required when applicable. This area may be used to capture any additional information needed to adjudicate the claim.</td>
</tr>
</tbody>
</table>