20. CLAIMS PROCESSING

A. Claims Processing

APPLIES TO:

A. This policy applies to all Capitated Providers (Payers) delegated for claims payment for IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. All claims must be paid or denied in accordance with all federal and state laws, regulations and the IEHP agreement.

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

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

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

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

F. If the Payer pays clean claims from non-contracted providers after thirty (30) calendar days, interest must be paid at the rate used for such late payments as stated in federal regulations 42 CFR § 422.520(a)(2); Manual Ch. 11 – Section 100.2.

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

PROCEDURES:

A. Payer must have written procedures for claims processing that are available for review. In addition, Payer must disclose claim filing directions, payment rates and disposition of Provider payment disputes in accordance with Policy 20A2, “Claims Processing - Provider Payment Dispute Resolution”. These written procedures and disclosures must comply with federal regulations and IEHP contractual standards and requirements. Such disclosures must also be made available upon request to Providers of Service, IEHP or a regulatory agency.
20. CLAIMS PROCESSING

A. Claims Processing

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

C. Non-contracted providers of service are allowed up to three hundred sixty-five (365) days from the date of service or date of discharge to submit a new or corrected claim.
   1. Claims received after three hundred sixty-five (365) days from the date of service or date of discharge are not deemed payable.
   2. New or corrected claims received after the filing deadline are reconsidered for payment only when the Provider of Service has submitted an explanation of the circumstances as outlined in Policy 20A2, “Claims Processing - Provider Payment Dispute Resolution” surrounding the late filing, or the Provider of Service believes IEHP or the Provider are responsible due to an administrative error.

D. Payers must redirect claims that are not their financial responsibility to the appropriate responsible party within ten (10) calendar days of receipt.
   1. If the Member cannot be identified or the financially responsible entity is not affiliated with the Payer’s network, the claim may be denied and/or returned to the Provider of Service advising the billing Provider to verify eligibility assignment and to bill the appropriate responsible party.
   2. All redirected claims must be tracked and reported as outlined in Policy 20F, “Claims and Payment Appeal Reporting.”

E. Clean claims are those claims and attachments or other documentation that includes all reasonably relevant information necessary to determine Payer liability and in which no further information is required from the Provider of Service or a third party to develop the claim. To be considered a clean claim, 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 claim form or Electronic Data Interchange (EDI) file that contains:
      a. A description of the service rendered using valid Current Procedural Terminology (CPT), National Drug Code (NDC), International Classification of Diseases (ICD) codes, Healthcare Common Procedure Coding System (HCPCS), Revenue codes and/or Present on Admission (POA) indicator as applicable. Additionally, the number of days or units for each service line, the place of service code, the type of service code and the charge for each listed service must be indicated.
      b. Other claim specific information as dictated by Medicare for Provider of Service type (i.e., Hospital, lab, etc.).
      c. Member (patient) demographic information, which must at a minimum include the Member’s last name and first name and date of birth.
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d. Provider of Service name, address, state license number, tax identification number; Medicare Health Insurance Claim Number (HICN), and National Provider Identifier (NPI) number and National Supplier Clearing House Number, if applicable.

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

f. Valid date(s) of service.

g. Amount billed.

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

2. Other documentation necessary to adjudicate the claim, such as medical records, claims itemization or detailed invoice, medical necessity documentation, other insurance payment information and referring Provider information (or copy of referral) as applicable.

F. If a non-contracted provider claim is missing required information, as defined in Procedure E1 above, or requires additional information to complete the claim, the claim will be developed as follows:

1. The Payer must make at least two (2) attempts to obtain the missing information by sending a written notice to the Provider of Service requesting the missing information or other reasonably relevant information necessary to determine Payer liability within sixty (60) calendar days after the date of receipt.

2. If the Payer does not receive the requested information from a Provider of Service after two (2) attempts, the Payer must review the claim and make a decision to pay or deny the claim based on available information. For non-contracted providers, any subsequent payment or denial must be issued within sixty (60) calendar days of receipt of the claim. For contracted Providers, refer to the contract with the payer.

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

1. Ambulance services dispatched through 911;

2. Emergency services in accordance with 42 C.F.R. § 438.114(c);

3. Urgently needed services;

4. Post-stabilization care services obtained within or outside the organization that are pre-approved by a Contractor’s provider or other Contractor representative or are administered to maintain the Enrollee’s stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further Post-Stabilization Care Services;

5. Renal dialysis services when the Member is temporarily out of the service area;

6. Services for which coverage has been denied by the Payer but found to be services the Member was entitled to upon appeal;
20. CLAIMS PROCESSING

A. Claims Processing

7. Services obtained from a non-contracted provider when the services were authorized by IEHP; and
8. Services obtained from a non-contracted provider when the services were referred by a contracted Provider.

H. Payers must coordinate benefits and follow Medicare Secondary Payer rules as outlined in Policy 20E, “Coordination of Benefits”. Claims submitted for secondary payment must follow the submission timeframes stated in Procedure D, from the date the primary Payer’s notice of payment or denial is received by the Provider of Service in order to be considered timely.

I. Clean claims from non-contracted providers of service rendering services to IEHP Members must be paid within thirty (30) calendar days of receipt, or sixty (60) calendar days for all other claims that do not meet the definition of “clean claims”.

1. Non-contracted claims that do not meet the clean claim requirements as noted in E1 and E2 above require additional information from the Provider of Service to develop the claim. This includes but is not limited to requests for additional information from the physician/supplier or other external source such as routine data omitted from the claim, medical information, or information to resolve discrepancies.

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

3. Payment timeliness standards are based on the timeframe from the initial date of receipt of the claim (e.g., EDI receipt date or paper claim date stamp) until the check or denial is issued to the Provider of Service, regardless of when the check is dated.

4. The payment date used to meet timeliness standards is the actual date the check is mailed or electronically deposited into the Provider of Service’s account.

J. Reimbursement for services rendered to an IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) 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 (2) types:
   a. Procedure-to-procedure (Column1/Column2) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons; and
   b. Medically Unlikely Edits (MUE), which are units of service edits, that define for each HCPCS/CPT code identified, the allowable number of units of service; units of service in excess of this value are not feasible for the procedure under normal
20. CLAIMS PROCESSING

A. Claims Processing

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

2. Physicians are paid using the lesser of the billed charges, or the Medicare Physician Fee Schedule (MPFS).

3. Acute Care hospitals are paid a DRG amount using the Medicare prospective payment system (PPS) in all States except Maryland per CMS guidelines.

4. Skilled Nursing Facilities (SNF), Home Health, Outpatient Hospital Services, Long Term Acute Care Hospital, Acute Psychiatric and Acute Rehab Facility claims are paid at PPS methodology.

5. End Stage Renal Disease Facilities are paid, for certain routine services, an amount called a composite rate. Composite rates are geographically adjusted and also adjusted for patient specific parameters.

6. Ambulance Services are paid based on the ambulance fee schedule.

7. Ambulatory Surgery Centers are paid on a fee schedule comprised of wage adjusted payment groups. ASC payments have limits based on the hospital OPD rates.

8. Clinical Lab are generally based on the lab fee schedule.

9. Part B Drugs are mostly included in PPS reimbursement methodology or on cost but are based on a percentage of the Average Sales Price (ASP) methodology.

10. Critical Access Hospitals (CAH) - Payment determination is based upon the billing hospital to submitting a copy of their most recent interim rate letter from their Medicare Fiscal Intermediary (FI).

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

12. Rural Health Clinic (RHC) - RHC’s are paid the lesser of the provider specific AIR or a national per-visit limit. The AIR is determined for each center based on historical costs.

13. For services provided on or after January 1, 2018, IEHP shall reimburse Indian Health Care Providers who provide Covered Services to Indian Enrollees, who are eligible to receive services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service (IHS), and IEHP shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Care Provider.
14. For Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, the required payment is the difference between the “Outpatient Per Visit Rate (Excluding Medicare)” listed in the Federal Register and 80 percent of the Medicare FQHC PPS rate, as set forth in 42 USC 1395w-4(e)(6)(A)(ii).

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

16. IEHP will not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

K. If the Payer fails to pay a clean claim from a non-contracted Provider of Service within thirty (30) calendar days after receipt, the Payer must pay interest at the rate used for such late payments, as stated in federal regulations 42 CFR § 422.520(a)(2); Manual Ch. 11 – Section 100.2.

1. Interest rates are updated twice annually on January 1st and July 1st.

2. Interest accrues beginning on the first calendar day following thirty (30) calendar days from the date of receipt until the date the check is mailed or electronically deposited into the Provider of Service’s account.

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

1. Any claim that is denied must include an accurate and clear written explanation of the actions taken. Both the Provider of Service and Member must be notified of the denial.

2. All denial notifications and the Remittance Advice or Explanation of Benefits, to the Provider of Service must include mandated language and be properly formatted in accordance with Medicare specifications, See Attachments “Notice of Denial of Payment – English” and “Notice of Denial of Payment – Spanish” in Section 20 for a sample. Accompanied with the Notice of Denial of Payment is a Non Discrimination Tagline (outlined in Attachment, “Non Discrimination Tagline” in Section 20) which states Inland Empire Health Plan (IEHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. At a minimum, the denial notification must:

   a. Use approved notice language in a readable and understandable format;
   
   b. State the specific reason for the denial;
   
   c. Inform the Member of his or her right to reconsideration of the payment determination;
   
   d. For non-contracted provider claim denials, the standard appeal process is outlined in Policy 20A1, “Claims Processing - Claims Appeals – Denied Claims.” For non-
20. CLAIMS PROCESSING

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contracted provider payment disputes, the standard payment dispute process is outlined in Policy 20A2, “Claims Processing – Provider Payment Dispute Resolution”; and

e. Comply with any other notice requirements specified by CMS.


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

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

REFERENCES:

A. 42 CFR § 422.520(a)(2); Manual Ch. 11 –100.2.

20. CLAIMS PROCESSING

A. Claims Processing
   1. Claim Appeals - Denied Claims

APPLIES TO:

A. This policy applies to non-contracted providers of service whose IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) claim was previously denied.

POLICY:

A. Financially responsible Payers must establish and maintain a process that addresses the receipt, handling and disposition of an appeal in accordance with applicable statutes and regulatory requirements.

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

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

D. Appeals are requests for reconsideration of a claim denial and must be submitted to IEHP within sixty (60) calendar days of the denial notice.

E. If a favorable or partially favorable determination is made, the payment must be issued at the time of determination. If the determination is to uphold the original denial, IEHP must immediately forward the appeal to the Centers for Medicare and Medicaid Services (CMS) Independent Review Entity (IRE) for review and resolution in accordance with Medicare requirements.

F. IEHP does not delegate claim appeals to Delegated IPAs.

PROCEDURES:

A. Inquiries regarding the status of a claim or requests for intervention by IEHP on behalf of the billing Provider in an attempt to get an initial adjudication decision for services that are the Delegated IPA’s responsibility (payment or denial) made on a claim by the Delegated IPA are not considered appeals and are handled in accordance with Policy 20C, “Claim Deduction From Capitation – 7-Day Letter”.

B. Appeals relate to the initial determination of a claim denial.
   1. A claim appeal involving payment should be filed in accordance with the guidelines provided in Policy 20A2, “Claims Processing - Provider Payment Dispute Resolution”.
   2. Grievances and appeals are separate and distinct. If the documentation submitted is considered to be a grievance, Payers must resolve it in accordance with their grievance
20. CLAIMS PROCESSING

A. Claims Processing
   1. Claim Appeals - Denied Claims

   policies and procedures as outlined in Policy 16B1, “Grievance and Appeal Resolution Process for Providers – Initial”.

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

IEHP may accept a request for reconsideration of an appeal filed after sixty (60) calendar days if the Member, the Member’s authorized representative or non-contracted provider of service submits a written request for an extension of the timeframe for good cause.

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

1. The Member did not personally receive the adverse organization determination notice, or he/she received it late;
2. The Member was seriously ill, which prevented a timely appeal;
3. There was a death or serious illness in the Member’s immediate family;
4. An accident caused important records to be destroyed;
5. Documentation was difficult to locate within the time limits;
6. The Member had incorrect or incomplete information concerning the reconsideration process; or
7. The Member lacked capacity to understand the time frame for filing a request for reconsideration.

D. Non-contracted providers or suppliers of service may file a payment appeal if they have furnished a covered service to a Member and complete a waiver of liability statement indicating they will not bill the Member regardless of the outcome of the case (See Attachment, “Medicare Waiver of Liability Statement” in Section 20).

E. Written appeals must be submitted to IEHP and in accordance with the appeal process guidelines to:

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

Written appeals must include:

1. The IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) health insurance claim number and Member identification number.
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A. Claims Processing
   1. Claim Appeals - Denied Claims

   2. Specific service(s) and/or item(s) for which reconsideration is being requested including the date(s) of service.
   3. The name and signature of the party or the representative of the party filing the appeal.
   4. A clear explanation of why the appealing party disagrees with Payer’s initial determination and expected outcome.
   5. Any supporting documentation the appealing party wants to be considered, including the claim and the original payment determination.

F. IEHP will make every effort to investigate and take into consideration all information on file or received from the Provider of Service. If supporting documentation is not available or IEHP does not have enough information to make a determination on the appeal, IEHP may send a request for additional information to the Provider of Service and will make at least two (2) attempts to obtain the requested information. If the Provider of Service fails to provide the requested information IEHP must make a determination based on the information available. IEHP must send written notice of the resolution, including pertinent facts and an explanation of the reason for the determination, within sixty (60) calendar days of the receipt of the appeal. The notification will be sent to the appealing party.

   1. Written notification of affirmative (uphold) determinations, whether in whole or in part, must be written in a manner easily understood and include:
      a. A clear statement indicating the extent to which the reconsideration is favorable or unfavorable;
      b. A summary of the facts, including, as appropriate, a summary of the clinical or scientific evidence used in making the redetermination;
      c. An explanation of how pertinent laws, regulations, coverage rules and CMS policy applies to the facts of the case;
      d. A summary of the rationale for the redetermination in clear, understandable language;
      e. The procedures for obtaining additional information concerning determinations, such as specific provisions of the policy, manual or regulation used in making the determination;
      f. Appealing party notified that appeal sent to CMS’ IRE for review and resolution in accordance with Medicare requirements; and
      g. Any other requirements specified by CMS.

   2. Failure to respond to the request for reconsideration with a determination within the specified timeframe must consider the failure as an affirmation of the adverse decision and the request for reconsideration must be forwarded to Maximus, the CMS Independent
20. CLAIMS PROCESSING

A. Claims Processing
1. Claim Appeals - Denied Claims

Review Entity (IRE) for review in accordance with Medicare requirements, within sixty (60) calendar days after receiving the request for reconsideration.

G. If the written determination results in payment, payment must be made within sixty (60) calendar days of receipt. There is no interest due on payments made as a result of an appeal.

H. If the determination is to affirm or uphold the initial determination, a written determination will be sent to the appealing party informing them of the decision and immediately forward the appeal and determination and supporting documentation to the IRE for final review in accordance with Medicare guidelines.

1. The information must be forwarded to the IRE within five (5) calendar days of the determination or within sixty (60) calendar days of receipt of the appeal from the appealing party, whichever occurs first.

2. The IRE will make a decision on the payment appeal in accordance with CMS contracted timeframes.

3. The IRE may request additional information, and upon receipt of such request, IEHP and/or the Payer must make every effort to provide the requested information within the timeframe specified by the IRE.

4. If the IRE upholds the original adverse determination, the IRE will notify the Member and other parties to the appeal in writing of such decision following CMS guidelines.

5. If the IRE reverses or partially reverses the original adverse determination, the IRE notifies the Payer and the payer in turn must notify the appealing party of the decision.

6. If payment is required as a result of the IRE, the IRE notifies the Payer of the requirement to pay the claim. Payment must be issued within thirty (30) calendar days of receipt of the decision by the IRE. No interest is due on favorable payment determinations made by the IRE.

I. If the appealing party is not satisfied with the decision of the IRE, and the projected value of the disputed service after reconsideration is $120 or more, the appealing party may request a review by an Administrative Law Judge (ALJ) within sixty (60) calendar days of receipt of the decision from the IRE.

J. Subsequently, any party dissatisfied with the outcome of the Administration Law Judge Hearing, may request a Medicare Appeals Council review.

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

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

A. Claims Processing
   1. Claim Appeals - Denied Claims

M. Copies of all appeals and related documentation must be retained for at least ten (10) years. A minimum of the last two (2) years must be easily accessible and available within five (5) days of request from IEHP or regulatory agency.

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

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

A. Claims Processing

2. Provider Payment Dispute Resolution

APPLIES TO:

A. This policy applies to all Providers of Service that render services to IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

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

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

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

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

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

PROCEDURES:

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

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

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

2. Any appeal involving a determination unrelated to a claim should be filed in accordance with the guidelines provided in Policy 16B1, “Grievance and Appeal Resolution Process for Providers - Initial”.
20. **CLAIMS PROCESSING**

A. **Claims Processing**

2. **Provider Payment Dispute Resolution**

3. Grievances and appeals are separate and distinct. If the documentation submitted is considered to be a grievance, Payors must resolve it in accordance with their grievance policies and procedures as outlined in Policy 16B1, “Grievance and Appeal Resolution Process for Providers - Initial” or 16A, “Grievance and Appeal Resolution Process for Members (Standard and Expedited)”.

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

1. If a Provider or supplier has failed to establish a good cause for late filing of a Provider dispute, the Payor may dismiss the Provider dispute as untimely filed. The Payor’s notification must explain the reason for dismissal and that the Provider or supplier has up to one hundred eighty (180) calendar days from the date of the notification to provide additional documentation for good cause.

2. If Provider or supplier submits evidence within one hundred eighty (180) calendar days of dismissal that supports a finding of good cause for late filing and the Payor makes a favorable good cause determination and issues a redetermination.

3. If the Payor does not find good cause, the dismissal remains in effect and Payor issues a letter explaining that good cause has not been established.

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

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

1. For PDR’s involving IEHP as the Payor, disputes must be sent to:

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

2. Written payment disputes to the Payor must include:

   a. IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) health insurance claim number and Member identification number.

   b. Specific service(s) and/or item(s) for which reconsideration is being requested including the date(s) of service.

   c. The name and signature of the party or the representative of the party filing the dispute.
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   d. A clear explanation of why the party disagrees with Payor’s initial determination and should include any supporting documentation the appealing party wants to be considered with the dispute.

3. If supporting documentation is not available or the Payor does not have enough information to make a determination on the PDR, the Payor may send a request for additional information to the Provider of Service. If the Provider of Service fails to provide requested information within seven (7) calendar days of the request, the Payor must make a determination on the information available.

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

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

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

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

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

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

   e. Any other requirements specified by CMS.

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

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

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

J. Members or Providers of Service not satisfied with the initial determination by the Payor where the determination is related to medical necessity, utilization management or pre-service referral denials or modifications may submit a written dispute to IEHP within sixty (60) calendar days, for review as outlined in Policy 16B3, “Grievance and Appeal Resolution Process for Providers – UM Decisions”.
20. CLAIMS PROCESSING

A. Claims Processing
   2. Provider Payment Dispute Resolution

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

L. Copies of all PDR’s and related documentation must be retained for at least ten (10) years. A minimum of the last two (2) years must be easily accessible and available within five (5) days of request from IEHP or regulatory agency.

M. Payors must track and report all PDR’s received in accordance with Policy 20F, “Claims and Payment Appeal Reporting.”
20. CLAIMS PROCESSING

B. Billing of IEHP Members

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan).

POLICY:

A. Under the Knox-Keene Act, Health and Safety Code 1379 of the State of California and 22 CCR § 51002, it is illegal to bill a Health Maintenance Organization (HMO) Member for whom services were provided, except for non-benefit items or non-covered services.

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

PROCEDURES:

A. When IEHP is notified by a Member stating they are being billed, 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 opens a case and instructs the Member to obtain all pertinent information regarding the bill. Additionally, IEHP instructs the Member to mail the received bill to IEHP for further research and action.

B. When IEHP receives the Member’s bill, IEHP reviews the information logged and verifies eligibility, 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 and sends all items to the financially responsible Provider in accordance with Policy 20C, “Claims Deduction From Capitation - 7-Day Letter.”

C. When IEHP receives a “Balance Bill” statement from a contracted Provider IEHP notifies the Provider they are in violation of the terms of their signed contract with IEHP (as outlined in Attachment “Balance Bill – Out of State Provider” in section 20). If the Provider of Services is non-contracted and accepts Medicare assignment, IEHP will notify the provider of federal regulations that prohibit a Member from being balanced billed.

D. 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 an additional seven (7) days is provided to submit the information. If no response is received, IEHP closes the case. If the Provider of Service is a participating practitioner, the responsible payer must intervene and contact the practitioner to ensure that the billing of the assigned Member is discontinued.

E. 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

REFERENCES:
B. 22 CCR § 51002.
20. CLAIMS PROCESSING

C. Claims Deduction From Capitation - 7-Day Letter

APPLIES TO:

A. This policy applies to all IEHP Capitated Providers who have been delegated to pay claims for IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

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

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

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

PROCEDURE:

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

B. The 7-Day letter process is available for unpaid, underpaid and/or unresponded to claims inquiries as follows:

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

C. Providers 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. Providers of Service must submit documentation demonstrating an attempt to obtain payment from the Payor. Documentation can include:

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;
20. CLAIMS PROCESSING

C. Claims Deduction From Capitation - 7-Day Letter

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 and billed.

E. Upon receipt of the claim IEHP verifies Member eligibility on the date of service and ensures that the claim was sent to the appropriate payor. If the Member is not eligible with IEHP for the date of service, the request is rejected and a denial letter is issued to the Provider of Service explaining the reason for the rejection. If the claim was sent to the incorrect payor IEHP returns the claim to the Provider of Service advising them to re-bill the correct payor (See Attachments, “Notice of Denial of Payment – English” and “Notice of Denial of Payment – Spanish” in Section 20). Accompanied with the Notice of Denial of Payment is a Non Discrimination Tagline (outlined in section 20 “Non Discrimination Tagline”) which states Inland Empire Health Plan (IEHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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. Providers must respond to all requested items on the 7-Day Letter request.

H. The following are examples of unacceptable responses to the 7-day letter:
   1. Not Payor’s Delegated Responsibility (IEHP confirms financial responsibility prior to 7-day notification).
   2. Member Not Eligible (IEHP confirms eligibility prior to 7-day notification).
   3. Not Authorized (it is inappropriate to deny a claim due to “No Authorization” as medical review must be performed prior to denial).
20. CLAIMS PROCESSING

C. Claims Deduction From Capitation - 7-Day Letter

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

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

APPLIES TO:

A. This policy applies to all Capitated Providers who provide services to IEHP DualChoice Cal MediConnect Plan (Medicare - Medicaid Plan) Providers.

POLICY:

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. IEHP audits all Capitated Providers annually or as necessary.

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

D. Audited Capitated Providers are required to cure any deficiencies in their systems in order to bring them into compliance.

PROCEDURES:

A. 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 necessitate a focused audit including but not limited to the following circumstances:

1. Failure to meet IEHP Financial Viability Standards.
2. Excessive claims appeals that are overturned by IEHP.
3. Excessive 7-day letters that result in payment to the Provider of Service.
4. Excessive claims grievances and payment appeals received by IEHP for claims that are the responsibility of the Capitated Provider.
5. Failure to submit completed claims reports timely.
6. Failure to meet claims payment standards and other indicators and measures based on IEHP review of claims reports.
7. Unfair payment patterns based on claims inquiries, grievances and appeals, IEHP review of periodic claims reports, contracts or other indicators and measures.
8. Change in claims processing system.
9. Change in management oversight, including management services organization.
20. CLAIMS PROCESSING

D. Claims and Compliance Audits

B. Audits ensure Capitated Providers:
   1. Are paying and denying claims and resolving Provider payment disputes in accordance with regulatory and contractual requirements.
   2. Have appropriate systems and protocols in place to ensure each and every claim and dispute received is logged, tracked, acknowledged and appropriately resolved 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.
   4. Policies and procedures are adequate to meet regulatory and contractual requirements and that such policies and procedures reflect actual operations.
   5. Contracts with subcontracted Capitated Providers include mandatory language pertaining to claims processing, appeals and other requirements outlined in state and federal regulations.

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.
   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 20F, “Claims and Payment Appeal Reporting.”
   2. By the 30th of the month following the end of the quarter, for the previous quarter, Capitated Providers must submit to IEHP the Quarterly Provider Payment Dispute Resolution Report. The report contains information regarding disputes and adjustments and is as outlined in Policy 20F, “Claims and Payment Appeal Reporting.”
   3. IEHP reserves the right to request additional reports as deemed necessary.
   4. 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 notifies the Capitated Provider in writing at least ninety (90) days in advance of the scheduled audit. The notice is explicit in its request for documents and access to Capitated Provider staff. For Focused Audits, IEHP reserves the right to give a minimum of three (3) working days prior notice.
   1. Approximately sixty (60) days prior to the scheduled audit, Capitated Providers must
20. CLAIMS PROCESSING

D. Claims and Compliance Audits

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

a. Paid Non-Contracted Provider Clean Claims;
b. Paid Non-Contracted Provider Unclean Claims;
c. Paid Contracted Provider Claims;
d. Denied Claims – Member Liability;
e. Denied Claims – Provider Liability;
f. Provider Payment Disputes; and
  g. Recovered Overpayments;

2. 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. Pending Claims (those pended for development)
   b. Open Claims
   c. Log of Redirected Claims

3. See Attachment, “Medicare Universe Reporting Elements” and “Medicare Reporting Elements Definitions” in Section 20, for a detailed description of each report, the required reporting elements and its definitions.

F. IEHP randomly selects claims to audit and generally covers a twelve (12) month period.

1. For annual audits the type of claims selected for review includes but is not limited to:

   a. 30 – Paid Non-Contracted Provider Clean Claims
   b. 30 – Paid Non-Contracted Provider Unclean Claims
   c. 20 – Paid Contracted Provider Claims
   d. 30 – Denied Claims – Member Liability
   e. 10 – Denied Claims – Provider Liability
   f. 10 – Provider Payment Disputes
   g. 10 - Recovered Overpayments

2. The random claims 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 working days per additional entity.

3. At the time of the onsite visit, IEHP will review current received, open and pending reports (as of the date of the audit), as well as a log of redirected claims and may select
20. CLAIMS PROCESSING

D. Claims and Compliance Audits

additional claims for review.

4. IEHP will also randomly select ten (10) Provider contracts for review. IEHP reserves the right to request additional claims, reports or other documents on-site for review.

5. For verification and focused audits, the number and type of claims selected for review depends on the nature and issue of the deficiencies identified.

E. One (1) week prior to the start of the audit, Capitated Providers are required to submit to IEHP the claims and supporting documentation for the selected claims or Provider payment disputes. For detailed information on the required audit documentation, please see attachment, “Required Medicare Audit Documentation Checklist”, in section 20.

Note: If any of the documentation is not available at the time of the audit the claim or dispute will be deemed non-compliant.

F. 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 pass an audit, including regulatory standards pertaining to the processing of claims or Provider payment disputes and potential unfair payment patterns. Each measure is considered a scorable element of the audit under the area assessed.

G. 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.

H. During the course of or subsequent to the audit, if IEHP suspects fraud, findings are submitted to IEHP’s Compliance Department.

I. Capitated Providers must meet all measurements under each area, at the threshold noted in the table below in order to pass an audit. Any measurement that is not met within any area is considered non-compliant and a Corrective Action Plan (CAP) is required. Failure to meet 80% or more of the total number of claims in the audit overall results in failure of the overall audit. Such failure is deemed a breach of contract and subjects the Provider to a cure process, including but not limited to submission of a CAP, a monthly deduction of the capitation payment and possible contract termination as outlined below.

<table>
<thead>
<tr>
<th>Pass</th>
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<th>Fail</th>
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<tr>
<td>All elements are met</td>
<td>One to four (1 to 4) elements are missed AND Claims compliance is 95% or higher</td>
<td>Five to eight (5 to 8) elements are missed OR Claims compliance is less than</td>
<td>Nine (9) or more elements are missed OR Less than 80% of the claims are compliant OR Any suspected illegal, fraudulent or abusive practices or violation of</td>
</tr>
</tbody>
</table>
20. CLAIMS PROCESSING

D. Claims and Compliance Audits

| 95% Note: Repeatedly missing one or more of the same elements over the course of two (2) consecutive audits will result in Non-Compliance | regulatory requirements that could result in sanctions by a regulatory agency is identified during the audit OR Repeatedly missing one or more of the same elements over the course of three (3) or more consecutive audits. The failing score will continue to be assigned until such time as a Passing score has been achieved |

J. Within thirty (30) days of the on-site audit, 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 submit any rebuttals.

K. Within six (6) weeks of the on-site audit, IEHP sends a final letter of findings, audit report and Corrective Action Plan Request (CAPR) as applicable.

L. 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. 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 Capitated Provider’s written policies and procedures or workflow charts, copies of this information must be submitted along with the CAP.

M. 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. The Capitated Provider 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 Chief Network Officer or IEHP’s Delegation Oversight Committee.

N. 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.

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

1. IEHP reserves the right to initiate immediate cure and/or contract termination.

2. 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.

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

4. 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.

P. 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.
20. CLAIMS PROCESSING

E. Coordination of Benefits

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

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

B. COB is applied in accordance with state and federal law governing COB, including the Order of Determination of payment.

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

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

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

PROCEDURES:

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

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

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

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

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

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

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

E. Coordination of Benefits

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

2. Members are over the age of 65 and are covered by an employer group health plan as an employee or a spouse for an employer group with twenty (20) or more employees.

3. Members covered under an employer group health plan because they are eligible for or entitled to benefits on the basis of end-stage renal disease (ESRD) during a period of up to thirty (30) months if Medicare was not the proper primary payer for the Member on the basis of age or disability at the time the Member became eligible or entitled to Medicare on the basis of ESRD.

4. Members under age 65 entitled to Medicare on the basis of disability and are covered under a large group health plan (one hundred (100) or more employees) on the basis of their own employment status or the current employment status of a family member.

5. If the Member is covered both as a dependent under the spouse’s group health plan and as a non-dependent under another plan, such as a retiree plan, the group plan would pay first, Medicare would be second and the retiree plan third.

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

F. Claims and Payment Appeal Reporting

APPLIES TO:

A. This policy applies to all Capitated Providers who provide services to IEHP DualChoice Cal MediConnect Plan (Medicare - Medicaid Plan) Providers.

POLICY:

A. IEHP provides oversight of claims processing by Capitated Providers through monitoring of their claims payments and denial processes, Provider payment dispute processes 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 Reports to IEHP.

C. Failure to submit all required reports within the indicated timeframes accurately and completely in their entirety may result in the Provider being subjected to a focused audit. Such action may negatively impact the Provider’s contract renewal terms and may ultimately lead to contract termination or conversion.

PROCEDURES:

A. Capitated Providers’ claims processing systems must be able to identify, track and report all claims and disputes by line of business and produce the following ad hoc reports:

1. Received Claims – all claims received regardless of outcome.
2. Paid Claims – all claims paid for services, whether paid in part or whole.
3. Denied Claims – all claims denied for services. (Note: IEHP considers denied claims to be all claims adjudicated in which the total dollars adjudicated is $0.00. This includes all claims denied for non-contracted and contracted Providers, as well as those in which the Member may be liable).
4. Pended – includes claims forwarded for internal review, or when additional information has been requested from external sources (i.e., Provider of Service, Member, etc) in order to finalize the claim.
5. Claims Inventory – all claims received and open that have not been issued a payment or denial, whether or not entered in the claims system.
6. Claims Overpayments – all claims in which an overpayment has been identified and/or recovered.
7. Claims Adjustments – all claims in which an adjustment due to internal discovery, disputes or appeals, inquiries, retroactive contract or rate adjustments, etc., has been made.
20. CLAIMS PROCESSING

F. Claims and Payment Appeal Reporting

8. Claims Aging – all claims by age of claim, regardless of status based on receipt date of the claim.
9. Provider Payment Disputes – all disputes received where the Provider is disputing an underpayment or down coded service.
10. Redirected Claims – all misdirected claims forwarded to another Payer or denied to the Provider of Service, whether or not entered in the claims system.
11. Emergency Services Claims – all claims received involving emergency services, regardless of outcome.
12. Denied Claims by Type/Volume – number of claims denied by type (reason).
13. Paid Claims by Date/Volume – number of claims paid by day of month.
14. Pended Claims by Type/Volume – number of claims pended by type (reason).

B. By the 15th of each month, Providers must submit to IEHP, for the previous month’s activity, a monthly Claims Timeliness Report. The Monthly Timeliness Report must be reviewed by a Claims Manager and include a signed attestation as to the accuracy and validity of the report.

C. On a quarterly basis, Capitated Providers must submit a Quarterly Provider Payment Dispute Resolution Report. The report is due to IEHP by the 30th of the month following the end of the quarter (i.e., the quarterly report for the period 10/1/18 through 12/31/18 would be due on January 30, 2019).

D. As outlined in Policy 20D, “Claims and Compliance Audits”, for audit purposes, Capitated Providers must also generate the following universal reports at the time of each annual audit, for claims selection and/or review (detailed specifications are outlined in Attachment, “Medicare Universe Reporting Elements” in Section 20):

1. Paid Non-Contracted Provider Clean Claims;
2. Paid Non-Contracted Provider Unclean Claims;
3. Paid Contracted Provider Claims;
4. Denied Claims – Member Liability;
5. Denied Claims – Provider Liability;
6. Provider Payment Disputes;
7. Pended/Contested Claims; and
8. Recovered Overpayments.

E. Failure to provide the required reports within mandated timeframes may subject the Provider to a focused audit or possible contract termination. IEHP reviews reports for compliance with regulatory and contractual requirements, as well as to identify possible trends or patterns that may be indicators of potential unfair payment practices or other issues that may trigger out-
20. CLAIMS PROCESSING

F. Claims and Payment Appeal Reporting

of-cycle corrective actions, including but not limited to increased reporting and monitoring, submission of a Corrective Action Plan (CAP) or a focused audit.

F. 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.
20. CLAIMS PROCESSING

G. Third-Party Liability

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare - Medicaid Plan) Providers.

POLICY:

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

PROCEDURES:

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

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

1. Itemization should include the following information:
   a. Member First and Last Name
   b. Social Security Number
   c. Date of Birth
   d. Date of Injury
   e. Claim Numbers
   f. Dates of Service
   g. Amount Billed
   h. Amount Paid
   j. Modifier
   k. Diagnosis Code
   l. Provider of Service
20. CLAIMS PROCESSING

G. Third-Party Liability

C. The Payor may follow-up every thirty (30) days from the date of the initial correspondence until resolution is complete.
## 20. CLAIMS PROCESSING

### Attachments

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>POLICY CROSS REFERENCE</th>
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<tbody>
<tr>
<td>7-Day Non–Response Letter</td>
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<td>7-Day Inappropriate Denial Letter</td>
<td>20C</td>
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<td>Balance Bill – Out of State Provider</td>
<td>20B</td>
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<td>CMS 1500 Form</td>
<td>20C</td>
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<tr>
<td>ICE - Claim Denial Reason Guide – IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan)</td>
<td>20A</td>
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<td>Medicare Reporting Elements Definitions</td>
<td>20D</td>
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<td>Medicare Universe Reporting Elements</td>
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<td>Medicare Waiver of Liability Statement</td>
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<td>Non Discrimination Tagline</td>
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<td>Notice of Denial of Payment - Spanish</td>
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<td>Required Medicare Audit Documentation Checklist</td>
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<td>UB04 Inpatient Form</td>
<td>20C</td>
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<td>UB04 Outpatient Form</td>
<td>20C</td>
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</table>
{(Date)}

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

Due Date:

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>

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<tr>
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</tbody>
</table>

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 7 calendar days. If you fail to provide proof of payment within 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>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>IEHP MEMBER ID</td>
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</tr>
<tr>
<td>IEHP Claim Number</td>
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</tr>
<tr>
<td>Provider of Service</td>
<td></td>
</tr>
<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>
</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>
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<tr>
<td>Patient Account No.</td>
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</tr>
<tr>
<td>Notification Date</td>
<td></td>
</tr>
<tr>
<td>CAP Deduction Amount</td>
<td></td>
</tr>
<tr>
<td>Process Date</td>
<td></td>
</tr>
</tbody>
</table>

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

IEHP
{(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-day 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 Service
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.

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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.

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<th>IEHP MEMBER ID</th>
<th>Claim Number</th>
<th>Provider of Service</th>
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<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

<Inse4 Processor Initials>
{(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
# HEALTH INSURANCE CLAIM FORM

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Medicare, Medicaid, Tricare, CHAMPVA, Group Health Plan, FEHB, Other</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Patient's Name (Last Name, First Name, Middle Initial)</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Patient's Birth Date (MM DD YY)</td>
<td>Male</td>
</tr>
<tr>
<td>4.</td>
<td>Insured's Name (Last Name, First Name, Middle Initial)</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Patient's Address (No., Street)</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Patient Relationship to Insured</td>
<td>Self</td>
</tr>
<tr>
<td>7.</td>
<td>Insured's Address (No., Street)</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Reserved for NUC Use</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Other Insured's Name (Last Name, First Name, Middle Initial)</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Is Patient's Condition Related To:</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Insured's Policy Group or FEHB Number</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Patient's or authorized person's signature</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Dates Patient Unable to Work in Current Occupation</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Date of Current Illness, Injury, or Pregnancy (MM DD YY)</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Other Date (MM DD YY)</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Dates Hospitalization Dates Related to Current Services</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Name of Referring Provider or Other Source</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>NPI</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Additional Claim Information (Designated by NUCC)</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Outside Lab?</td>
<td>Yes</td>
</tr>
<tr>
<td>21.</td>
<td>Diagnosis or Nature of Illness or Injury</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Resubmission Code</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Prior Authorization Number</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>A. Date(s) of Service</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>B. Place of Service</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>C. Procedure(s), Services, or Supplies</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>Diagnosis Pointer</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Provider ID, #</td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>F. Service Facility Location Information</td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>G. Billing Provider Info &amp; Ph #</td>
<td></td>
</tr>
</tbody>
</table>

*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 requires that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided on this form is true, accurate and complete. In the case of a Medicare or TRICARE provider, the patient's signature authorizes any entity to release 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 6 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare or TRICARE, 25% of the greatest amount subject to the determination of the Medicare carrier or TRICARE fiscal intermediary is paid to the patient. This determination of the Medicare carrier or TRICARE fiscal intermediary is the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

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

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

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and primarily rendered and paid for by the patient and were not furnished to the patient by professional services by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered to my professional services, 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 contractor 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 law and regulations (42 CFR 424.32).

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

NOTICE TO PATIENT ABOUT THE COLLECT AND USE OF INFORMATION, 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 sections 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, 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 MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, as updated and republished.


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

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of services or persons 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 exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

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

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

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

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

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

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

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 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 required data need, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or proposals for improving this form, please write to: CMS, 2500 E Street NW, Attention: PRA Reports Clearance Officer, Mail Stop CA-26-05, 20410, Maryland 21244-1850. This address is for comments and/or suggestions only, DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.
CONTRACTED

This section should be utilized for contracted providers only.
<table>
<thead>
<tr>
<th>Applicable Situation/Type of Service</th>
<th>Contracted Provider Denial Denial Language</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Records Requested and not received (services other than those related to emergency room)</strong></td>
<td>Medical records requested were not received. In order to determine financial liability or medical necessity, medical records are required to assist in a clinical determination. As these records have not been received, this claim in not payable by (Health Plan). You are a contracted provider with (PMG / IPA Name) and you are not allowed to balance bill the member for these services. <strong>THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.</strong></td>
<td><strong>Caution:</strong> These denials need to clearly indicate that there is no member liability and that any disagreement must be resolved between the parties so that the member is not billed. For use when contracted provider has not submitted requested medical records. The medical necessity decision cannot be made without the medical records. (Note: CMS expects plan providers to submit necessary records in a timely manner).</td>
</tr>
<tr>
<td><strong>Outpatient Services (office visits, lab, diagnostic imaging)</strong></td>
<td>According to our records, there is no authorization for the services rendered. Contracted providers are required to provide documentation or other evidence that the member was advised prior to the services being rendered that they may be financially responsible for such services. You are a contracted provider with (PMG / IPA Name) and you are not allowed to balance bill the member for these services. <strong>THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.</strong></td>
<td><strong>Caution:</strong> Contracted providers should not provide unauthorized services unless the member is informed in advance of liability for the services and agrees to pay for non-covered care. Such conversations must be documented prior to the non-covered service services being rendered. Use caution when the member identifies self as Medicare fee-for-service and not HMO, as specialists may be unaware of MA HMO coverage initially.</td>
</tr>
<tr>
<td><strong>Contracted Hospital or Provider Services (non-emergent - no triage call)</strong></td>
<td>Emergency services are services needed immediately due to sudden illness, injury, or prudent layperson perception, and additional time spent to reach the member’s assigned Medical Group or IPA would have meant risk of permanent damage to the member’s health. The services you provided do not meet this definition and therefore required that you obtain prior authorization or provide documented proof the member was advised prior to services being rendered that they may be financially liable for such services. As a contracted provider, you are precluded from billing the member for these services. <strong>THE MEMBER IS NOT RESPONSIBLE FOR THE PAYMENT OF THIS CLAIM.</strong></td>
<td>Emergency services are defined in the regulations to include prudent layperson standards, but there are also requirements for contracted providers. This denial reason is for use when contracted hospital services are non-emergent. Example: An ER treats minor problems without triage or phone call to PCP for authorization. (Note: Initial triage of the condition is covered).</td>
</tr>
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<td>Applicable Situation/Type of Service</td>
<td>Contracted Provider Denial Denial Language</td>
<td>Comments</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>Contracted Provider Denial Denial Language</strong></td>
<td>Medical Management has reviewed the care provided and determined that a delay in services provided resulted in unnecessary inpatient days listed above. As a contracted provider, you are not allowed to balance bill the member for these non-covered services. <strong>THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.</strong></td>
<td>For use when delay in care or delay in discharge resulted in additional facility days that are unapproved and must be written off by the provider under the terms of their agreement. <strong>Cautions:</strong> A claim with only this problem can result in a denial. However, if the claim can be properly denied for any other reason, a denial notice appropriate to that reason should be issued without a request for further information and situation code ERIA-01 would not be used.</td>
</tr>
<tr>
<td><strong>Contracted Provider Denial Denial Language</strong></td>
<td>The services provided were not reasonable and or medically necessary for the patient’s condition based on the medical records received and were not authorized. You are a contracted provider with (PMG/IPA) and you are not allowed to balance bill the member for these services. <strong>THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.</strong></td>
<td>For use when IPA has confirmed that there is no authorization on file and medical records requested/received do not meet medical necessity requirements. Requires UM review. Contracted/Affiliated providers should not provide services that are not medically necessary unless the member is informed in advance of liability for such services and agrees to pay for non-covered care.</td>
</tr>
<tr>
<td><strong>Contracted Provider Denial Denial Language</strong></td>
<td>Medical records do not support that the presenting symptoms meet the below definition of emergency. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to the member’s health. <strong>THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.</strong></td>
<td>The denial language addresses both the non-urgent/emergent situations in area and the lack of authorization for routine care. CMS applies the prudent layperson rule in evaluation of emergency services. If there is clear documentation that the member is responsible for the service (i.e., PCP was available and member was instructed to go to PCP office but chose to go to ER) and services were clearly non-urgent/ emergent, the language listed to the left should be modified to exclude the last sentence. <strong>NOTE:</strong> Medicare Advantage organization is not responsible for the care provided for unrelated non-emergency problem during treatment for an emergency situation, per CMS Manual Pub 100-16</td>
</tr>
<tr>
<td><strong>Contracted Provider Denial Denial Language</strong></td>
<td><strong>Urgently needed services</strong> means covered services that are not emergency services, provided when the enrollee is in the service or continuation area but the organization provider network is temporarily unavailable or inaccessible when the services are medically necessary and immediately required. As a result of an unforeseen illness, injury or condition and it was not reasonable given the circumstances to obtain the services through the organization offering the MA plan. <strong>THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.</strong></td>
<td>The denial language addresses both the non-urgent situations in area and the lack of authorization for routine care. If there is clear documentation that the member is responsible for the service (i.e., PCP was available and member was instructed to go to PCP office but chose to go to UC) and services were clearly non-urgent/emergent, the language listed to the left should be modified to exclude the last sentence.</td>
</tr>
</tbody>
</table>
NON-CONTRACTED

This section should be utilized for Non-contracted providers only.
### Non-Contracted Provider Denial

<table>
<thead>
<tr>
<th>Applicable Situation/Type of Service</th>
<th>Non-Contracted Provider Denial Language</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Claim Data Missing or Spoiled</td>
<td>[This page presents an approach to developing these problem claims when they are received from non-contracting providers. Please note that unlike for contracting provider claims on the preceding page, non-contracting provider claims cannot initially be denied for lack of complete, correct CMS required encounter data elements. CMS required data elements includes submission of a complete claim including complete diagnosis coding required for submission of risk adjustment information to CMS. Such incomplete claims from non-contracted providers are defined as non-clean and should be developed for up to 60 calendar days. If the claim data remains incomplete after requesting complete information, the claim should be denied on day 60 for incomplete information.]</td>
<td>Under Medicare regulations, a claim with incomplete data, including proper diagnosis coding required by CMS for submission for risk adjustment, is not a clean claim. Accordingly, we have up to 60 calendar days to work with non-contracted providers by asking them to provide complete claims data so that a proper evaluation of the claim can occur. Typically two requests should be made to the provider for complete claims data. If a complete claim is not received prior to day 60, the claim can be denied as an incomplete claim. To develop the claim, the text below is recommended for requesting that a non-contracted provider submit a corrected claim. (Please see contracted section for language to be sent to a contracted provider.) Medicare requires us to report more complete information than you provided on this claim. Your claim as submitted is missing one or more essential items of information or has codes that are not sufficiently specific or do not conform to national standards (e.g., are incomplete, invalid or out of date). 42 CFR 422.257(d) paragraphs (1) and (4) require Medicare Advantage organizations to submit complete, conforming encounter data from paid claims. Unless otherwise specified, the missing or deficient items include one or more of the items listed below this paragraph that is not to the highest level of specificity or in accordance with currently valid Medicare codes. Until you provide us with the requested information, THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS INCOMPLETE CLAIM and should not be billed. (INSERT EITHER THE CMS-1500 OR UB-92 LIST FROM THE PRIOR PAGE HERE) <strong>Important Note:</strong> If you are dealing with a non-contracted provider, you have up to the 60th calendar day to develop the claim, but at that time, you must pay or can only deny when missing any of the CMS required fields.</td>
</tr>
</tbody>
</table>

![Denial Notice to Member and/or Provider](Not Applicable)
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<tr>
<th>Applicable Situation/Type of Service</th>
<th>Denial Language</th>
<th>Comments</th>
<th>Denial Notice to Member and/or Provider</th>
<th>Situation Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Contracted In-Area Emergency Services (non-emergent) (presenting circumstances fail test)</td>
<td>Medical records do not support that the presenting symptoms meet the below definition of emergency. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to your health. Use of non-Plan providers in nonemergency situations is not payable by [Name of Health Plan]</td>
<td>The denial language addresses both the non-urgent/emergent situations in area and the lack of authorization for routine care. CMS applies the prudent layperson rule in evaluation of emergency services. CAUTION: Only to be used if there is clear documentation that the member is responsible for the service (i.e., PCP was available and member was instructed to go to PCP office but chose to go to ER) and services were clearly non-urgent/emergent, the language listed to the left should be modified to exclude the last 2 sentences. NOTE: Medicare Advantage organization is not responsible for the care provided for unrelated non-emergency problem during treatment for an emergency situation, per CMS Manual Pub 100-16</td>
<td>Yes</td>
<td>ERIA-04</td>
</tr>
<tr>
<td>Non-Contracted In-Area Urgent Care Services (non-urgent) (presenting circumstances fail test)</td>
<td>Urgently needed services means covered services that are not emergency services, provided when the enrollee is in the service or continuation area but the organization provider network is temporarily unavailable or inaccessible when the services are medically necessary and immediately required. As a result of an unforeseen illness, injury or condition and it was not reasonable given the circumstances to obtain the services through the organization offering the MA plan.</td>
<td>The denial language addresses both the non-urgent situations in area and the lack of authorization for routine care. If there is clear documentation that the member is responsible for the service (i.e., PCP was available and member was instructed to go to PCP office but chose to go to UC) and services were clearly non-urgent/emergent, the language listed to the left should be modified to exclude the last sentence.</td>
<td>Yes</td>
<td>UCIA-02</td>
</tr>
<tr>
<td>Medical Records Requested and not received (services other than those related to emergency room)</td>
<td>Medical records requested were not received. In order to determine financial liability or medical necessity, medical records are required to assist in a clinical determination. As these records have not been received, this claim is not payable by [Health Plan].</td>
<td>For use when non-contracted provider has not submitted requested medical records. The medical necessity decision cannot be made without the medical records. Member may be billed.</td>
<td>Yes</td>
<td>NON-01</td>
</tr>
<tr>
<td>Not Medically Necessary</td>
<td>The services provided were not reasonable and or medically necessary for the patient’s condition based on the medical records received and were not authorized.</td>
<td>For use when IPA has confirmed that there is no authorization on file and medical records requested/received do not meet medical necessity requirements. Requires UM review. Caution: If a Plan provider arranges, refers, or renders services that are not medically necessary without advising the member of non-coverage and financial liability in advance, the member is not financially liable for the services.</td>
<td>Yes</td>
<td>NMN-01</td>
</tr>
</tbody>
</table>
CONTRACTED / NON-CONTRACTED

This section may be utilized for Contracted and Non-contracted providers.
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<tr>
<th>Applicable Situation/Type of Service</th>
<th>Denial Language</th>
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</thead>
<tbody>
<tr>
<td>Incomplete or Invalid Claim (Initial Claim Development)</td>
<td>Your claim contains incomplete and/or invalid information and no appeal rights are afforded because we are not able to process the claim. Please submit a new claim with the complete/correct information. The following data element(s) are required (insert specific claim data element required).</td>
<td>Under Medicare regulations, a claim with incomplete data, including proper diagnosis coding required by CMS for submission for risk adjustment, is not a clean claim. Accordingly, we have up to 60 calendar days to work with providers by asking them to provide complete claims data so that a proper evaluation of the claim can occur. Typically two requests should be made to the provider for complete claims data. If a complete claim is not received prior to day 60, the claim can be denied as an incomplete claim. To develop the claim, this message is recommended for requesting that a provider submit a corrected claim. Required Claim Data Elements:</td>
</tr>
</tbody>
</table>

<p>| CMS-1500: Billing Provider Name | UB-04/CMS-1450: Billing Provider Name |
| CMS-1500: Federal Tax Number | UB-04/CMS-1450: Patient Control Number |
| CMS-1500: Patient's Name | UB-04/CMS-1450: Type of Bill |
| CMS-1500: Patient's Address | UB-04/CMS-1450: Federal Tax Number |
| CMS-1500: Date of Birth | UB-04/CMS-1450: Statement Covers Period |
| CMS-1500: Sex | UB-04/CMS-1450: Patient's Name |
| CMS-1500: Service Date | UB-04/CMS-1450: Patient's Address |
| CMS-1500: Diagnosis Code | UB-04/CMS-1450: Date of Birth |
| Procedure, Service, Supply Code | | |
| Days or Units | | |
| Place of Service | | |
| Anesthesia/Oxygen Min. NPI | | |
| Insured’s Name | | |
| Patient’s Relationship | | |
| Insured’s ID | | |
| CMSE01 | | |</p>
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<tr>
<td>Incomplete or Invalid Claim (Reject/Deny due to non-receipt of corrected claim)</td>
<td>Your claim as submitted is missing one or more essential items of information or has codes that are not sufficiently specific or do not conform to national standards (e.g., are incomplete, invalid or out of date). 42 CFR 422.257(d) paragraphs (1) and (4) require Medicare Advantage organizations to submit complete, conforming encounter data from paid claims. You have not responded to our previous request for the specific required data. Until you provide us with the requested information, THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS INCOMPLETE CLAIM and should not be billed.</td>
<td>Caution: Do not deny to member without verification of eligibility through the plan. Forward to the appropriate Service Partner or Health Plan with whom the member is eligible. NOTE: This message is to be used at the expiration of the 60-day development period and when a corrected claim has not been received. If the information is received after the actual denial notice has been sent, the claim is treated as a new claim.</td>
</tr>
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</table>

Provider Only | INC-02 |
<table>
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<tr>
<th>Applicable Situation/Type of Service</th>
<th>Eligibility Denial Language</th>
<th>Comments</th>
<th>Denial Notice to Member and or Provider</th>
<th>Situation Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predates Eligibility with Plan</td>
<td>The date you received medical services on the above claim was prior to your effective date of eligibility with {Name of Health Plan}. Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered.</td>
<td>Eligibility Note related to liability for services under MA: For Coverage that Begins or Ends During an Inpatient Stay (MMA §422.318), Medicare has expanded the definition for services for which we have liability until discharge. Previously Plan remains liable until discharge for any PPS (e.g. DRG) hospital services for a member who is an inpatient at the time of disenrollment. This list has expanded to include acute rehab hospitals, distinct part rehab units, and long term care hospitals. Physician services continue to revert to Medicare (or any new MA Plan) as of the date of disenrollment. The reverse applies on enrollment. Medicare (or the prior MA Plan) pays for the hospitalization until discharge, but the current Plan pays for physician charges upon enrollment.</td>
<td>Applicable when services rendered prior to HMO enrollment date.</td>
<td>Yes (note caution)</td>
</tr>
<tr>
<td>In-between Eligibility</td>
<td>The date of service is between your eligibility for {Name of Health Plan}. Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered.</td>
<td>Applicable when services rendered in between HMO enrollment dates. Caution: Denials that read &quot;Not eligible with IPA or medical group at the time of service&quot; are inappropriate denials. Contact Plan to verify eligibility and for routing instructions. NOTE: If the DOS is between eligibility with 2 different Health plans please refer to ELIG-01 or ELIG-02 based on the closest date of eligibility.</td>
<td>Yes (note caution)</td>
<td>ELIG-04</td>
</tr>
<tr>
<td>Postdates Eligibility with Plan</td>
<td>The date you received medical services on the above claim was after your effective date of disenrollment with {Name of Health Plan}. Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered.</td>
<td>Applicable when service rendered after HMO disenrollment date. Caution: Denials that read &quot;not eligible with IPA or medical group at the time of service&quot; are inappropriate denials. Contact Plan to verify eligibility and for routing instructions.</td>
<td>Yes (note caution)</td>
<td>ELIG-02</td>
</tr>
<tr>
<td>Service Postdates Member’s Death</td>
<td>Our records show the date of service was after the date of death.</td>
<td>Applicable for services billed with a date of service after the members date of death (e.g. post death transportation to a mortuary, hospital bed charges post death until pick up, pathology read post death).</td>
<td>Provider Only</td>
<td>ELIG-03</td>
</tr>
</tbody>
</table>

Caution: Do not deny to member without verification of eligibility through the plan. Forward to the appropriate Service Partner or Health Plan with whom the member is eligible.

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07   ICE Approved: 5/16
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<tr>
<th>Situation/Type of Service</th>
<th>Emergency and Urgently Needed Services Denial Language</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>In-Area Emergency Services (records not received)</td>
<td>Medical records requested were never received. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to your health. The services received and circumstances do not meet these requirements based on the information available. THE MEMBER IS NOT RESPONSIBLE FOR THE PAYMENT OF THIS CLAIM.</td>
<td>The denial language addresses situation where an emergent situation is not evident based on the information available and adequate development took place, but medical records were not received. CAUTION: If non-contracted provider is rendering services, the language listed to the left should be modified to exclude the last sentence. NOTE: Medicare Advantage organization is not responsible for the care provided for unrelated non-emergency problem during treatment for an emergency situation, per CMS Manual Pub 100-16</td>
</tr>
<tr>
<td>In-Area (partial denial of inappropriate services)</td>
<td>Services delivered as emergency care were not consistent with presenting symptoms or emergency diagnosis.</td>
<td>Use after medical review when you are making a partial denial of a selected line item(s) for unrelated or inappropriate services provided after triage and there is evidence that the member had accepted liability. NOTE: Medicare Advantage organization is not responsible for the care provided for unrelated non-emergency problem during treatment for an emergency situation, per CMS Manual Pub 100-16</td>
</tr>
<tr>
<td>Out-of-Area Emergency Services (not urgently needed)</td>
<td>Emergency services are covered outside of the service area if necessary to prevent deterioration of health due to unforeseen illness while temporarily out of the service area. The services received were not emergent and were not authorized.</td>
<td>Emergently needed services are by definition applicable to out-of-area care. Denials for out-of-area care should be based on the urgently needed services criteria, which is more liberal than the in-area emergency criteria. CMS applies the prudent layperson rule in evaluation of emergency services. NOTE: Medicare Advantage organization is not responsible for the care provided for unrelated non-emergency problem during treatment for an emergency situation, per CMS Manual Pub 100-16</td>
</tr>
<tr>
<td>Out-of-Area Urgently Needed Services (not urgently needed)</td>
<td>Urgently needed services means covered services that are not emergency services, provided when an enrollee is temporarily absent from the MA plan’s service area and when the services are medically necessary and immediately required. As a result of an unforeseen illness, injury or condition and it was not reasonable given the circumstances to obtain the services through the organization offering the MA plan.</td>
<td>Urgently needed services are by definition applicable to out-of-area care. Denials for out-of-area care should be based on the urgently needed services criteria, which is more liberal than the in-area emergency criteria. NOTE: Medicare Advantage organization is not responsible for the care provided for unrelated non-urgently problem during treatment for an urgent situation, per CMS Manual Pub 100-16</td>
</tr>
<tr>
<td>Out-of-Area Emergency Needed Services (records not received)</td>
<td>Emergent services are covered outside of the service area if necessary to prevent deterioration of health due to unforeseen illness while temporarily out of the service area. Medical records requested were never received. The services received cannot be determined to meet these requirements based on the information available.</td>
<td>Emergently needed services are by definition applicable to out-of-area care. Denials for out-of-area care should be based on the urgently needed services criteria, which is more liberal than the in-area emergency criteria. CMS applies the prudent layperson rule in evaluation of emergency services. NOTE: Medicare Advantage organization is not responsible for the care provided for unrelated non-emergency problem during treatment for an emergency situation, per CMS Manual Pub 100-16</td>
</tr>
</tbody>
</table>

Denial Notice to Member and/or Provider: Yes (note caution) Situation Code: ERIA-02

Denial Notice to Member and/or Provider: Yes Situation Code: ERIA-03

Denial Notice to Member and/or Provider: Yes Situation Code: EROA-01

Denial Notice to Member and/or Provider: Yes Situation Code: UCOA-01

Denial Notice to Member and/or Provider: Yes Situation Code: EROA-02
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<tr>
<th>Applicable Situation/Type of Service</th>
<th>Maximum Allowable Benefit</th>
<th>Denial Notice to Member and or Provider</th>
<th>Comments</th>
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<tr>
<td><strong>Chiropractic</strong> (non-Medicare covered)</td>
<td>The maximum calendar year additional chiropractic benefit is (#) visits per year. Our records indicate you reached that limit on {date}. The maximum benefit was paid at that time.</td>
<td>Yes</td>
<td>Plan benefits for routine chiropractic services vary. Please refer to the Plan's member materials for benefit guidelines</td>
</tr>
<tr>
<td><strong>Inpatient Psychiatric</strong></td>
<td>Inpatient psychiatric care is covered according to Medicare guidelines and is limited to 190 days per lifetime in a Medicare certified psychiatric hospital. Our records indicate you reached 190 lifetime days on {date}.</td>
<td>Yes</td>
<td>Coverage is limited to 190 lifetime inpatient days if services are provided in a Medicare certified psychiatric hospital. Inpatient psych days in a general hospital psych unit do not count towards the lifetime 190 day limit and would continue to be Medicare-covered even if the 190 day limit has been reached. Caution: If a member exhausts the 190 day lifetime maximum at a Medicare certified psychiatric hospital, they may qualify for inpatient benefits at a general hospital's psychiatric unit.</td>
</tr>
<tr>
<td><strong>Podiatry</strong> (non-Medicare covered)</td>
<td>The maximum calendar year additional podiatry benefit is (#) visits per year. Our records indicate you reached that limit on {date}. The maximum benefit was paid at that time.</td>
<td>Yes</td>
<td>Plan benefits for routine podiatry services vary. Please refer to the Plan's member materials for benefit guidelines</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong> (non-Medicare covered)</td>
<td>The maximum calendar year benefit allowance for outpatient prescription drugs is $( benefit max amount ). Our records indicate you reached that limit on {date}. The maximum benefit was paid at that time.</td>
<td>Yes</td>
<td>Benefit maximums should exclude Medicare covered drugs and biologicals. Please refer to the Plan's member materials for benefit coverage guidelines. Caution: Per ACA, non-grandfathered plans and select grandfathered plan do not have an annual or lifetime $$ amount benefit maximum under the essential health benefit.</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>Skilled Nursing Facilities are covered by {Name of Health Plan} up to 100 days per benefit period. Our records indicate that on {date}, you reached your 100 day benefit maximum for this benefit period.</td>
<td>Yes</td>
<td>Coverage is limited to a 100 day Maximum Medicare Benefit for Skilled Nursing per benefit period (Requires Notice of Non-Coverage). Caution: Some Plans may provide additional SNF benefits. Refer to the Plan's member materials for benefit guidelines.</td>
</tr>
<tr>
<td><strong>Miscellaneous (Insert other specific benefits with annual maximums)</strong></td>
<td>{Insert other specific benefits with annual maximums} are covered by {Name of Health Plan}. Our records indicate that on {date}, you reached your {benefit maximum} for {Insert other specific benefits maximums}.</td>
<td>Yes</td>
<td>Benefit maximums must be supported by the Plan's member materials. SPECIFIC denial information is required.</td>
</tr>
</tbody>
</table>

Note: Specified date placeholders {date} are used to represent specific dates.
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<tbody>
<tr>
<td>Ambulance (not medically necessary)</td>
<td>Ambulance transportation is covered if you could not have used another means of transportation without endangering your health. The transport you received does not meet this criterion</td>
<td>For use where transport is not medically necessary and not authorized.</td>
<td>Yes</td>
<td>NCAM-01</td>
</tr>
<tr>
<td>Ambulance (no patient transport)</td>
<td>As you were not transported by ambulance, the services are not covered by Medicare or {Name of Health Plan}.</td>
<td>For denial of services where no patient has been transported, such as paramedic intercept calls where no transport occurs.</td>
<td>Yes</td>
<td>NCAM-02</td>
</tr>
<tr>
<td>Assistant Surgeon (Medicare guidelines)</td>
<td>Medicare does not pay for an assistant surgeon for this procedure/surgery. Payment for the assistant surgeon is denied by {Name of Health Plan}. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THESE SERVICES.</td>
<td>Denial to provider per Medicare guidelines. Member should not be involved. The member has no financial responsibility for these services.</td>
<td>Provider Only</td>
<td>NCAS-01</td>
</tr>
<tr>
<td>Bundling (Medicare guidelines)</td>
<td>Medicare does not pay separately for this service. Payment is included in another service the member has received. The member has no financial liability and should not be billed for these services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THESE SERVICES.</td>
<td>For use in rebundling services per Medicare guidelines. Plans cannot apply to non-contracted Clinical Lab, Radiology (facility component), DME, Ambulance, ESRD Medications, or Home Health. The member has no financial responsibility for these services.</td>
<td>Provider Only</td>
<td>NCBU-01</td>
</tr>
<tr>
<td>Chiropractic (Medicare criteria)</td>
<td>Medicare coverage for chiropractic care requires that you be diagnosed with subluxation of the spine. The services received do not meet this criterion and are not covered by Medicare or {Name of Health Plan}.</td>
<td>For denial of service or claim where Medicare criteria are not met. <strong>Caution:</strong> Some Plans may provide additional chiropractic care benefits. Refer to the Plan's member materials for benefit guidelines.</td>
<td>Yes (note caution)</td>
<td>NCCH-01</td>
</tr>
<tr>
<td>Cosmetic</td>
<td>The procedure you received is considered a cosmetic procedure. Cosmetic procedures are not a benefit covered by Medicare or {Name of Health Plan}, except for post-accident repair/reconstruction. Please refer to your Health Plan's member materials for benefit guidelines.</td>
<td>Cosmetic procedures are normally excluded with specific exceptions for post-accident repair/reconstruction or where applicable as a prosthetic, such as post mastectomy. Please refer to the Plan's member materials for benefit guidelines.</td>
<td>Yes</td>
<td>NCCO-01</td>
</tr>
<tr>
<td>Applicable Situation/Type of Service</td>
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</tr>
<tr>
<td>Dental Services</td>
<td>Dental services are not a benefit covered under Medicare or {Name of Health Plan} except for surgery related to the jaw or any structure related to the jaw or any facial bone. Please refer to your Health Plan's member materials for benefit guidelines.</td>
<td>Caution: Members may have additional coverage through their HMO for non-Medicare covered dental services. Please refer to the Plan member materials for benefit guidelines.</td>
<td>Yes (note caution)</td>
<td>NCDS-01</td>
</tr>
<tr>
<td>DME-Durable Medical Equipment (does not meet Medicare DME criteria)</td>
<td>Medicare defines durable medical equipment as an item that is medical in nature, can withstand repeated use, and is used in the home. The item received does not meet these requirements and is not payable by Medicare or {Name of Health Plan}.</td>
<td>For use when the item does not meet Medicare DME criteria. <strong>Caution:</strong> If a plan physician (PCP or SCP) prescribes equipment that is not covered, the member cannot be held liable without prior disclosure of financial liability.</td>
<td>Yes (note caution)</td>
<td>NCDM-01</td>
</tr>
<tr>
<td>DME-Durable Medical Equipment (not authorized)</td>
<td>The durable medical equipment received was not prescribed/authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not payable by {Name of Health Plan}.</td>
<td>For use when DME is not prescribed/authorized by a Plan physician. <strong>Caution:</strong> IPA needs to coordinate with Plan before issuing denials for DME to avoid possible duplication.</td>
<td>Yes (note caution)</td>
<td>NCDM-02</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Hearing Aids are not a benefit covered under Medicare or {Name of Health Plan}.</td>
<td>Medicare does not cover Hearing Aids. <strong>Caution:</strong> IPA needs to coordinate with Plan for possible additional coverage.</td>
<td>Yes (note caution)</td>
<td>NCHA-01</td>
</tr>
<tr>
<td>Home Health (does not meet skilled guidelines)</td>
<td>Home health services must include intermittent skilled care (skilled nursing, PT, or speech therapy) to qualify under Medicare guidelines. The services received were not skilled care and are not payable by Medicare or {Name of Health Plan}.</td>
<td>For use when the member requests home health care and does not require skilled care.</td>
<td>Yes</td>
<td>NCHH-01</td>
</tr>
<tr>
<td>Home Health (member not homebound)</td>
<td>Home health care must meet Medicare guidelines, which require that you are confined to your home. You are not homebound and consequently the home health services received are not payable by Medicare or {Name of Health Plan}.</td>
<td>For use when the member requests home health care and does not meet Medicare criteria for being homebound or for coverage determinations for Out of Plan services under emergent or urgently needed criteria.</td>
<td>Yes</td>
<td>NCHH-02</td>
</tr>
<tr>
<td>Applicable Situation/Type of Service</td>
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</tr>
<tr>
<td>Home Health (not authorized)</td>
<td>The home health services you received were not authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not payable by {Name of Health Plan}.</td>
<td>For use when patient self refers or has home health ordered by an Out of Plan physicians. <strong>Caution:</strong> IPA needs to coordinate with Plan before issuing denials for Home Health Care</td>
<td>Yes (note caution)</td>
<td>NCHH-03</td>
</tr>
<tr>
<td>Non-Formulary Drugs</td>
<td>The {list specific prescription drug/ medication} you received is not on the listing or formulary of approved drugs for {Name of Health Plan}. Non-formulary drugs are not a covered benefit. Please refer to your Health Plan's member materials for benefit guidelines.</td>
<td>Prescription drugs/medications are typically Plan liability. This denial is applicable where a closed formulary is stipulated in the member materials and a claim is received for non-formulary drugs.</td>
<td>Yes (by plan)</td>
<td>NCRX-01</td>
</tr>
<tr>
<td>Non Medicare/FDA Approved Drugs or Devices</td>
<td>{ list specific drug or devise } is not approved by Medicare/the FDA and is excluded from coverage by {Name of Health Plan}. Please refer to your Health Plan's member materials for benefit guidelines.</td>
<td>For denials of services or equipment not approved by Medicare/the FDA for use under the Medicare Program or otherwise specifically excluded in the member materials. Please refer to the Plan's member materials for benefit guidelines.</td>
<td>Yes</td>
<td>NCRX-02</td>
</tr>
<tr>
<td>Not Authorized In-Area Non-ER Services (If ER / emergent, use emergency denial message)</td>
<td>When you enrolled in a Medicare Advantage Plan, you selected a Primary Care Physician to coordinate/authorize your medical care. The services received were not authorized and are not payable by {Name of Health Plan}.</td>
<td><strong>Caution:</strong> If a Plan provider arranges, refers, or renders services that are not medically necessary without advising the member of non-coverage and financial liability in advance, the member is not financially liable for the services.</td>
<td>Yes (note caution)</td>
<td>NCNA-01</td>
</tr>
<tr>
<td>Over the Counter Items/Medications</td>
<td>The drugs/medication received is available over the counter without a prescription and are not a benefit covered by {Name of Health Plan}. Please refer to your Health Plan's member materials for benefit guidelines.</td>
<td>Over the counter drugs/medicines, supplies and items are typically excluded under the EOC / Member Agreement. Please refer to the Plan's member materials for the benefit guidelines. OTC items would include but are not limited to: mouthwash, supplements, homeopathic, antacids, thermometers, insoles, hearing aid batteries, etc… (refer to MCM Chapter 4, section 40.3)</td>
<td>Yes (by plan)</td>
<td>NCRX-03</td>
</tr>
<tr>
<td>Personal Comfort Items</td>
<td>The {list specific item} you were provided is considered a personal comfort item and is not a covered benefit under Medicare or {Name of Health Plan}. Please refer to your Health Plan's member materials for benefit guidelines.</td>
<td>(For use with facility claims only) Personal comfort items are not a covered Medicare benefit. This would include charges for telephone, slippers, videos, bathrobes, etc… <strong>Caution:</strong> For non-facility related supplies and items billed, refer to NCRX-03. Refer to MCM Chapter 4, section 40.3 for examples of non-covered items.</td>
<td>Yes</td>
<td>NCPC-01</td>
</tr>
<tr>
<td>Applicable Situation/Type of Service</td>
<td>Not a Covered Benefit Denial Language</td>
<td>Comments</td>
<td>Denial Notice to Member and/or Provider</td>
<td>Situation Code</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>--------------------------------------</td>
<td>----------</td>
<td>-----------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Podiatry services for routine foot care, such as toe nail trimming, or corn/callus removal is not a benefit covered under Medicare or (Name of Health Plan). Please refer to your Health Plan's member materials for benefit guidelines.</td>
<td><strong>Caution:</strong> Medicare covers routine foot care for specific conditions related to diabetic &amp; systemic foot disease. Members may have additional podiatry benefits with direct access for routine podiatry services. Please refer to the Plan's member materials for benefit guidelines.</td>
<td>Yes (note caution)</td>
<td>NCPO091</td>
</tr>
<tr>
<td>Shoe Orthotics</td>
<td>Shoe orthotics, including inserts and modifications, are only covered by Medicare or (Name of Health Plan) for diabetics or when the shoe is an integral part of a leg brace. Please refer to your Health Plan's member materials for benefit guidelines.</td>
<td><strong>Caution:</strong> Some Plans may offer additional shoe orthotic coverage. Please refer to the Plan's member materials for benefit guidelines.</td>
<td>Yes (note caution)</td>
<td>NCSO-01</td>
</tr>
<tr>
<td>Skilled Nursing Facility (custodial care or not daily SNF care)</td>
<td>Medicare guidelines require that skilled nursing facility care be needed daily, as certified by your physician. The services received were custodial in nature and/or not required daily. They are not covered by Medicare or (Name of Health Plan).</td>
<td>For use when care is custodial or daily skilled care is not medically necessary.</td>
<td>Yes</td>
<td>NCSN-01</td>
</tr>
<tr>
<td>Skilled Nursing Facility (not authorized)</td>
<td>The skilled nursing facility services you received were not authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not a covered benefit under (Name of Health Plan).</td>
<td>For use when care is not authorized, i.e. member self refers or is referred by a non-Plan physician. <strong>Caution:</strong> IPA needs to coordinate with Plan before issuing denials for Skilled Nursing Care.</td>
<td>Yes (note caution)</td>
<td>NCSN-02</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>{List specific item(s)} is not a Medicare covered benefit and excluded from coverage under (Name of Health Plan). Please refer to your Health Plan's member materials for benefit guidelines.</td>
<td>For use with other specific services that are not a covered benefit.</td>
<td>Yes</td>
<td>NCMI-01</td>
</tr>
<tr>
<td>Applicable Situation/Type of Service</td>
<td>Advanced Diagnostic Imaging Accreditation</td>
<td>Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------------------------------</td>
<td>----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADI – Rendered by non-accredited provider</td>
<td>Medicare does not pay for services rendered by a non-accredited provider. Payment for this advanced diagnostic imaging service is denied. <strong>THE MEMBER IS NOT RESPONSIBLE FOR THE PAYMENT OF THIS SERVICE.</strong></td>
<td>For use when an advanced diagnostic imaging service listed on the CMS listing of CPT codes requiring accreditation and the rendering provider is not found on the accreditation lists of the accreditation organizations recognized by CMS.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Applicable Situation/Type of Service</th>
<th>Provider Opted Out of Medicare</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim is submitted inadvertently by the opt-out physician/practitioner or beneficiary</td>
<td>The provider decided to drop out of Medicare. No payment can be made for this service. You are responsible for this charge. Under Federal law your doctor cannot charge you more than the limiting charge amount.</td>
<td>For use when the rendering provider has opted out of Medicare. <strong>Caution:</strong> See 42 CFR 405.440. An MA organization must pay for emergency or urgently needed services furnished by a physician or practitioner to an enrollee in their MA plan who has not signed a private contract with a beneficiary, but may not otherwise pay opt-out providers.</td>
</tr>
<tr>
<td>Claim is submitted knowingly and willfully by the opt-out physician/practitioner</td>
<td>The provider decided to drop out of Medicare. No payment can be made for this service. You are responsible for this charge. Under Federal law your doctor cannot charge you more than the limiting charge amount.</td>
<td>For use when the rendering provider has opted out of Medicare. <strong>Caution:</strong> See 42 CFR 405.440. An MA organization must pay for emergency or urgently needed services furnished by a physician or practitioner to an enrollee in their MA plan who has not signed a private contract with a beneficiary, but may not otherwise pay opt-out providers</td>
</tr>
</tbody>
</table>

Provider Only |

<p>| Situation Code | | |
|----------------|------------------|
| NCAD-01 | Yes NCOO-01 | Yes NCOO-02 |</p>
<table>
<thead>
<tr>
<th>Applicable Situation/Type of Service</th>
<th>Workers Compensation Denial Language</th>
<th>Comments</th>
<th>Denial Notice to Member and or Provider</th>
<th>Situation Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any visit documented as workers compensation</td>
<td>According to our records the services that have been rendered fall under your worker's compensation case.</td>
<td>For use when member has filed a worker's compensation case. Evidence of first report of injury should be indicated.</td>
<td>Yes</td>
<td>WC-01</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Applicable Situation/Type of Service</th>
<th>Coordination of Benefits Denial Language</th>
<th>Comments</th>
<th>Denial Notice to Member and or Provider</th>
<th>Situation Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requested information not received from member</td>
<td>Our records indicate that you may have other insurance coverage. Coordination of benefits information (primary insurance carrier information) was requested from you and has not been received. In order to determine financial liability this information is required. As this information has not been received, this claim in not payable by [Health Plan].</td>
<td>CAUTION: Before denying, you must be able to demonstrate two requests for information have been sent to the member. For use when records indicate other insurance coverage and information has not been received from member.</td>
<td>Yes</td>
<td>COB-01</td>
</tr>
</tbody>
</table>
The following documents are provided for your reference and information to aid you in working with this ICE Tool:

- History of Revisions
- Instructions
- FAQs
History of Revisions

01/2016  - Added denial reason codes CONT-07 and NVMN-01 for services determined to be not medically necessary.

01/22/14  Corrected grammatical errors. Removed denial reasons CONT-04 and CONT-05. New denial reasons added for Urgent Care UCIA-01 UCIA-02. Added language pertaining to ACA non-grandfathered plans. Removed diagnosis codes related to chiropractic care denial reason NCCH-01. Added examples of OTC items NCRX-03 changed description to include items. Added a caution to personal comfort items NCPC-01. Added new denial reason for ADI regulations mandated by CMS NCAD-01. Added new denial reasons for opt out providers NCOO-01 NCOO-02.

11/2005  Updated ERIA-01 to be listed only once and added ERIA-04.


2/27/03  No denial reasons have been changed, added or deleted. Several format changes to other elements of this tool were made. Inclusive braces { } were added to distinguish {text inserts} from [instructions or descriptions] in the guide. More about the use of braces is explained on one of the pages below. This revision has included adding this and other informational pages that are not part of the guide itself. They are aids to understanding the guide, including: a history of revisions (this page), instructions, and a place-holder for frequently asked questions (FAQs).

3/01  The Industry Collaboration Effort (ICE) implemented modifications to comply with the Balanced Budget Act (BBA) and the related Final Rule. Prudent Layperson language was added to denial reasons CONT-3, ERIA-01 and ERIA-02. CONT-04 and CONT-05 were added for use when contracted providers don’t submit claims that include minimally complete encounter data items. Chiropractic denial reason NCCH-01 was revised. HCFA/CMS Region IX reviewed and approved the modifications.

1/24/97  The original version was presented by the HCFA Managed Care Operations Team (HMCOT) in response to a request from Bruce Fried of HCFA Central Office. It was developed by participating health plans and HCFA Region IX, with input from IPAAC and other participating provider organizations.
Instructions

Using the Guide

☐ All information in inclusive braces {} and the braces themselves must be replaced by inserted text as indicated.

☐ Please read all comments and cautions very carefully. Consult with a health plan or the ICE Claims Standardization Team if you need assistance or clarification.

☐ The situation code column shows generic codes to aid in referring to different reasons in this guide. You can change these codes to fit the nomenclature of your own claim system; however, it is a best practice to create a cross-reference list of generic and actual codes so that you can easily refer back to this guide when needed.

Guidelines for Health Plan Auditors

☐ This guide has been reviewed and approved by CMS Region IX. Check with your health plan management before accepting any deviation from the exact text of the denial reasons. Denial reason modifications that omit essential information or make the reason text inappropriate for claim (post-service) denial notices should not be accepted.
Frequently Asked Questions (FAQs)

None. May be developed at a future time.
Provided Prior to the Audit

I. Universal Non-Contracted Paid Claims Report:
   - Member name
   - Member ID
   - Date of Service (mm/dd/yy)
   - Provider Name
   - Claim Number
   - Date Claim Received
   - Net Amount Paid (excluding interest)
   - Interest Amount Paid (as applicable)
   - Date Claim Paid (check date)
   - Date Interest Paid
   - Check Number
   - Clean/Unclean Claim Indicator (Clean = C, Unclean = UC)

II. Universal Contracted Paid Claims Report:
   - Member name
   - Member ID
   - Date of Service (mm/dd/yy)
   - Provider Name
   - Claim Number
   - Date Claim Received
   - Net Amount Paid (excluding interest)
   - Date Claim Paid (check date)
   - Check Number

III. Universal Denied Claims Report:
Attachment 20 – Medicare Universe Reporting Elements

IV. Universal Provider Payment Dispute Report:

- Member Name
- Member ID
- Date of Service (mm/dd/yy)
- Original Claim Number
- Date Original Claim Received
- Dispute Claim Number
- Date Dispute Received
- Provider Name
- Dispute Decision (uphold/overturn = U/O)
- Date Dispute Resolved (date of written determination)
- Amount Paid on Dispute, as applicable
- Date Dispute Paid (check/EOB date)
- Check Number (for dispute)

V. Universal Recovered Overpayment Report:

- Member Name
- Member ID
- Date of Service (mm/dd/yy)
- Original Claim Number
- Date Original Claim Paid
- Provider Name
- Provider Contract Status (Contract/Non-Contract = C/NC)
Attachment 20 – Medicare Universe Reporting Elements

- Date Recovery Notice Sent (letter date)
- Total Dollars Requested
- Date Overpayment Recovered (refund date or retraction date)
- Total Dollars Recovered

Provided at the On-Site Visit

I. Pended Claims Report:

- Member Name
- Member ID
- Date of Service (mm/dd/yy)
- Provider Name
- Provider Contract Status (Contract/Non-Contract = C/NC)
- Amount Billed
- Date Claim Received
- Claim Number
- Date Claim Pended
- Pend Reason (must separately identify requests for ER Notes, Medical Records and all other information; if coded, provide legend)

II. Open Inventory Report:

- Member Name
- Member ID
- Date of Service
- Provider Name
- Provider Contract Status (Contract/Non-Contract = C/NC)
- Amount Billed
- Date Claim Received
- Claim Number (if available)
- Claim Status (Open, Pend= O/PN)
- Lag
III. Universal Log of Redirected Claims:

- Date Received
- Provider Name
- Date of Service
- Member Identifier (Name and/or ID#)
- Date Redirected
- Where Redirected
- Lag
IEHP DualChoice Cal MediConnect Plan
(Medicare – Medicaid Plan)

WAIVER OF LIABILITY STATEMENT

__________________________________________________________________________
Enrollee Name                                      Medicare/HIC Number

__________________________________________________________________________
Provider                                          Dates of Service

I hereby waive any right to collect payment from the above-mentioned enrollee for the
aforementioned services for which payment has been denied by the above referenced health plan.
I understand that the signing of this waiver does not negate my right to request further appeal under
42 CFR 422.600.

__________________________________________________________________________
Signature                                           Date

Rev 07/2013
Inland Empire Health Plan (IEHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. IEHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

IEHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact IEHP Member Services at 1-877-273-4347 (TTY: 1-800-718-4347).

If you believe that IEHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Inland Empire Health Plan, Attn: Civil Rights Coordinator,
10801 Sixth Street, Suite 120, Rancho Cucamonga, CA 91730
Tel. 1-877-273-4347, (TTY: 1-800-718-4347), Fax: 1-909-890-5748,
Email: CivilRights@iehp.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201
DISCRIMINATION IS AGAINST THE LAW
LA DISCRIMINACIÓN ES UN ACTO CONTRA LA LEY

Inland Empire Health Plan (IEHP) cumple con las leyes Federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. IEHP no excluye a las personas ni las trata de forma diferente debido a su raza, color, nacionalidad, edad, discapacidad o sexo.

IEHP:
- Proporciona asistencia y servicios gratuitos a personas con discapacidad para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - Intérpretes de lenguaje de señas calificados
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios lingüísticos gratuitos a personas que prefieren comunicarse en un idioma diferente al inglés, como los siguientes servicios:
  - Intérpretes calificados
  - Información escrita en otros idiomas


Si considera que IEHP no le proporcionó estos servicios o lo discriminó de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja formal ante el Coordinador de Derechos Civiles:

Inland Empire Health Plan, Attn: Civil Rights Coordinator,
10801 Sixth Street, Suite 120, Rancho Cucamonga, CA 91730
Tel. 1-877-273-4347, (TTY: 1-800-718-4347), Fax: 1-909-890-5748,
Email: CivilRights@iehp.org

Puede presentar una queja formal en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, el Coordinador de Derechos Civiles está a su disposición para ayudarle.
DISCRIMINATION IS AGAINST THE LAW
LA DISCRIMINACIÓN ES UN ACTO CONTRA LA LEY

También puede presentar una queja de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los Estados Unidos de manera electrónica a través del Portal de Quejas de la Oficina de Derechos Civiles, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-877-273-4347(TTY: 1-800-718-4347).

Español (Spanish)

دَوْلَةً (ARABIC)

Հայերեն (ARMENIAN)
Մեկնարկող հեղափոխական ծառայություններ կարող են տրամադրվել թեև հայերենով. Անհրաժեշտության դեպքում կարող են կազմել՝ Հայաստանի 1-877-273-4347(TTY (հանրապետություն) 1-800-718-4347):

繁體中文 (CHINESE)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-273-4347 (TTY：1-800-718-4347)。

پیسراف (FAHERI)

हिंदी (HINDI)
ध्यान दे: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-877-273-4347(TTY: 1-800-718-4347) पर कॉल करें।
Hmoob (HMONG)

日本語 (JAPANESE)
注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。
1-877-273-4347（TTY:1-800-718-4347）まで、お電話にてご連絡ください。

ខ្មែរ (KHMER)
ប្រការ: ប្រឈមផ្លូវការភាសាចាក់ដៃ (Khmer) អាចផ្តល់ការជំនួយសម្រាប់អ្នកដែលប្រឈមផ្លូវការមិនឃើញ ឬទៅបានប្រឈមដែលផ្លូវការមិនឃើញ 1-877-273-4347 (TTY: 1-800-718-4347)។

한국어 (KOREAN)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

ລາວ (LAO)

ਪੰਜਾਬੀ (PUNJABI)
ਵਿਗਿਆਤ: ਪੰਜਾਬੀ ਦੇ ਭਾਸ਼ਾ ਦੇ ਸੇਵਕਾਂ ਦੀ ਸਹਾਇਤਾ ਕੋਡ ਵਿਚ ਮੁਫ਼ਤ ਹੁੰਦੀ ਹੈ। ਸੋਂ ਤੁਹਾਡੀ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਨੂੰ ਵਿਚ ਵੇਂਦੇ ਹੋਣ ਦੀ ਮੁਫ਼ਤ ਸੇਵਾ ਹੈ।

Русский (RUSSIAN)

TAGALOG (TAGALOG – FILIPINO)

ภาษาไทย (THAI)

Tiếng Việt (VIETNAMESE)
Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.” You can also see Chapter 9 of the Member Handbook for information about how to make an appeal.

Notice of Denial of Medical Coverage
<Replace Denial of Medical Coverage with Denial of Payment, if applicable>

Date: Member number:

Name:

<Insert other identifying information, as necessary (e.g., provider name, enrollee’s Medicaid number, service subject to notice, date of service).>

Your request was denied
We’ve <denied, stopped, reduced, suspended> the <payment of> medical services/items listed below requested by you or your doctor <provider>:

Why did we deny your request?
We <denied, stopped, reduced, suspended> the <payment of> medical services/items listed above because <Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage (Member Handbook) provisions to support decision>:

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision
You have the right to ask IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) to review our decision by asking us for a Level 1 Appeal (sometimes called an “internal appeal” or “plan appeal”). In special cases, you can also ask for an Independent Medical Review (IMR) without first appealing to our plan. You cannot ask for an IMR if you have already had a State Hearing on the same issue. If you get an IMR and you are not satisfied with the result, you can still ask for a State Hearing.
Ask IEHP DualChoice for a Level 1 Appeal within 60 calendar days of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled “How to ask for a Level 1 Appeal with IEHP DualChoice” for information on how to ask for a plan level appeal.

How to keep your services while we review your case: If we’re stopping or reducing a service, you can keep getting the service while your case is being reviewed. If you want the service to continue, you must ask for an appeal within 10 calendar days of the date of this notice or before the service is stopped or reduced, whichever is later.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-877-273-IEHP (4347), 8am-8pm (PST), 7 days a week, including holidays to learn how to name your representative. TTY users call 1-800-718-4347. Both you and the person you want to act for you must sign and date a statement saying this is what you want. You’ll need to mail or fax this statement to us. Keep a copy for your records.

There are 2 kinds of Level 1 appeals with IEHP DualChoice

Standard Appeal – We’ll give you a written decision on a standard appeal within 30 calendar days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. If your appeal is for payment of a service you’ve already received, we’ll give you a written decision within 60 calendar days.

Fast (Expedited) Appeal – We’ll give you a decision on a fast appeal as quickly as your condition requires, and always within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting for a decision on a standard appeal. We’ll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within 30 calendar days.

How to ask for a Level 1 Appeal with IEHP DualChoice

Step 1: You, your representative, or your provider must ask for an appeal within 60 calendar days of getting this notice.

Your request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Whether you want a standard or fast appeal (for a fast appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors’ letters (such as a doctor’s supporting statement if you request a fast appeal), or other information that explains why you need the item or service. Call your doctor if you need this information.
We recommend keeping a copy of everything you send us for your records.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

**Step 2:** Mail, fax, or deliver your appeal or call us.

**For a Standard Appeal:**

- **Mailing Address:** IEHP DualChoice
  
P.O. Box 1800
  
Rancho Cucamonga, CA 91729-1800

- **Phone:** 1-877-273-IEHP (4347)

- **TTY Users Call:** 1-800-718-4347

- **Fax:** 909-890-5748

If you ask for a standard appeal by phone, we will repeat your request back to you to be sure we have documented it correctly. We will also send you a letter confirming what you told us. The letter will tell you how to make any corrections.

<May be deleted if the notice is for a denial of payment:

For a Fast Appeal:

- **Phone:** 1-877-273-IEHP (4347)

- **TTY Users Call:** 1-800-718-4347

- **Fax:** 909-890-5748>

**What happens next?**

If you ask for a Level 1 Appeal and we continue to deny your request for a service, we’ll send you a written decision.

If the service was originally a Medicare service or a service covered by both Medicare and Medi-Cal, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

If the service was a Medi-Cal service, you can ask for an Independent Medical Review (IMR) or a State Hearing. Your written decision will give you instructions on how to request the next level of appeal. Information is also below.

**How to ask for an Independent Medical Review (IMR)**

You can ask for an Independent Medical Review (IMR) for Medi-Cal covered services and items from the California Department of Managed Health Care (Department). You can ask for an IMR if you disagree with IEHP DualChoice’s Level 1 Appeal decision or if IEHP DualChoice has not resolved your Level 1 Appeal after 30 days. In special cases, you can also ask for an Independent Medical Review (IMR) without first appealing to our plan.

In most cases, you must file a Level 1 Appeal with IEHP DualChoice before requesting an IMR; however, you may be able to have an IMR without appealing to IEHP DualChoice first if:

- Your problem is urgent and involves an immediate and serious threat to your health.
- IEHP DualChoice denied a Medi-Cal service or treatment because it is experimental or investigational.
You cannot ask for an IMR if you have already had a State Hearing on the same issue. If you get an IMR and you are not satisfied with the result, you can still ask for a State Hearing.

**How to ask for an IMR.** Fill out the online Independent Medical Review/Complaint Form available at https://www.dmhc.ca.gov/fileacomplaint/submitanindependentmedicalreviewcomplaintform.aspx or you can fill out the hard copy IMR application form that is included with this notice and send it to:

Help Center  
Department of Managed Health Care  
980 Ninth Street, Suite 500  
Sacramento, CA 95814-2725  
FAX: 916-255-5241

If you choose to do so, you may attach copies of letters or other documents about the service or item that was denied. If you do, send copies of documents, not originals. The Department Help Center may not be able to return all original documents.

You or your representative must ask for an IMR within 6 months after we send you a written decision. However, the Department may extend the 6-month deadline for good reasons such as you had a medical condition that prevented you from asking for the IMR within 6 months or you did not get adequate notice of the IMR process.

Call the **California Department of Managed Health Care (DMHC) toll-free at 1-888-466-2219** for free help. The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-877-273-IEHP (4347)** and use your health plan’s grievance process before contacting the Department. Using this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department’s Internet Web site [http://www.hmohelp.ca.gov](http://www.hmohelp.ca.gov) has complaint forms, IMR application forms, and instructions online.

**What happens next?**
If you qualify for an IMR, the DMHC will review your case and send you a letter within 7 calendar days telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within 30 calendar days. You should receive the IMR decision within 45 calendar days of the submission of the completed application.

If your case is urgent and you qualify for an IMR, the DMHC will review your case and send you a letter within 2 calendar days telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within 3 calendar days. You should receive the IMR decision within 7 calendar days of the submission of the completed application.

Doctors who are not part of IEHP DualChoice will review your case. The DMHC will send you a letter explaining the decision. If the IMR decision is in your favor, IEHP DualChoice must give you the service or treatment you asked for. If you do not agree with the decision, you can ask for a State Hearing as long as you have not had a State Hearing on the same issue.
If you do not qualify for an IMR, your issue will be reviewed through DMHC’s standard complaint process. You will receive a written notice of the decision within 30 days. If you decide not to use the IMR process, you may be giving up your rights under California law to pursue legal action against IEHP DualChoice about the service or treatment you are asking for.

**How to ask for a State Hearing**

If the service was a Medi-Cal covered service or item, you can ask for a State Hearing. You can only ask for a State Hearing after you have appealed to our health plan and received a written decision with which you disagree. Please note that if you have a State Hearing, you will not be able to ask for an Independent Medical Review (IMR).

**Step 1:** You or your representative must ask for a State Hearing within 120 days of the date of our notice to you that the adverse benefit determination (Level 1 appeal decision) has been upheld. Fill out the “Form to File a State Hearing” that will be provided with your appeal decision notice. Make sure you include all of the requested information.

**Step 2:** Send your completed form to:

California Department of Social Services  
State Hearings Division  
P.O. Box 944243, Mail Station 9-17-37  
Sacramento, CA 94244-2430  
FAX: 916-651-5210 or 916-651-2789

You can also request a State Hearing by calling 1-800-952-5253 (TDD: 1-800-952-8349). If you decide to make a request by phone, you should be aware that the phone lines are very busy.

**What happens next?**

The State will hold a hearing. You may attend the hearing in person or by phone. You’ll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You’ll get a written decision that will explain if you have additional appeal rights.

A copy of this notice has been sent to: **<insert name>**

**Get help & more information**

- Call **IEHP DualChoice** at 1-877-273-IEHP (4347), 8am–8pm (PST), 7 days a week, including holidays. TTY users call 1-800-718-4347. You can also visit our website at www.iehp.org.

- Call the California Department of Managed Health Care for free help in understanding your rights and information about the complaint and Independent Medical Review (IMR) process at 1-888-466-2219.

- Call the Health Consumer Alliance for free help with your health care at 1-888-804-3536.

- Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. They can talk with you about how to make an appeal and what to expect during the appeal process. The phone number is 1-855-501-3077.

- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

- Call the **Medicare Rights Center** at 1-888-HMO-9050.
- Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.

- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.

- You can also see **Chapter 9 of the Member Handbook** for information about how to make an appeal.

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IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

**ATTENTION:** If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-877-273-IEHP (4347), 8am–8pm (PST), 7 days a week, including holidays. TTY/TDD users should call 1-800-718-4347. The call is free.

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-877-273-IEHP (4347), 8am–8pm (PST), 7 days a week, including holidays. TTY/TDD users should call 1-800-718-4347. The call is free.
Importante: Este aviso explica su derecho a apelar nuestra decisión. Léalo detalladamente. Si necesita ayuda, puede llamar a uno de los números que aparecen en la última página en “Obtener ayuda y más información”. También puede consultar el Capítulo 9 del Manual para Miembros para obtener información sobre cómo presentar una apelación.

Aviso de Denegación de Cobertura Médica
<Replace Denegación de cobertura médica with Denegación de pago, if applicable>

Fecha: Número de Miembro:
Nombre:
<Insert other identifying information, as necessary (e.g., provider name, enrollee’s Medicaid number, service subject to notice, date of service)>

Su solicitud fue denegada
Hemos <denegado, interrumpido, reducido, suspendido> <el pago de> los servicios/artículos médicos que se enumeran a continuación y que usted o su doctor <proveedor> habían solicitado:

¿Por qué denegamos su solicitud?
Hemos <denegado, interrumpido, reducido, suspendido> <el pago de> los servicios/artículos médicos enumerados arriba porque <Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage (Member Handbook) provisions to support decision>:

Debe entregar o mostrar una copia de esta decisión a su doctor para que usted y su doctor puedan hablar de los próximos pasos. Si su doctor solicitó cobertura en su nombre, hemos enviado una copia de esta decisión a su doctor.

Usted tiene derecho a apelar nuestra decisión
Usted tiene derecho a pedir que IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) revise esta decisión, solicitándonos una Apelación de Nivel 1 (a veces llamada “apelación interna” o “apelación del plan”). En casos especiales, también puede solicitar una Revisión Médica Independiente (Independent Medical Review, IMR) sin apelar primero ante nuestro plan. Usted no puede solicitar una IMR si ya recurrió a una Audiencia Estatal (State Hearing) sobre el mismo asunto. Si obtiene una IMR, pero no está conforme con el resultado, todavía puede solicitar una Audiencia Estatal.
Solicite a IEHP DualChoice una Apelación de Nivel 1 dentro de los 60 días del calendario posteriores a la fecha de este aviso. Le podemos otorgar más tiempo si tiene un buen motivo para no cumplir el plazo. Consulte la sección titulada “Cómo solicitar una Apelación de Nivel 1 ante IEHP DualChoice” para saber cómo solicitar una apelación de nivel del plan.

Cómo conservar sus servicios mientras revisamos su caso: Si nuestra decisión es interrumpir o reducir un servicio, usted puede seguir obteniéndolo mientras se revisa su caso. Si desea continuar con el servicio, debe presentar una apelación dentro de los 10 días del calendario de la fecha de este aviso o antes de que se interrumpa o reduzca el servicio, lo que ocurra después. Su proveedor debe estar de acuerdo en que usted debería seguir recibiendo el servicio.

Si desea que otra persona actúe en su nombre

Usted puede designar a un pariente, amigo, abogado, doctor u otra persona para que actúe como su representante. Si desea que otra persona actúe en su nombre, lláménos al: 1-877-273-IEHP (4347), de 8am-8pm (Hora del Pacífico), los 7 días de la semana, incluidos los días festivos, para obtener información sobre cómo designar a su representante. Los usuarios de TTY deben llamar al 1-800-718-4347. Tanto usted como la persona que desea que actúe en su nombre deben firmar y fechar una declaración para confirmar que usted así lo desea. Usted deberá enviarnos esta declaración por correo o por fax. Consérve una copia para sus registros.

Existen 2 tipos de apelaciones de Nivel 1 para presentar ante IEHP DualChoice

Apelación estándar: Le comunicaremos una decisión por escrito sobre una apelación estándar dentro de los 30 días del calendario posteriores a haber recibido su apelación. Nuestra decisión podría llevar más tiempo si usted solicita una extensión o si nosotros necesitamos más información sobre su caso. Le informaremos si tomamos un tiempo adicional y le explicaremos por qué se necesita más tiempo. Si su apelación es por el pago de un servicio que ya recibió, le comunicaremos una decisión por escrito dentro de los 60 días del calendario posteriores.

Apelación rápida (acelerada): Le comunicaremos una decisión sobre una apelación acelerada con la rapidez que lo requiera su condición, y siempre dentro de las 72 horas posteriores a haber recibido su apelación. Puede solicitar una apelación rápida si usted o su doctor consideran que esperar a obtener una decisión sobre una apelación estándar podría dañar gravemente su salud.

Le otorgaremos automáticamente una apelación rápida si un doctor la solicita en su nombre o si su doctor respalda su solicitud. Si usted solicita una apelación rápida sin el respaldo de un doctor, nosotros decidiremos si su solicitud requiere una apelación rápida. Si no le otorgamos una apelación rápida, le comunicaremos una decisión dentro de los 30 días del calendario posteriores.

Cómo solicitar una Apelación de Nivel 1 ante IEHP DualChoice

Paso 1: Usted, su representante o su proveedor deben solicitar una apelación dentro de los 60 días del calendario posteriores a la recepción de este aviso.

Su solicitud <escrita> debe incluir:
• Su nombre
• Dirección
• Número de Miembro
• Motivos por los que apela
• <May be deleted if the notice is for a denial of payment: Si desea una apelación estándar o rápida (para una apelación rápida, explique por qué la necesita).>
• Cualquier evidencia (prueba) que desee que revisemos, como registros médicos, cartas de doctores <may be deleted if the notice is for a denial of payment: (como una declaración de respaldo de un doctor si usted solicita una apelación rápida)>, u otra información que explique por qué usted necesita el artículo o servicio. Llame a su doctor si necesita esta información.

Le recomendamos que conserve una copia de todo lo que nos envíe para sus registros.

Usted puede solicitar revisar los registros médicos y otros documentos que utilicemos para tomar nuestra decisión antes de o durante la apelación. También puede solicitar una copia de las pautas que usamos para tomar nuestra decisión, sin costo alguno para usted.

**Paso 2:** Presente su apelación personalmente o por correo, fax o teléfono.

**Para una apelación estándar:** Dirección postal: IEHP DualChoice
P.O. Box 1800
Rancho Cucamonga CA 91729-1800
Teléfono: 1-877-273-IEHP (4347)
Los usuarios de TTY deben llamar al: 1-800-718-4347
Fax: 909-890-5748

Si solicita una apelación estándar por teléfono, le repetiremos su solicitud para asegurarnos de que la ha documentado correctamente. También le enviaremos una carta para confirmar lo que nos informó. La carta le indicará cómo hacer correcciones.

<May be deleted if the notice is for a denial of payment:
**Para una apelación rápida:** Teléfono: 1-877-273-IEHP (4347)
Los usuarios de TTY deben llamar al: 1-800-718-4347
Fax: 909-890-5748>

**¿Qué sucederá después?**

Si solicita una Apelación de Nivel 1 y continuamos denegando su solicitud de <pago de> un servicio, le enviaremos una decisión por escrito.

Si originalmente el servicio era un servicio de Medicare o un servicio cubierto tanto por Medicare como por Medi-Cal, automáticamente enviaremos su caso a un revisor independiente. Si el revisor independiente deniega su solicitud, la decisión escrita le explicará si usted tiene derechos de apelación adicionales.

Si el servicio fue un servicio de Medi-Cal, usted puede solicitar una **Revisión Médica Independiente (Independent Medical Review, IMR)** o una **Audencia Estatal**. La decisión escrita le proporcionará instrucciones sobre cómo solicitar el siguiente nivel de apelación. A continuación, también se brinda esa información.

**Cómo solicitar una Revisión Médica Independiente (IMR)**
Usted puede solicitar una Revisión Médica Independiente (IMR) para servicios y artículos cubiertos por Medi-Cal de parte del Departamento de Administración de Servicios Médicos (Department of Managed Health Care, DMHC) de California (Departamento). Puede solicitar una IMR si no está de acuerdo con la decisión sobre la Apelación de Nivel 1 de IEHP DualChoice o si IEHP DualChoice no ha resuelto su Apelación de Nivel 1 después de 30 días. En casos especiales, también puede solicitar una Revisión Médica Independiente (IMR) sin apelar antes a nuestro plan.

En la mayoría de los casos, debe presentar una Apelación de Nivel 1 ante IEHP DualChoice antes de solicitar una IMR. Usted podría tener una IMR sin apelar ante IEHP DualChoice primero si:

- Su problema es urgente y representa una amenaza inmediata y seria para su salud.
- IEHP DualChoice denegó un servicio o tratamiento de Medi-Cal porque es experimental o de investigación.

No puede solicitar una IMR si ya recurrió a una Audiencia Estatal sobre el mismo asunto. Si obtiene una IMR, pero no está conforme con el resultado, todavía puede solicitar una Audiencia Estatal.

Cómo solicitar una IMR. Conteste el Formulario de Queja/Revisión Médica Independiente disponible en https://www.dmhc.ca.gov/fileacomplaint/submitanindependentmedicalreviewcomplaintform.aspx, o bien, puede responder la copia impresa del formulario de solicitud de IMR que se incluye junto con este aviso y enviarla a:

Help Center
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
FAX: 916-255-5241

Si decide enviar el formulario impreso, le sugerimos que adjunte copias de cartas u otros documentos sobre el servicio o artículo que se denegó. De ser así, envíe las copias de los documentos, no los originales. Es posible que el Centro de Ayuda del Departamento (Department Help Center) no pueda devolver todos los documentos originales.

Usted o su representante deben solicitar una IMR dentro de los 6 meses posteriores a que le enviemos una decisión por escrito. Sin embargo, es posible que el Departamento extienda el plazo de 6 meses si hay buenos motivos, como que usted tenga una condición médica que le impida solicitar la IMR dentro de 6 meses o que no haya recibido el aviso adecuado del proceso de IMR.

Llame al número gratuito del Departamento de Administración de Servicios Médicos (DMHC) de California al 1-888-466-2219 para obtener ayuda gratuita. El Departamento de Administración de Servicios Médicos es responsable de reglamentar los planes de servicios médicos. Si usted tiene una queja en contra de su plan de salud, debe llamar primero a su plan de salud al 1-877-273-IEHP (4347) y usar el proceso de quejas formales de su plan de salud antes de comunicarse con el Departamento. El uso de este proceso de quejas formales no prohíbe el ejercicio de ningún derecho o recurso legal potencial que pueda estar a su disposición. Si necesita ayuda con una queja formal relacionada con una emergencia, una queja formal que su plan de salud no haya resuelto satisfactoriamente o una queja que haya quedado sin resolver durante más de 30 días, puede llamar al Departamento de Administración de Servicios Médicos para solicitar asistencia. También podría ser elegible para una Revisión Médica Independiente (IMR). Si es elegible para una IMR, el proceso de IMR brindará una revisión imparcial de las decisiones médicas tomadas por un plan de salud en relación con la necesidad médica de un servicio o tratamiento propuesto, las decisiones de cobertura de tratamientos que son de naturaleza experimental o de investigación y las disputas por el pago de servicios médicos de emergencia o de urgencia. El Departamento
también tiene un número de teléfono gratuito (1-888-466-2219) y una línea TDD (1-877-688-9891) para las personas con dificultades auditivas y del habla. El sitio web del departamento http://www.hmohelp.ca.gov ofrece formularios de quejas, formularios de solicitud de IMR e instrucciones en línea.

¿Qué sucederá después?
Si usted califica para una IMR, el DMHC revisará su caso y le enviará una carta dentro de los siguientes 7 días del calendario para decirle que usted califica para una IMR. Una vez que su plan reciba su solicitud junto con los documentos de respaldo, se tomará la decisión de la IMR dentro de los 30 días del calendario posteriores. Usted deberá recibir la decisión de IMR dentro de los 45 días del calendario posteriores a que presente la solicitud completada.

Si su caso es urgente y usted no califica para una IMR, el DMHC revisará su caso y le enviará una carta dentro de los 2 días del calendario posteriores para decirle que usted califica para una IMR. Una vez que se reciba su solicitud junto con los documentos de respaldo, se tomará la decisión de la IMR dentro de los 3 días del calendario posteriores. Usted deberá recibir la decisión de IMR dentro de los 7 días del calendario posteriores a que presente la solicitud completada.

Los doctores que no forman parte de IEHP DualChoice revisarán su caso. El DMHC le enviará una carta para explicarle la decisión. Si la decisión de la IMR es a su favor, IEHP DualChoice debe darle el servicio o el tratamiento que usted solicitó. Si usted no está de acuerdo con la decisión, puede solicitar una Audiencia Estatal, siempre y cuando no haya recurrido ya una Audiencia Estatal sobre el mismo asunto.

Si usted no califica para una IMR, su asunto será revisado según el proceso de quejas estándar del DMHC. Recibirá un aviso escrito de la decisión en un plazo de 30 días. Si decide no usar el proceso de la IMR, podría estar renunciando a los derechos que le otorgan las leyes de California de entablar acciones legales contra IEHP DualChoice sobre el servicio o el tratamiento que está solicitando.

Cómo solicitar una Audiencia Estatal
Si el servicio fue un servicio o artículo cubierto por Medi-Cal, puede solicitar una Audiencia Estatal. Solamente puede solicitar una Audiencia Estatal después de haber apelado ante nuestro plan de salud y de haber recibido una decisión por escrito con la cual usted no está de acuerdo. Tenga en cuenta que, si recurrió a una Audiencia Estatal, no podrá solicitar una Revisión Médica Independiente (IMR).

**Paso 1:** Usted o su representante deben solicitar una Audiencia Estatal dentro de los **120 días** posteriores a la fecha en que le notifiquemos que la decisión de apelación de Nivel 1 ha sido confirmada. Conteste el “Formulario para presentar una Audiencia Estatal” que se incluye junto con este aviso. Asegúrese de incluir toda la información solicitada.

**Paso 2:** Envíe su formulario completado a:
California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430
FAX: 916-651-5210 o 916-651-2789
También puede solicitar una Audiencia Estatal al 1-800-952-5253 (TDD: 1-800-952-8349). Si decide realizar la solicitud por teléfono, debe saber que las líneas telefónicas están muy ocupadas.

¿Qué sucederá después?
El Estado llevará a cabo una audiencia. Usted puede presenciar la audiencia o escucharla por teléfono. Se le solicitará que le informe al Estado por qué no está de acuerdo con nuestra decisión. Puede pedirle a un amigo, familiar, defensor, proveedor o abogado que le ayude. Recibirá una decisión por escrito en la que se le explicará si tiene derechos de apelación adicionales.

Se ha enviado una copia de este aviso a: <insert name>

Recibir ayuda y más información

- Llame a IEHP DualChoice al 1-877-273-IEHP (4347), de 8am–8pm (Hora del Pacífico), los 7 días de la semana, incluidos los días festivos. Los usuarios de TTY deben llamar al 1-800-718-4347. También puede visitar nuestro sitio web en www.iehp.org.

- Llame al Departamento de Administración de Servicios Médicos para recibir ayuda gratuita para entender sus derechos y la información sobre el proceso de quejas y de Revisión Médica Independiente (IMR) al 1-888-466-2219.

- Llame a la Health Consumer Alliance para recibir ayuda gratuita con su atención médica al 1-888-804-3536.


- Llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048.

- Llame al Centro de Derechos de Medicare al 1-888-HMO-9050.


- Hable con su doctor u otro proveedor. Ellos pueden solicitar una decisión de cobertura o apelación en su nombre.

- También puede consultar el Capítulo 9 del Manual para Miembros para obtener información sobre cómo presentar una apelación.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) es un plan de salud que tiene contratos con Medicare y Medi-Cal para proporcionar los beneficios de ambos programas a los afiliados.

ATENCIÓN: Si usted habla un idioma diferente al español, tenemos disponible para usted el servicio de un intérprete de idiomas, libre de costo. Llame al 1-877-273-IEHP (4347), de 8am–8pm (Hora del Pacífico),
los 7 días de la semana, incluidos los días festivos. Los usuarios de TTY/TDD deben llamar al 1-800-718-4347. La llamada es gratuita.

Usted puede obtener este documento gratis en formatos alternativos, como impresión con letra grande, Braille o audio. Llame al 1-877-273-IEHP (4347), de 8am–8pm (Hora del Pacífico), los 7 días de la semana, incluidos los días festivos. Los usuarios de TTY/TDD deben llamar al 1-800-718-4347. La llamada es gratuita.
Attachment 20 – Required Medicare Audit Documentation Checklist

REQUIRED MEDICARE AUDIT DOCUMENTATION CHECKLIST:

Miscellaneous Items

☐ Pre-Audit Questionnaire

Paid & Denied (Favorable & Unfavorable)

☐ Claim and attachments, including claim image for electronic claims
☐ Eligibility as applicable (must be included for eligibility denials)
☐ Proof of date entered into the system, such as print screen from claim system showing create date
☐ Proof of date of receipt on electronic claims
☐ EOB/RA (if codes used, must include legend/explanation)
☐ Proof of date paid (e.g., screen prints showing day check was mailed or other screen prints that document date paid)
☐ Copy of canceled check or bank statement
☐ Copy of fee schedule applied from the contract (including effective date)
☐ Documentation of interest calculation as applicable
☐ Information Request Letter, as applicable or any other documentation of requests for additional information (e.g. phone calls)
☐ If new information is used as basis for date of receipt for calculating interest, documentation regarding the new information, including original
request and proof of date of receipt of the new information and copy of the information (i.e. medical records) received

☐ For duplicate denials, a copy of the original claim EOB/RA

☐ Denial letter to member or provider or both as applicable

☐ Evidence of Medical Review as applicable (must include for UM denials or downcodes) and medical review notes related to disposition of claim

☐ Authorization as applicable (must include for claims downcoded based on authorized services)

☐ Explanation of reason for denial and documentation supporting the determination, such as clinical information, or assumptions made by system edits

☐ If denied because service was bundled, provide documentation of payment of the initial claim

☐ If denied because the claim did not meet definition of emergency or urgent care, claims history identifying all claims associated with each episode of care, including whether they were paid or denied

☐ All claim notes

☐ Full claims history including post payment adjustments with copy of claims and EOB/RAs, claim notes and customer service call log, if applicable

☐ Any other documentation pertinent to specific claim(s)

☐ Key for interpreting claims processing/payment screens and any other system screens included in the file

Provider Payment Disputes

☐ Dispute with legible date of receipt and attachments
Resolution Letter

Information Request letter as applicable

EOB/RA for dispute payment as applicable

Copy of canceled check or bank statement for dispute

Copy of original claim (include attachments if pertinent to dispute) with legible date of receipt; if an electronic claim, proof of date of receipt

Copy of EOB/RA or denial letter for original claim

All dispute/claim notes (i.e. reason for uphold)

All claims history pertaining to claim or dispute, including post payment adjustments

Any other documentation pertinent to dispute and resolution

Overpayment refund request letter and supporting documentation

Copy of original claim and EOB/RA for which the refund was requested

If refunded - copy of refunded check if available and/or system notes indicating date processed and amount

If retracted - copy of contractual language or other documentation and

The following items must be available at the time of the on-site visit:

system notes indicating date retraction processed and amount

Other notes as applicable
Attachment 20 – Required Medicare Audit Documentation Checklist

☐ Pended Claims Report

☐ Open Inventory Report

☐ Report Log of Redirected Claims

☐ Copy of signed check mailing/check attestation log, with check number, check date, check amount and date mailed

☐ Copy of current operational and summary level claims policies and procedures and workflows pertaining to Medicare line of business

☐ Copy of 10 selected Medicare contracts

I have acknowledged that I have verified all the required documentation noted above is herein attached to the submitted claims.

_______________________________ ____________________________
Signature     Date:

_______________________________
Title
<table>
<thead>
<tr>
<th>FIELD</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-28</td>
<td><strong>CONDITION CODES</strong> - 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><strong>OCCURRENCE CODE AND DATES</strong> - 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>
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<td><strong>OCCURRENCE SPAN</strong> - 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>
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<td><strong>VALUE CODES AND AMOUNTS</strong> 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>
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<td>43</td>
<td><strong>DESCRIPTION</strong> 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>
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<td>44</td>
<td><strong>HCPCS/RATE/HIPPS CODE</strong> - 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>
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<td><strong>NON-COVERED CHARGES</strong> - 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>
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<td>51</td>
<td><strong>HEALTH PLAN ID</strong> - This field is required if applicable. This is the alphanumeric identifier used by the health plan to identify itself.</td>
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<td>54</td>
<td><strong>PRIOR PAYMENTS</strong> - This field is required if applicable. This field should reflect any payment from the health plan for this bill.</td>
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<td><strong>EST. AMOUNT DUE</strong> This field should reflect the estimate how much is due from the payer (estimate less prior payments).</td>
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<tr>
<td>57</td>
<td><strong>OTHER / PRV ID</strong> 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><strong>GROUP NAME/ INSURANCE GROUP NUMBER</strong> 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>
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<td><strong>TREATMENT AUTHORIZATION CODES</strong> An indicator that designates the treatment indicated on this bill has been authorized by the payer.</td>
</tr>
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<td><strong>EMPLOYER NAME</strong> - The name of the insured’s employer.</td>
</tr>
<tr>
<td>67</td>
<td><strong>OTHER DIAGNOSIS CODE</strong> - This field is required when applicable Other conditions that coexist or develop during the patient’s treatment.</td>
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<td><strong>PATIENT REASON DX</strong> - 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>
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<td><strong>PPS CODE</strong> - This field is required when applicable. Fill in the Prospective Payment System code for the applicable claim type.</td>
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<td><strong>ECI</strong> - 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>
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<td><strong>REMARKS</strong> - 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>
Attachment 20 - UB04 Outpatient Form

### OUTPATIENT

<table>
<thead>
<tr>
<th><strong>Page Dimensions:</strong> 612.0x792.0</th>
<th><strong>Statement Covers Period:</strong> From</th>
<th>Through</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>8 Patient Name:</strong></th>
<th><strong>9 Patient Address:</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>10 Birthdate</strong></th>
<th><strong>11 Sex</strong></th>
<th><strong>12 Date:</strong></th>
<th><strong>13 HR:</strong></th>
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</table>

<table>
<thead>
<tr>
<th><strong>14 Type</strong></th>
<th><strong>15 Src:</strong></th>
<th><strong>16 Div:</strong></th>
<th><strong>17 Sta:</strong></th>
<th><strong>18 Cond Code:</strong></th>
<th><strong>19 Occurrence Code:</strong></th>
<th><strong>20 Occurrence Date:</strong></th>
<th><strong>21 Occurrence Code:</strong></th>
<th><strong>22 Occurrence Date:</strong></th>
<th><strong>23 Occurrence Code:</strong></th>
<th><strong>24 Occurrence Date:</strong></th>
<th><strong>25 Occurrence Code:</strong></th>
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<th><strong>27 Occurrence Code:</strong></th>
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<th><strong>29 Occurrence Code:</strong></th>
<th><strong>30 Occurrence Date:</strong></th>
</tr>
</thead>
</table>

| **31 Occurrence Code:** | **32 Occurrence Date:** | **33 Occurrence Code:** | **34 Occurrence Date:** | **35 Occurrence Code:** | **36 Occurrence Date:** | **37 Occurrence Code:** | **38 Occurrence Date:** | **39 Occurrence Code:** | **40 Occurrence Date:** | **41 Occurrence Code:** | **42 Occurrence Date:** | **43 Occurrence Code:** | **44 Occurrence Date:** | **45 Occurrence Code:** | **46 Occurrence Date:** | **47 Occurrence Code:** | **48 Occurrence Date:** | **49 Occurrence Code:** | **50 Occurrence Date:** |
|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|

<table>
<thead>
<tr>
<th><strong>51 Health Plan Id:</strong></th>
<th><strong>52 Payer Info:</strong></th>
<th><strong>53 Plan Beneficiary:</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>54 Prior Payments:</strong></th>
<th><strong>55 Est. Amount Due:</strong></th>
<th><strong>56 Npi:</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>57 Other Prv Id:</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>58 Insured’s Name:</strong></th>
<th><strong>59 Pref:</strong></th>
<th><strong>60 Insured’s Unique Id:</strong></th>
<th><strong>61 Group Name:</strong></th>
<th><strong>62 Insurance Group No.:</strong></th>
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<table>
<thead>
<tr>
<th><strong>63 Treatment Authorization Codes:</strong></th>
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</thead>
</table>

<table>
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<tr>
<th><strong>64 Document Control Number:</strong></th>
<th><strong>65 Employer Name:</strong></th>
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</thead>
</table>

<table>
<thead>
<tr>
<th><strong>66 Attending Npi:</strong></th>
<th><strong>67 First Last:</strong></th>
<th><strong>68 Reason:</strong></th>
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</table>

<table>
<thead>
<tr>
<th><strong>69 Other Npi:</strong></th>
<th><strong>70 First Last:</strong></th>
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<table>
<thead>
<tr>
<th><strong>71 Other Npi:</strong></th>
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<tr>
<th><strong>73 Eoc:</strong></th>
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<tr>
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<th><strong>75 Procedure Date:</strong></th>
<th><strong>76 Attending Npi:</strong></th>
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### REQUIRED

### SITUATIONAL

### NOT REQUIRED
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<tbody>
<tr>
<td>12</td>
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<td>ADMISSION HR - This field is required if applicable. Enter the hour during which the patient was admitted for inpatient or outpatient care. This field is required if applicable.</td>
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<td>16</td>
<td>DHR - This field is required if applicable. DHR refers to the code indicating the discharge hour of the patient from inpatient care. This field is required if applicable.</td>
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