20. CLAIMS PROCESSING

A. Claims Processing

APPLIES TO:

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

POLICY:

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

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

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

D. Misdirected claims must be forwarded to the appropriate financially responsible Payer within 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.[3] Calendar day timeframes include all Holidays and weekends. Payment to contracted Providers should be made in accordance with the provisions outlined in their contract with the payer.

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

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

PROCEDURES:

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

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

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

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

C. Delegates are allowed up to three hundred sixty-five (365) days from the date of service or date of discharge to submit a new or corrected claim.[5]

1. Claims received after three hundred sixty-five (365) days from the date of service or date of discharge are not deemed payable.[6]

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

D. Payers must redirect claims that are not their financial responsibility to the appropriate responsible party within 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,[7] the claim should be prepared in accordance with The National Uniform Billing Committee and The National Uniform Claim Committee standards and should include,[8] but is not limited to the following information:

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

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

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

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

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

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

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

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

f. Valid date(s) of service;

g. Amount billed;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   NCCI edits consist of two (2) types:

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

   b. Medically Unlikely Edits (MUE), which are units of service edits, that define for each HCPCS/CPT code identified, the allowable number of units of service; units of service in excess of this value are not feasible for the procedure under normal conditions (e.g., claims for excision of more than one gallbladder or more than one appendix).

2. Physicians are paid using the lesser of the billed charges, or the Medicare Physician Fee Schedule (MPFS)
3. Acute Care hospitals are paid a DRG amount using the Medicare prospective payment system (PPS) in all States except Maryland per CMS guidelines.
   a. When IEHP coverage begins during an inpatient hospital stay:
      1) The member's previous Medicare Fee for Service or Medicare Advantage health plan will continue to pay for inpatient hospital services until the discharge date. IEHP is not responsible for inpatient hospital services until after the Member's discharge.
      2) IEHP is responsible for non-hospital charges incurred during an inpatient stay beginning on the date the Member is eligible with IEHP.
   b. When IEHP coverage ends during an inpatient hospital stay and the Member becomes eligible under another Medicare Fee for Service or Medicare Advantage health plan:
      1) IEHP is responsible to pay for inpatient hospital services until the discharge date.

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

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

4. Skilled Nursing Facilities (SNF), Home Health, Outpatient Hospital Services, Long Term Acute Care Hospital, Acute Psychiatric and Acute Rehab Facility claims are paid at PPS methodology.
5. End Stage Renal Disease Facilities are paid, for certain routine services, an amount called a composite rate. Composite rates are geographically adjusted to patient specific parameters.
6. Ambulance Services are paid based on the ambulance fee schedule.
7. Ambulatory Surgery Centers 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 claims are generally based on the lab fee schedule.
9. Part B Drugs are mostly included in PPS reimbursement methodology or on cost but are based on a percentage of the Average Sales Price (ASP) methodology. If no ASP rate is available a specific procedure code, the Wholesale Acquisition Cost + 5% will be used.
10. Critical Access Hospitals (CAH) - Payment determination is based upon the billing hospital to submitting a copy of their most recent interim rate letter from their Medicare Fiscal Intermediary (FI).
11. Federally Qualified Health Centers (FQHC) - FQHCs are paid an all-inclusive rate (AIR) for primary health services and qualified preventive health services. Beginning on or after October 1, 2014, FQHCs will transition to the FQHC prospective payment system (PPS) as required by Section 10501(i)(3)(B) of the Affordable Care Act.[18]
12. Rural Health Clinic (RHC) - RHC's are paid the lesser of the provider specific AIR or a national per-visit limit. The AIR is determined for each center based on historical costs.
13. For services provided on or after January 1, 2018, IEHP shall reimburse Indian Health Facilities (IHF) who provide Covered Services to Indian Enrollees, who are eligible to receive services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Facilities, and IEHP shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Facilities.[19]
14. For Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, the required payment is the difference between the "Outpatient Per Visit Rate (Excluding Medicare)" listed in the Federal Register and 80 percent of the Medicare FQHC PPS rate.[20]

[18] Coordinated Care Initiative (CCI) Three-Way Contract, Section - 2.10
[19] Ibid.
[20] 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.[21]

J. 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.[22]

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.

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

1. Any claim that is denied must include an accurate and clear written explanation of the actions taken. Both the Provider of Service and Member must be notified of the denial.
2. All denial notifications and the Remittance Advice or Explanation of Benefits, to the Provider of Service must include mandated language and be properly formatted in accordance with Medicare specifications, See Attachments, "Notice of Denial of Payment – English" and "Notice of Denial of Payment – Spanish" in Section 20. Accompanied with the Notice of Denial of Payment is a Non-Discrimination Tagline (See 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, SeePolicy 20A1, "Claims Processing - Claims Appeals – Denied Claims. For non-contracted provider payment disputes, the standard payment dispute process, See Policy 20A2, "Claims Processing – Provider Payment Dispute Resolution"; and

[21] Assisted Suicide Funding Restriction Act of 1997
[22] 42 CFR § 422.520

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

3. The denial notification must incorporate appropriate denial reason language (see Attachment "ICE – Claim Denial Reason Guide –IEHP DualChoice in Section 20).

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

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023

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 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 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 IPA's responsibility (payment or denial) made on a claim by the 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

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
7. The Member lacked the capacity to understand the timeframe 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 health insurance claim number and Member identification number.

2. Specific service(s) and/or item(s) for which reconsideration is being requested including the date(s) of service.
3. The name and signature of the party or the representative of the party filing the appeal.
4. A clear explanation of why the appealing party disagrees with Payer's initial determination and expected outcome.
5. 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 if 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 was sent to CMS' IRE for review and resolution in accordance with Medicare requirements
    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 Review Entity (IRE) for review in accordance with Medicare requirements, within sixty

(60) calendar days after receiving the request for reconsideration.

3. Failure to respond to the request for a waiver of liability and/or submit a written request for an extension of the submission timeframe for good cause will result in a dismissal of the appeal. A dismissal letter (See Attachment, "Notice of Dismissal of Appeal Request" in Section 20) will be sent to the Provider of Service following 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 the appeal and determination and supporting documentation will be immediately forwarded 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.

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.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2012
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023

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 Members.

POLICY:

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

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

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

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

DEFINITION:

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

PROCEDURES:

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

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

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

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

3. Grievances and appeals are separate and distinct. If the documentation submitted is considered to be a grievance, Payors must resolve it in accordance with their grievance policies and procedures as outlined in Policy 16C1, "Grievance and Appeal Resolution Process for Providers - Initial" or 16A, "Member Grievance Resolution Process."

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 then the Payor makes a favorable good cause determination and issues a redetermination.

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

D. Payors may accept a PDR request filed after 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 PDRs involving IEHP as the Payor, disputes must be sent to:

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

2. Written payment disputes to the Payor must include:

a. IEHP DualChoice health insurance claim number and Member identification number.

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

c. The name and signature of the party or the representative of the party filing the dispute.

d. A clear explanation of why the party disagrees with Payor's initial determination and should include any supporting documentation the appealing party wants to be considered with the dispute.

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

F. Payors must send written notice of the resolution, including pertinent facts and an explanation of the reason for the determination, within 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

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 16C1, "Grievance and Appeal Resolution Process for Providers – Initial"

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

L. Copies of all PDRs and related documentation must be retained for at least 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 PDRs received in accordance with Policy 20F, "Claims and Payment Appeal Reporting."

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2012
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023

20. CLAIMS PROCESSING

B. Billing of IEHP Members

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

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

DEFINITION:

A. Balance Billing - The practice of billing Members for any charges related to covered services that are not reimbursed by Medicare or Medi-Cal. Balance billing is prohibited by state and federal law.[1]

B. Provider - Any individual or entity who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State.[2]

PROCEDURES:

A. When IEHP is notified by a Member or their representative, stating they are being billed, IEHP obtains all pertinent information to determine financial responsibility for the services rendered.

   1. If it is determined that the services are the responsibility of the Member, the Member is advised accordingly.
   2. If the Member's IPA is determined to be financially responsible, IEHP will contact the billing Provider on the Member's behalf and advise to bill the IPA. IEHP instructs the billing Provider in writing to cease and desist from billing the Member for covered services (See Attachment, "Cease and Desist Letter" in Section 20). Please see Policy 20C, "Claims Deduction from Capitation – 7-Day Letter" for information on IEHP's process for ensuring claims payment by the IPA.
   3. If IEHP is determined to be financially responsible, IEHP instructs the billing Provider in writing to cease and desist from billing the Member for covered services (See Attachment, "Cease and Desist Letter" in Section 20).

B. A Member has the right to file a grievance at any time following any incident or action that is the subject of Member dissatisfaction, including those pertaining to inappropriate billing, in accordance with Policy 16A, "Member Grievance Resolution Process."

[1] Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 16-002 Supersedes 15-003, "Continuity of Care"
[2] Title 42 Code of Federal Regulations (CFR) § 422.2

C. If the services provided are deemed medically necessary and the Member was sent to collections, IEHP reserves the right to pay the Provider and reduce the responsible Provider's next monthly capitation check, as applicable.

D. IEHP will take disciplinary action against Providers that continue to inappropriately bill Members after being educated on IEHP's policy against billing Members or sends the Member's account to a collections agency. This may include but not be limited to Provider education, issuing a Corrective Action Plan, reporting to regulatory agencies, up to and including termination of contract.

E. Contracted and non-contracted providers who continue to inappropriately bill Members are reported to IEHP's Compliance Special Investigation Unit (SIU) for further investigation and may be reported to the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS), as deemed appropriate.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023

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

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

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

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
    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. IEHP sends a secure email 7-Day letter (See Attachment, "Demand for Payment Letter" in Section 20). The 7-Day letter requests information on the status of the claim, which must be completed by the Provider and returned to IEHP within seven (7) days from the sent date.

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

G. 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).

H. If Payor fails to respond to an IEHP inquiry, a demand letter will be issued requiring proof of payment within the timeline outlined in (See Attachment, "Notice of Cap Deduction" in Section 20)."

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2012
Chief Title: Chief Operating Officer	**Revision Date:**	January1, 2023

20. CLAIMS PROCESSING

D. Claims and Compliance Audits

APPLIES TO:

A. This policy applies to all Delegates who provide services to IEHP DualChoice Members.

POLICY:

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

B. IEHP audits all Delegates annually or as necessary.

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

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

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

DEFINITION:

A. Delegate – For the purpose of this policy, this is defined as an organization authorized to perform certain functions on IEHP's behalf.

***PROCEDURES*:**

A. IEHP provides comprehensive oversight of Delegate's responsibilities to process claims and resolve disputes in accordance with contractual and regulatory requirements. IEHP performs this oversight through routine audits and review of monthly Delegates' and quarterly reporting to IEHP.

B. Audits ensure:

1. Delegates are paying and denying claims and resolving Provider payment disputes in accordance with regulatory and contractual requirements.
2. Delegates have adequate system protocols in place to log, track, acknowledge, monitor and appropriately adjudicate or resolve all claims and disputes received and that these systems are operating as designed and do not result in unfair payment patterns.
3. Delegates' claims processing systems are adequate to meet the terms of the IEHP contract

as well as regulatory requirements.

4. Delegates' policies and procedures are adequate to meet regulatory and contractual requirements and that such policies and procedures reflect actual operations.
5. Delegates' contracts with subcontracted Delegates include mandatory language pertaining to claims processing, appeals and other requirements outlined in state and federal regulations.

C. IEHP monitors the performance of Delegates in between audits through monthly and quarterly reporting. Review of reports enables IEHP to assess compliance with regulatory and contractual requirements, as well as to perform comparative analysis and trending for possible indicators of potential or emerging patterns of unfair payment practices or inability to perform delegated functions.

D. Delegates must submit the following monthly and quarterly reports to IEHP within the specified timeframes, in a format designated by IEHP.

1. By the 15th of each month, Delegates must submit to IEHP the Monthly Timeliness Report (MTR) for the previous month's activity. The MTR contains information regarding claims processing timeliness and is outlined in Policy 20F, "Claims and Payment Appeal Reporting".
2. By the 15th of each month Delegates must submit to IEHP a Payment Organization Determinations and Reconsiderations report for the previous month's activity, as outlined in Policy 20F, "Claims and Payment Appeal Reporting."
3. By the 30th of the month following the end of the quarter, for the previous quarter, Delegates must submit to IEHP the Quarterly Provider Payment Dispute Resolution Report. The report contains information regarding disputes and adjustments and is as outlined in Policy 20F, "Claims and Payment Appeal Reporting."
4. IEHP reserves the right to request additional reports as deemed necessary.
5. Failure to submit required reports that include all required information in a complete and accurate manner in IEHP's required format, within the indicated timeframes, may result in the Delegate being subjected to a focused audit and negatively impact the Delegate's contract renewal terms.

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

1. Failure to meet IEHP Financial Viability Standards.
2. Non-compliance with monthly and quarterly self-reporting requirements to IEHP or discovery during an audit or through other means.
3. Excessive claims appeals that are overturned by IEHP.

4. Excessive number of insufficient or inappropriate responses to 7-day letters that result in payment by IEHP to the Provider of Service that is deducted from capitation.
5. Excessive claims grievances and appeals, Provider inquiries or other information received by IEHP from subcontracted entities or other outside sources.
6. Failure to submit accurate and completed reports to IEHP within specified timeframes.
7. Failure to meet claims payment standards and other indicators and measures based on IEHP review of periodic reports and other internally and externally available information.
8. Identification of potential or emerging unfair payment patterns or other indicators of payment practices that possibly pose undue risk to IEHP and/or its Members or Providers based on claims inquiries, grievances and appeals, IEHP review of periodic reports, contracts or other internally or externally available information.
9. Change in claims processing system.
10. Change in management oversight, including Management Services Organization (MSO).

F. IEHP notifies the Delegate in writing at least six (6) weeks in advance of the scheduled audit. The notice is explicit in the timeframe being audited, the request for documents and access to Delegate staff. For Focused Audits, IEHP reserves the right to give a minimum of three (3) working days prior notice.

1. Routine Audits may include a Webinar Audit and an on-site review.
2. Webinar Audit: Approximately two (2) weeks prior to the scheduled audit, Delegates must submit a Payment Organization Determinations and Reconsiderations report covering the audit period, to IEHP for review and selection of claims.

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

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

H. IEHP selects claims to audit based upon a focused, targeted approach. The number of claims selected varies depending on the type and scope of the audit and generally covers a three (3) month period.

1. For routine annual audits the type of claims selected is as follows:

a. Paid Non-Contracted Provider Clean Claims

b. Paid Non-Contracted Provider Unclean Claims

c. Denied Non-Contracted Provider Claims

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

3. IEHP performs the claims review noted above via Webinar and is scheduled for two (2) days. IEHP may also schedule a one (1) day on-site visit.

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

5. IEHP may also randomly select Provider contracts for review.

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

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

I. One (1) week before the scheduled first day of the claims audit, a Universe Integrity Audit (UIA) is performed. The UIA is conducted for all claim universes submitted to ensure that data elements generated from the Delegate's claims processing system and/or other systems in the universe are accurate. The sample selection is based on a focused, targeted approach and cases that are outliers with potential risk of data element errors are selected. Generally, five (5) cases are selected from each universe to validate against the Delegate's system and documentation to ensure the information is consistent and accurate. Delegates must successfully pass three (3) of the five (5) cases selected from each universe. Three failed universe resubmissions will result in an audit finding.

J. The claims audit consists of a review of three (3) areas: timeliness, appropriateness and systems. Within each area claims are reviewed to determine compliance with contractual and regulatory standards pertaining to the processing of claims or Provider payment disputes.

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

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

M. IEHP determines the significance of audit findings based on results of the claims review and impact analysis, if applicable. Audit findings can result in an Corrective Action Required or Observation as described below:

1. Corrective Action Required (CAR) – A CAR is the result of a systemic deficiency

identified during an audit that must be corrected. These issues may affect beneficiaries but are not of a nature that immediately affects their health and safety. Generally, they involve deficiencies with respect to non-existent or inadequate policies and procedures, systems, internal controls, training, operations or staffing.

2. Observations (OBS) – Observations are identified conditions of non-compliance that are not systemic or represent a "one-off issue". A "one-off issue" may be an issue dealing with one employee or a singular case.

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

N. Within thirty (30) days of the last day of the audit, IEHP sends a preliminary audit report to the Delegate documenting the outcome of the audit, findings and recommended corrective actions. Delegates have one (1) week to review the preliminary report and notify IEHP if the Delegate disagrees with any of the findings listed in the report through the formal rebuttal process.

O. Within two (2) weeks of receipt of the Delegate's rebuttal to the preliminary report, IEHP sends a Final Findings Report and Corrective Action Plan Request (CAPR).

P. The CAPR lists IEHP's findings with respect to deficiencies, along with specific recommendations to bring the Delegate into regulatory and contractual compliance. Delegates are required to respond in writing to the CAPR by submitting a CAP within the timeframe specified by IEHP, generally thirty (30) days from the date of the Final Findings Report. The CAP should explain in detail how the Delegate has modified (or will modify) its claims processing system to address the findings of the CAPR. If the CAP necessitates changes to the Delegate's written policies and procedures or workflow charts, copies of this information must be submitted along with the CAP.

Q. IEHP evaluates and issues a letter of acceptance or rejection of the submitted CAP within two (2) weeks of receipt.

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

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

3. The Delegate 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 accepted, an acceptance letter is issued.

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

R. Failure to provide an adequate CAP within the required timeframe is deemed as a contractual breach and may result in the Delegate being sanctioned and subjected up to a 2% reduction of their monthly capitation payment until such time as an acceptable CAP is received. An

untimely or inadequate CAP may also impact the Delegate's contract renewal terms.

S. CAP verification audits are performed to verify the implementation of corrective actions required as a result of receiving a Corrective Action Required (CAR) in the previous audit.

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

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

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

T. Delegates who do not receive a CAR in 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.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2012
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023

20. CLAIMS PROCESSING

E. Coordination of Benefits

APPLIES TO:

A. This policy applies to all IEHP DualChoice 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 its Delegates are responsible for identifying Payers that are primary to IEHP and must coordinate benefits for Members in accordance with state and federal law.

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

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

PROCEDURES:

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

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

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

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

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

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

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

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

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

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2012
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023

20. CLAIMS PROCESSING

F. Claims and Payment Appeal Reporting

APPLIES TO:

A. This policy applies to all Delegates who provide services to IEHP DualChoice Members.

POLICY:

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

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

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

DEFINITION:

A. Delegate – For the purpose of this policy, this is defined as an organization authorized to perform certain functions on IEHP's behalf.

PROCEDURES:

A. Delegate's claims processing systems must be able to identify, track and report all claims and Provider payment disputes and produce the following reports:

1. Received Claims – all claims received for a specified period regardless of status.
2. Paid Claims – all claims paid for services rendered to Members.
3. Denied Claims – all claims denied for services rendered to Members. (Note: IEHP considers denied claims to be all claims adjudicated whether denied in part or whole. This includes all claims denied for non-contracted and contracted Providers, as well as those in which the Member may be liable).
4. Pended – claims pended for development or in which a determination to pay or deny cannot be made without further information. Examples include claims forwarded for medical review or when additional information has been requested from external sources (i.e., Provider of Service, Member, etc.) in order to finalize the claim.
5. Claims Inventory – all claims received and open that have not been issued a payment or denial, whether or not entered in the claims system.
6. Claims Overpayments – all claims in which an overpayment has been identified and requests for reimbursement have been sent to the rendering Provider.

7. Claims Adjustments – all claims in which an adjustment has been made due to internal discovery, disputes or appeals, inquiries, retroactive contract or rate adjustments, etc.
8. Claims Aging – all claims by age of claim, regardless of status based on receipt date of the claim.
9. Provider Payment Disputes – all disputes received where the Provider is disputing an underpayment or down coded service.
10. Interest Paid – any claim in which interest was paid, including late paying claims, disputes or adjustments.
11. Redirected Claims – all misdirected claims forwarded to another Payer or denied to the Provider of Service, whether or not entered in the claims system.
12. Emergency Services Claims – all claims received involving emergency services, regardless of outcome.
13. Denied Claims by Type/Volume – number of claims denied by type (reason).
14. Paid Claims by Date/Volume – number of claims paid by check run date.
15. Pended Claims by Type/Volume – number of claims pended by type (reason).
16. Check Mailing/Attestation – an accounting of all checks mailed per check run whether scheduled or not.

B. IEHP requires Delegates to submit monthly and quarterly reports to self-report compliance with contractual and regulatory standards pertaining to claims and dispute processing. Each report must be submitted in IEHP's required format, using IEHP provided templates and/or designated format.

C. By the 15th of each month, Delegates must submit to IEHP the Monthly Claims Timeliness Summary Report (MTR) for the previous month's activity. Each report must be reviewed and include a signed attestation as to the accuracy and validity of the report by the appropriate management staff.

D. Delegates must also submit to IEHP by the 15th of each month a Payment Organization Determinations and Reconsiderations report for the previous month's activity, (See Attachments, "Part C Organization Determinations, Appeals, and Grievances (ODAG) Program Audit Protocol and Data Request" and "Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C) " in Section 20).

E. On a quarterly basis, Delegates must submit a Quarterly Provider Payment Dispute Resolution Report. The report is due to IEHP by the 30th of the month following the end of the quarter (i.e., the quarterly report for the period 10/1/22 through 12/31/22 would be due on January 30, 2023).

F. As outlined in Policy 20D, "Claims and Compliance Audits", Delegates must also generate a universal report of paid and denied claims at the time of each annual audit, for claims selection and/or review, (See Attachments, "Part C Organization Determinations, Appeals, and

Grievances (ODAG) Program Audit Protocol and Data Request " and, "Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C)" in Section 20).

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

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

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2012
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023

20. CLAIMS PROCESSING

G. Third-Party Liability

APPLIES TO:

A. This policy applies to all IEHP DualChoice Delegates.

POLICY:

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

PROCEDURES:

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

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

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

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2012
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023

20. CLAIMS PROCESSING

Attachments

DESCRIPTION	POLICY CROSS REFERENCE
CMS 1500 Form	20C20A
ICE - Claim Denial Reason Guide – IEHP DualChoice	
Medicare Waiver of Liability Statement	20A1
Non-Discrimination Tagline	20A,
Notice of Denial of Payment – English	20A
Notice of Denial of Payment - Spanish	20A20C
UB04 Inpatient Form	
UB04 Outpatient Form	20C
Part C Organization Determinations, Appeals, and Grievances (ODAG)	20F
Table 3 Payment Organization Determinations and Reconsiderations (PYMT_C)	20F
Cease and Desist Letter	20B
Notice of CAP Deduction	20C
Demand for Payment Letter	20C
Notice of Dismissal of Appeal Request	20A1

Inland Empire Health Plan

Month Day, Year

Facility Name
Facility Fax:

Beneficiary Name:
IEHP Member ID:
Account Number:
Claim Number
Claim Receipt Date:
Date of Service:
Amount Billed:

RE: Notice of Prohibition on Balance Billing IEHP Members

To Whom It May Concern:

Inland Empire Health Plan (IEHP) was notified that the above-mentioned IEHP Member was billed for services rendered by your organization, in violation of statutes that protect Medicare or Medi-Cal beneficiaries from balance billing and billing for any covered services.

The purpose of this letter is to request that your organization, **effective immediately**:

a) Cease and desist from any balance billing or collection activities as it relates to the Member referenced above and any IEHP Medicare or Medi-Cal Members;
b) Return to IEHP's Medicare and/or Medi-Cal Members any monies collected from such Members; and
c) Reverse any negative credit reporting made against any such Members.

The California Supreme Court has made it clear in Olszewski v. Scripps Health (2003) 30 Cal.4th 798, 812 that balance billing and collection activities from Medicare or Medi-Cal beneficiaries are strictly prohibited under both federal and state laws.[1,2,3] This prohibition against the balance billing of IEHP beneficiaries applies irrespective of whether the services are emergent or non-emergent.[4]

Violation of state laws prohibiting the balance billing of Medicare or Medi-Cal beneficiaries constitutes grounds for suspension from the Medicare or Medi-Cal programs.[5]

Thank you for your anticipated cooperation.

Sincerely,

Provider Payment Resolution Team
Inland Empire Health Plan

---

[1] Title 22 California Code of Regulations (CCR) § 51002(a)
[2] California Welfare and Institutions Code (Welf. & Inst. Code) § 14019.4
[3] Title 42 Code of Federal Regulations (CFR) § 422.2
[4] Title 28, CCR § 1300.71.39(a)
[5] CA Welf. & Inst. Code §§ 14123(a)(1); 14123.25

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

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

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as 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 amount paid by 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 personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either 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 COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

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

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

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, 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, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or 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 care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 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 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

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.

Member Name	
DOB	
IEHP MEMBER ID	
IEHP Claim Number	
Provider of Service	
Tax ID	
Date of Service	
Amount Billed	
Patient Account No.	

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

Secure E-mail Template Notice of CAP deduction

CONTRACTED

This section should be utilized for contracted providers only.

Applicable Situation/Type of Service	Contracted Provider Denial Denial Language	Comments **Caution**: These denials need to clearly indicate that there is no member liability and that nay disagreement must be resolved between the parties so that the member is not billed.	Denial Notice to Member and or Provider	Situation Code
Medical Records Requested and not received (services other than those related to emergency room)	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. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.	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).	Provider Only	CONT-06
Outpatient Services (office visits, lab, diagnostic imaging)	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 (PGM / IPA Name) and you are not allowed to balance bill the member for these services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.	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.	Provider Only	CONT-01
Contracted Hospital or Provider Services (non-emergent - no triage call)	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. THE MEMBER IS NOT RESPONSIBLE FOR THE PAYMENT OF THIS CLAIM.	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).	Provider Only	CONT-02

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

Applicable Situation/Type of Service	Contracted Provider Denial Denial Language	Comments	Denial Notice to Member and or Provider	Situation Code
Contracted Facility (delay in care resulted in unnecessary days)	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. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.	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. **Cautions**: 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.	Provider Only	CONT-03
Not Medically Necessary	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. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.	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.	Provider Only	CONT-07
Contracted In-Area Emergency Services (non-emergent) (presenting circumstances fail test)	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. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.	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. **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	Provider Only	ERIA-01
Contracted In-Area Urgent Care Services (non-urgent) (presenting circumstances fail test)	*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. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.	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.	Provider Only	UCIA-01

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

NON-CONTRACTED

This section should be utilized for
Non-contracted providers only.

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

Applicable Situation/Type of Service	Non-Contracted Provider Denial Denial Language	Comments	Denial Notice to Member and or Provider	Situation Code
Required Claim Data Missing or Spoiled	[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.]	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} **Important Note:** 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.	[Not Applicable]	[Not Applicable]

Applicable Situation/Type of Service	Denial Language	Comments	Denial Notice to Member and or Provider	Situation Code
Non-Contracted In-Area Emergency Services (non-emergent) (presenting circumstances fail test)	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}	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	Yes	ERIA-04
Non-Contracted In-Area Urgent Care Services (non-urgent) (presenting circumstances fail test)	. *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.	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.	Yes	UCIA-02
Medical Records Requested and not received (services other than those related to emergency room)	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}.	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.	Yes	NON-01
Not Medically Necessary	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.	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.	Yes	NMN-01

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

CONTRACTED / NON-CONTRACTED

This section may be utilized for
Contracted and Non-contracted providers.

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

Applicable Situation/Type of Service	Denial Language	Comments **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	Denial Notice to Member and or Provider	Situation Code
Incomplete or Invalid Claim (Initial Claim Development)	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}.	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: CMS-1500: Billing Provider Name Federal Tax Number Patient's Name Patient's Address Date of Birth Sex Service Date Diagnosis Code Procedure, Service, Supply Code Days or Units Place of Service Anesthesia/Oxygen Min. NPI Insured's Name Patient's Relationship Insured's ID UB-04/CMS-1450: Billing Provider Name Patient Control Number Type of Bill Federal Tax Number Statement Covers Period Patient's Name Patient's Address Date of Birth Sex Admission Date Priority of Admission Origin for Admission Discharge Status Value Codes & Amounts Revenue Code HCPCS/Rates/HIPPS DOS / UOS Total Charges–n/a for EDI Non-Covered Charges Payer Id Release of Information NPI Insured's Name & ID Patient's Relationship diagnosis& procedure Code Qualifier Principle or Admitting Diagnosis Code	Provider Only	INC-01

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

Applicable Situation/Type of Service	Denial Language	Comments **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	Applicable Situation/ Type of Service	Denial Language
Incomplete or Invalid Claim (Reject/Deny due to non-receipt of corrected 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. 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.	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.	Provider Only	INC-02

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

Applicable Situation/Type of Service	**Eligibility Denial Language**	**Comments**	Denial Notice to Member and or Provider	Situation Code
		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		
		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.		
Predates Eligibility with Plan	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.	Applicable when services rendered prior to HMO enrollment date.	Yes (note caution)	ELIG-01
In-between Eligibility	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.	Applicable when services rendered in between HMO enrollment dates. **Caution**: Denials that read "Not eligible with IPA or medical group at the time of service" 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.	Yes (note caution)	ELIG-04
Postdates Eligibility with Plan	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.	Applicable when service rendered after HMO disenrollment date. **Caution**: Denials that read "not eligible with IPA or medical group at the time of service" are inappropriate denials. Contact Plan to verify eligibility and for routing instructions.	Yes (note caution)	ELIG-02
Service Postdates Member's Death	Our records show the date of service was after the date of death.	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).	Provider Only	ELIG-03

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

Applicable Situation/Type of Service	Emergency and Urgently Needed Services Denial Language	Comments	Denial Notice to Member and or Provider	Situation Code
In-Area Emergency Services (records not received)	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.	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	Yes (note caution)	ERIA-02
In-Area (partial denial of inappropriate services)	Services delivered as emergency care were not consistent with presenting symptoms or emergency diagnosis.	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	Yes	ERIA-03
Out-of-Area Emergency Services (not urgently needed)	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.	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	Yes	EROA-01
Out-of-Area Urgently Needed Services (not urgently needed)	. *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.	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	Yes	UCOA-01
Out-of-Area Emergency Needed Services (records not received)	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.	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	Yes	EROA-02

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

Applicable Situation/Type of Service	**Maximum Allowable Benefit Denial Language**	**Comments**	Denial Notice to Member and or Provider	Situation Code
Chiropractic (non-Medicare covered)	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. Please refer to your Health Plan's member materials for benefit guidelines.	Plan benefits for routine chiropractic services vary. Please refer to the Plan's member materials for benefit guidelines	Yes	MACH-01
Inpatient Psychiatric	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}.	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.	Yes (note caution)	MAPY-01
Podiatry (non-Medicare covered)	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.	Plan benefits for routine podiatry services vary. Please refer to the Plan's member materials for benefit guidelines	Yes	MAPO-01
Prescription Drugs (non-Medicare covered)	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.	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.	Yes	MARX-01
Skilled Nursing Facility	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.	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.	Yes (note caution)	MASN-01
Miscellaneous (Insert other specific benefits with annual maximums	{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}.	Benefit maximums must be supported by the Plan's member materials. SPECIFIC denial information is required.	Yes	MAMI-01

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

Applicable Situation/Type of Service	Not a Covered Benefit Denial Language	Comments	Denial Notice to Member and or Provider	Situation Code
Ambulance (not medically necessary)	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	For use where transport is not medically necessary and not authorized.	Yes	NCAM-01
Ambulance (no patient transport)	As you were not transported by ambulance, the services are not covered by Medicare or {Name of Health Plan}.	For denial of services where no patient has been transported, such as paramedic intercept calls where no transport occurs.	Yes	NCAM-02
Assistant Surgeon (Medicare guidelines)	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.	Denial to provider per Medicare guidelines. Member should not be involved. The member has no financial responsibility for these services.	Provider Only	NCAS-01
Bundling (Medicare guidelines)	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.	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.	Provider Only	NCBU-01
Chiropractic (Medicare criteria)	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}.	For denial of service or claim where Medicare criteria are not met. **Caution**: Some Plans may provide additional chiropractic care benefits. Refer to the Plan's member materials for benefit guidelines.	Yes (note caution)	NCCH-01
Cosmetic	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.	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.	Yes	NCCO-01

Applicable Situation/Type of Service	**Not a Covered Benefit Denial Language**	**Comments**	Denial Notice to Member and or Provider	Situation Code
Dental Services	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.	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.	Yes (note caution)	NCDS-01
DME-Durable Medical Equipment (does not meet Medicare DME criteria)	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}.	For use when the item does not meet Medicare DME criteria. **Caution**: 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.	Yes (note caution)	NCDM-01
DME-Durable Medical Equipment (not authorized)	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}.	For use when DME is not prescribed/authorized by a Plan physician. **Caution**: IPA needs to coordinate with Plan before issuing denials for DME to avoid possible duplication.	Yes (note caution)	NCDM-02
Hearing Aids	Hearing Aids are not a benefit covered under Medicare or {Name of Health Plan}.	**Medicare does not cover Hearing Aids.** **Caution**: IPA needs to coordinate with Plan for possible additional coverage.	Yes (note caution)	NCHA-01
Home Health (does not meet skilled guidelines)	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}.	For use when the member requests home health care and does not require skilled care.	Yes	NCHH-01
Home Health (member not homebound)	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}.	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.	Yes	NCHH-02

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

Applicable Situation/Type of Service	**Not a Covered Benefit Denial Language**	**Comments**	Denial Notice to Member and or Provider	Situation Code
Home Health (not authorized)	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}.	For use when patient self refers or has home health ordered by an Out of Plan physicians. **Caution**: IPA needs to coordinate with Plan before issuing denials for Home Health Care	Yes (note caution)	NCHH-03
Non-Formulary Drugs	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.	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.	Yes (by plan)	NCRX-01
Non Medicare/FDA Approved Drugs or Devices	{ **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.	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.	Yes	NCRX-02
Not Authorized In-Area Non-ER Services (If ER / emergent, use emergency denial message)	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}.	**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.	Yes (note caution)	NCNA-01
Over the Counter Items/Medications	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.	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)	Yes (by plan)	NCRX-03
Personal Comfort Items	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.	(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… **Caution**: 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.	Yes	NCPC-01

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

Applicable Situation/Type of Service	**Not a Covered Benefit Denial Language**	**Comments**	Denial Notice to Member and or Provider	Situation Code
Podiatry	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	**Caution**: Medicare covers routine foot care for specific conditions related to diabetic & 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.	Yes (note caution)	NCPO091
Shoe Orthotics	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.	**Caution**: Some Plans may offer additional shoe orthotic coverage. Please refer to the Plan's member materials for benefit guidelines.	Yes (note caution)	NCSO-01
Skilled Nursing Facility (custodial care or not daily SNF care)	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}.	For use when care is custodial or daily skilled care is not medically necessary.	Yes	NCSN-01
Skilled Nursing Facility (not authorized)	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}.	For use when care is not authorized, i.e. member self refers or is referred by a non-Plan physician. **Caution**: IPA needs to coordinate with Plan before issuing denials for Skilled Nursing Care.	Yes (note caution)	NCSN-02
Miscellaneous	{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.	For use with other specific services that are not a covered benefit.	Yes	NCMI-01

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

Applicable Situation/Type of Service	**Advanced Diagnostic Imaging Accreditation**	**Comments**	Denial Notice to Member and Provider	Situation Code
ADI – Rendered by non-accredited provider	Medicare does not pay for services rendered by a non-accredited provider. Payment for this advanced diagnostic imaging service is denied .THE MEMBER IS NOT RESPONSIBLE FOR THE PAYMENT OF THIS SERVICE.	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.	Provider Only	NCAD-01

Applicable Situation/Type of Service	**Provider Opted Out of Medicare**	**Comments**	Denial Notice to Member and Provider	Situation Code
Claim is submitted **inadvertently** by the opt-out physician/practitioner or beneficiary	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.	For use when the rendering provider has opted out of Medicare. **Caution**: 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.	Yes	NCOO-01
Claim is submitted **knowingly and willfully** by the opt-out physician/practitioner	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.	For use when the rendering provider has opted out of Medicare. **Caution**: 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	Yes	NCOO-02

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

Applicable Situation/Type of Service	**Coordination of Benefits Denial Language**	**Comments**	Denial Notice to Member and or Provider	Situation Code
Requested information not received from member	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}.	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.	Yes	COB-01

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

[THIS PAGE AND THE PAGES THAT FOLLOW ARE INFORMATIONAL AND ARE NOT PART OF THE GUIDE, ITSELF.]

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 NMN-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.

05/2005 Separated document by non-contracted, contracted and non-contracted/contracted. Added headers for, workers compensation, and coordination of benefits. Added new denial reasons for “in-between eligibility”, “medical records not received”, “workers compensation”, “coordination of benefits”, modified Medicare + Choice to Medicare Advantage, modified HCFA-1500 to CMS-1500, added specific diagnosis codes to NCCH-01, added note to ERIA-01, ERIA-02, ERIA-03, EROA-01, EROA-02. Revised verbiage on ERIA-01 and ERIA-02 denial reason.

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.

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

Frequently Asked Questions (FAQs)

None. May be developed at a future time.

Original: 1/24/97 Revised: 11/05, 5/13, 1/14, 5/16
CMS Reviewed: 1/25/07 ICE Approved: 5/16

DISCRIMINATION IS AGAINST THE LAW
LA DISCRIMINACIÓN ES UN ACTO CONTRA LA LEY

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
Tel. 1-800-368-1019, (TDD: 800-537-7697). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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 necesita recibir estos servicios, comuníquese con Servicios para Miembros de IEHP al 1-877-273-4347 (TTY: 1-800-718-4347).

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
Tel. 1-800-368-1019, (TDD: 800-537-7697). Puede obtener los formularios de queja en el sitio web: http://www.hhs.gov/ocr/office/file/index.html

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)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-273-4347(TTY: 1-800-718-4347).

العربية (ARABIC)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-877-273-4347 (رقم هاتف الصم والبكم: 1-800-718-4347).

Հայերեն (ARMENIAN)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-877-273-4347(TTY (հեռատիպ)՝ 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)。

فارسی (FARSI)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-273-4347 (TTY: 1-800-718-4347) تماس بگیرید.

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

LANGUAGE ASSISTANCE

Hmoob (HMONG)
LUS CEEV: Yog tias koj hais lus Hmoob, muaj kev pab txhais lus hmoob pub dawb rau koj. Hu rau 1-877-273-4347(TTY: 1-800-718-4347).

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)
ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ
គឺមានសំរាប់អ្នក។ ទូរស័ព្ទទៅលេខ 1-877-273-4347 (TTY: 1-800-718-4347)។

한국어 (KOREAN)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-877-273-4347 (TTY: 1-800-718-4347)번으로 전화해 주십시오.

ພາສາລາວ (LAO)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່
ເສັ ຽ ຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-273-4347(TTY: 1-800-718-4347).

ਪੰਜਾਬੀ (PUNJABI)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ **(Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ।
ਕਿਰਪਾ ਕਰਕੇ 1-877-273-4347(TTY: 1-800-718-4347) 'ਤੇ ਕਾੱਲ ਕਰੋ।

Русский (RUSSIAN)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-273-4347(елетайп: 1-800-718-4347).

TAGALOG (TAGALOG – FILIPINO)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-273-4347(TTY: 1-800-718-4347).

ภาษาไทย (THAI)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-273-4347 (TTY: 1-800-718-4347).

Tiếng Việt (VIETNAMESE)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-273-4347(TTY: 1-800-718-4347).

Secure E-mail Template Notice of CAP deduction

From:
To:
Cc:
Subject: Notice of Cap deduction, <Insert Claim Number>

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

Member Name	
DOB	
IEHP MEMBER ID	
Claim Number	
Provider of Service	
Tax ID	
Date of Service	
Amount Billed	
Patient Account No.	
Notification Date	
Cap Deduction Amount	
Process Date Date	

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

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 toward the end 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 Payment

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 *or* Part B drug *or* Medi-Cal drug listed below requested by you or your provider:

_____

_____

_____

Why did we deny your request?

We <denied, stopped, reduced, suspended> the payment of medical services/items *or* Part B drug *or* Medi-Cal drug 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>*:

_____

_____

_____

<Where the plan has determined that the drug is covered under Medicare Part D, insert the following text: This request was denied under your Medicare Part B benefit; however, coverage/payment for the requested drug(s) has been approved under Medicare Part D. *<Insert, as applicable, an explanation of the conditions of approval in a readable and understandable format>*. If you think Medicare Part B should cover this drug for you, you may appeal.>

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.

Standard Appeal – We'll give you a written decision on a standard appeal within **<30 calendar days, 7 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 medical service/item *or* Part B drug *or* Medicaid drug you've already received, we'll give you a written decision within **60 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 <written> request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the medical services/items *or* Part B drug *or* Medicaid drug. 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.

What happens next?

If you ask for a Level 1 Appeal and we continue to deny your request for payment of 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 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 TTY line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet website **www.dmhc.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.

An IMR can take longer if the DMHC does not receive all of the medical records needed from you or your treating doctor. If you are seeing a doctor who is not in your health plan's network, it is important that you get and send us your medical records from that doctor. Your health plan is required to get copies of your medical records from doctors who are in the network.

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 (TTY: 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 1-800-333-4114.
- 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.

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.

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 users call 1-800-718-4347. The call is free.

Importante: Este aviso explica su derecho a apelar nuestra decisión. Lea este aviso detalladamente. Si necesita ayuda, puede llamar a uno de los números que aparecen al final en la sección “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 Pago

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 *o* medicamento de la Parte B *o* medicamento de Medi-Cal que aparecen a continuación solicitado por usted o su proveedor:

_____
_____
_____

¿Por qué denegamos su solicitud?

Hemos <denegado, detenido, reducido, suspendido> el pago de los servicios/artículos médicos *o* medicamento de la Parte B *o* medicamento de Medi-Cal mencionado anteriormente porque*<Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage (Member Handbook) provisions to support decision>*:

_____
_____
_____

<Where the plan has determined that the drug is covered under Medicare Part D, insert the following text: Esta solicitud se denegó bajo su beneficio de la Parte B de Medicare; sin embargo, la cobertura o el pago de los medicamentos solicitados se aprobó bajo la Parte D de Medicare. *<Insert, as applicable, an explanation of the conditions of approval in a readable and understandable format>*. Si cree que la Parte B de Medicare le debe cubrir este medicamento, puede presentar una apelación.>

Debe entregar 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, le enviamos a él una copia de esta decisión.

Usted tiene el derecho de apelar nuestra decisión

Usted tiene derecho a solicitar a IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) que revise nuestra decisión para lo cual nos deberá solicitar una Apelación de Nivel 1 (*Level 1 Appeal*) (a veces llamada "apelación interna" o "apelación del plan"). En casos especiales, también puede solicitar una Revisión Médica Independiente *(Independent Medical Review, IMR)* sin antes apelar ante nuestro plan. No puede solicitar una IMR si ya tuvo 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 a nivel del plan.

> **Cómo conservar sus servicios mientras revisamos su caso:** si nuestra decisión es interrumpir o reducir un servicio, usted puede seguir obteniendo el servicio mientras se revisa su caso. **Si desea continuar con el servicio, debe presentar una apelación dentro de los 10 días del calendario** posteriores a la fecha de este aviso o antes de que el servicio se interrumpa o reduzca, lo que sea posterior.

Si desea que otra persona actúe en su nombre

Usted puede designar a un familiar, amigo, abogado, doctor u otra persona para que actúe como su representante. Si desea que otra persona actúe en su nombre, llámenos al: 1-877-273-IEHP (4347), 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 usted desea que actúe por usted deben firmar y fechar una declaración que indique que usted así lo desea. Deberá enviarnos esta declaración por correo o por fax. Conserve una copia para sus registros.

Apelación estándar: Le comunicaremos una decisión por escrito sobre una apelación estándar en un plazo de **<30 días del calendario**, **7 días del calendario>** después de recibir su apelación. Nuestra decisión podría demorar más si solicita una extensión o si necesitamos más información sobre su caso. Le informaremos si estamos tomando un periodo de tiempo adicional y le explicaremos por qué se necesita más tiempo. Si su apelación es por el pago de un servicio/artículo médico *o* medicamento de la Parte B *o* medicamento de Medi-Cal que ya recibió, le comunicaremos una decisión por escrito dentro de los siguientes **60 días del calendario**.

Cómo solicitar una Apelación de Nivel 1 ante IEHP DualChoice

Paso 1: Usted, su representante o su proveedor deben solicitar una apelación en un plazo de **60 días del calendario** a partir de que reciba este aviso.

Su solicitud por <escrito> debe incluir:

- Su nombre
- Domicilio
- Número de Miembro
- Motivos por los que apela
- Cualquier evidencia que desee que revisemos, como registros médicos, cartas de los doctores u otra información que explique por qué necesita el (los) servicios/artículos médicos *o* medicamentos de la Parte B *o* medicamento de Medi-Cal. 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 los criterios que usamos para tomar nuestra decisión, sin costo alguno para usted.

Paso 2: Entregue su apelación personalmente o por correo, fax o llámenos.

Para una Apelación Estándar:	Dirección postal:	IEHP DualChoice P.O Box 1800 Rancho Cucamonga, CA 91729-1800
	Teléfono:	1-877-273-IEHP (4347)
	Usuarios de TTY:	1-800-718-4347
	Fax:	909-890-5748

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

¿Qué sigue?

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

Si el servicio fue originalmente un servicio de Medicare o un servicio cubierto por Medicare y Medi-Cal, enviaremos su caso a un revisor independiente automáticamente. 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, puede solicitar una **Revisión Médica Independiente** (*Independent Medical Review, IMR*) o una **Audiencia Estatal**. La decisión escrita le dará instrucciones sobre cómo solicitar el siguiente nivel de apelación. A continuación, también se proporciona esta información.

Cómo solicitar una Revisión Médica Independiente (IMR)

Puede solicitar una Revisión Médica Independiente para servicios y artículos cubiertos por Medi-Cal al Departamento de Atención Médica Administrada de California (Departamento) Puede solicitar una IMR si no está de acuerdo con la decisión de IEHP DualChoice sobre la Apelación de Nivel 1 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 antes apelar ante nuestro plan.

En la mayoría de los casos, debe presentar una apelación de Nivel 1 ante IEHP DualChoice antes de solicitar una IMR; sin embargo, es posible que pueda obtener una IMR sin antes apelar ante IEHP DualChoice si:

- Su problema es urgente e implica una amenaza inmediata y grave 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 usted ya ha tenido 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 Quejas/Revisión Médica Independiente en línea disponible en www.dmhc.ca.gov/fileacomplaint/submitanindependentmedicalreviewcomplaintform.aspx o puede contestar el formulario de solicitud de IMR impreso, que se incluye con este aviso y enviarlo a:

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

Si elige hacerlo, puede adjuntar copias de cartas u otros documentos sobre el servicio o artículo que denegamos. Si lo hace, envíe copias de los documentos, no los originales. Es posible que el Centro de Ayuda del Departamento no pueda devolver todos los documentos originales.

Usted o su representante deben solicitar una IMR dentro de los **6 meses** posteriores de que le enviemos una decisión por escrito. Sin embargo, el Departamento puede extender el plazo de 6 meses por razones justificadas; por ejemplo, si usted tenía una condición médica que le impidió solicitar la IMR dentro de los 6 meses o si no recibió una notificación adecuada del proceso de IMR.

Llame al **Departamento de Atención Médica Administrada de California** (*California Department of Managed Health Care, DMHC*) **sin cargo al 1-888-466-2219** para obtener ayuda gratuita. El Departamento de Atención Médica Administrada de California es responsable de regular los planes de servicios médicos. Si tiene una queja formal contra su plan de salud, primero debe llamar a su plan de salud al **1-877-273-IEHP (4347)** y usar el proceso de quejas 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 no haya sido resuelta satisfactoriamente por su plan de salud o una queja formal que haya permanecido sin resolverse durante más de 30 días, puede llamar al Departamento para solicitar ayuda. También usted podría ser elegible para una Revisión Médica Independiente (IMR). Si usted es elegible para una IMR, el proceso de IMR proporcionará una revisión imparcial de las decisiones médicas tomadas por un plan de salud relacionadas con la necesidad médica de un servicio o tratamiento propuesto, las decisiones de cobertura para tratamientos que sean experimentales o de investigación y las disputas de pago por servicios médicos urgentes o de emergencia. El Departamento también tiene un número de teléfono gratuito **(1-888-466-2219)** y una línea TTY **(1-877-688-9891)** para personas con problemas de audición y del habla. El sitio web de Internet del Departamento **www.dmhc.ca.gov** tiene formularios de quejas, formularios de solicitud de IMR e instrucciones en línea.

¿Qué sigue?

Si califica para una IMR, el DMHC revisará su caso y le enviará una carta dentro de los siguientes 7 días del calendario para informarle que califica para una IMR. Después de que se reciba su solicitud y los documentos de respaldo de su plan, la decisión de IMR se tomará dentro de los siguientes 30 días del calendario. Debe recibir la decisión de la IMR dentro de los 45 días del calendario posteriores a la presentación de la solicitud completa.

Si su caso es urgente y califica para una IMR, el DMHC revisará su caso y le enviará una carta en un plazo de 2 días del calendario para informarle que califica para una IMR. Después de que se reciba su solicitud y los documentos de respaldo de su plan, la decisión de la IMR se tomará dentro de los siguientes 3 días del calendario. Debe recibir la decisión de la IMR dentro de los 7 días del calendario posteriores a la presentación de la solicitud completa.

La IMR puede demorar más si el DMHC no recibe todos los registros médicos necesarios de su parte o de su doctor tratante. Si está recibiendo atención de un doctor que no está en la red de su plan de salud, es importante que le pida sus registros médicos y nos los envíe. Su plan de salud debe obtener copias de sus registros médicos de parte de los doctores que pertenecen a la red.

Serán doctores que no forman parte de IEHP DualChoice los que 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 proporcionarle el servicio o el tratamiento que usted solicitó. Si no está de acuerdo con la decisión, puede solicitar una Audiencia Estatal siempre que no haya tenido una Audiencia Estatal sobre el mismo asunto.

Si usted no califica para una IMR, su asunto será revisado a través del proceso de quejas estándar del DMHC. Usted 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 emprender acción legal 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. Usted únicamente puede solicitar una audiencia estatal después de haber apelado a nuestro plan de salud y recibido una decisión por escrito con la que no está de acuerdo. Tenga en cuenta que, si tiene una audiencia estatal, no podrá solicitar una Revisión Médica Independiente (IMR).

Paso 1: Usted o su representante deben solicitar una Audiencia Estatal en un plazo de **120 días** a partir de la fecha de nuestra notificación de que se ha confirmado la determinación adversa respecto a los beneficios (decisión de apelación de nivel 1). Responda el “Formulario para Presentar una Audiencia Estatal” (*Form to File a State Hearing*) que se incluye en el aviso de decisión de la apelación. Asegúrese de incluir toda la información solicitada.

Paso 2: Envíe su formulario completo 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 llamando al 1-800-952-5253 (TTY: 1-800-952-8349). Si decide realizar la solicitud por teléfono, debe saber que las líneas telefónicas están muy ocupadas.

¿Qué sigue?

El Estado llevará a cabo una audiencia. Usted puede presenciar la audiencia en persona o escucharla por teléfono. Se le solicitará a usted que 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 envió una copia de este aviso a: *<insert name>*.

Obtener 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 Atención Médica Administrada de California** para obtener ayuda gratuita para entender sus derechos y la información sobre el proceso de quejas y la Revisión Médica Independiente (IMR) al 1-888-466-2219.
- Llame a **Health Consumer Alliance** para obtener ayuda gratuita con su atención médica al 1-888-804-3536.
- Llame al **Programa de Defensoría de los Beneficiarios de Cal MediConnect** (*Cal MediConnect Ombuds Program*) para obtener ayuda gratuita. El Programa de Defensoría de los Beneficiarios de Cal MediConnect ayuda a las personas inscritas en Cal MediConnect a tratar los problemas sobre servicios o facturación. Pueden explicarle cómo presentar una apelación y qué esperar durante el proceso de apelación. El número de teléfono es 1-855-501-3077.
- 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 1-800-333-4114.
- Llame al **Programa de Asesoramiento y Defensoría sobre el Seguro Médico *(****Health Insurance Counseling and Advocacy Program, HICAP)*** para obtener ayuda gratuita. El HICAP es una organización independiente. No está vinculado con este plan. El número de teléfono es 1-800-434-0222.
- Hable con **su doctor o algún otro proveedor**. Su doctor o algún otro proveedor 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.

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

Usted puede solicitar esta información en otros formatos, como impresión con letra grande, Braille o audio. Llame al 1-877-273-IEHP (4347), 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. La llamada es gratuita.

Notice of Dismissal of Appeal Request

Date: _____

Enrollee's Name: _____ Enrollee ID Number: _____

(Insert Non-contract Provider Name, if applicable:) _____

Health Plan Name/Medicare Contract Number: _____

Health Plan Contact Fax Number: _____

- We dismissed the appeal request you filed on _____
  (Insert date request received by the plan.)
- We can't process your appeal request because:
  (Instructions: Use the space below to explain the specific reason for dismissal and what is missing from the request (e.g., lack of an appointment of representation (AOR) form, lack of waiver of liability (WOL) for a request filed by a non-contract provider). See Chapter 13 of the Medicare Managed Care Manual for guidance on when it may be appropriate to dismiss a reconsideration request.)

Do You Have Questions?

If you have questions about this notice, please contact _____at the following:
(Insert Health Plan Name)

Toll Free Phone: _____ Days & hours of operation: _____

TTY Users Phone: _____ Days & hours of operation: _____

If you disagree with our decision to dismiss your appeal request, you have the right to ask an independent reviewer contracted with Medicare to review our decision. You must mail or fax your written request within 60 calendar days of receipt of this ***Notice of Dismissal of Appeal Request*** to:

MAXIMUS Federal Services, Inc.
Medicare Managed Care & PACE Reconsideration Project
3750 Monroe Avenue, Suite 702
Pittsford, NY 14534-1302

Phone: 585-348-3300
Fax: 585-425-5292

Include a copy of this ***Notice of Dismissal of Appeal Request*** along with any supporting information with your request for review. The independent reviewer will send you a notice of its decision. If the independent reviewer agrees that your appeal should not have been dismissed, your appeal request will be returned to _____ for processing.
(Insert Health Plan Name)

INPATIENT

1	2	3a Pat. CNTL#	4 TYPE OF BILL
		b. Pat. CNTL#	
		5 FED. TAX. NO.	6 Statement Covers Period From / Through

7	8 PATIENT NAME a / b	9 PATIENT ADDRESS a / b / c / d / e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 Type	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 Acdt state	30

31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37

38		39 VALUE CODES AMOUNT	40 VALUE CODES AMOUNT	41 VALUE CODES AMOUNT
	a			
	b			
	c			
	d			

	42 REV.CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		*PAGE ____ OF ____*	*CREATION DATE*		TOTALS			23

	50 PAYER NAME	51 HEALTH PLAN ID	52 Rel INFO	53 Asg BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P.rel	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX	67	a	b	c	d	e	f	g	h	68
	i	j	k	l	m	n	o	p	q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81 cc			
	a.			
	b.			
	c.			
	d.			

78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

REQUIRED SITUATIONAL NOT REQUIRED

UB04 INPATIENT: SITUATIONAL FIELDS

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

OUTPATIENT

1	2	3a Pat. CNTL#	4 TYPE OF BILL
		b. Pat. CNTL#	
		5 FED. TAX NO.	6 Statement Covers Period From / Through	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c / d / e

10 BIRTHDATE	11 SEX	12 DATE	13 ADMISSION HR	14 Type	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 Acdt state	30

31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37

38		39 VALUE CODES AMOUNT	40 VALUE CODES AMOUNT	41 VALUE CODES AMOUNT
	a			
	b			
	c			
	d			

	42 REV.CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		*PAGE ____ OF ____*	*CREATION DATE*		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 Rel INFO	53 Asg BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P.rel	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX	67	a	b	c	d	e	f	g	h	68
	i	j	k	l	m	n	o	p	q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81 cc		
	a.		
	b.		
	c.		
	d.		

REQUIRED SITUATIONAL NOT REQUIRED

UB04 OUTPATIENT: SITUATIONAL FIELDS

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

Part C Organization Determinations, Appeals, and Grievances (ODAG)

PROGRAM AUDIT PROTOCOL AND DATA REQUEST

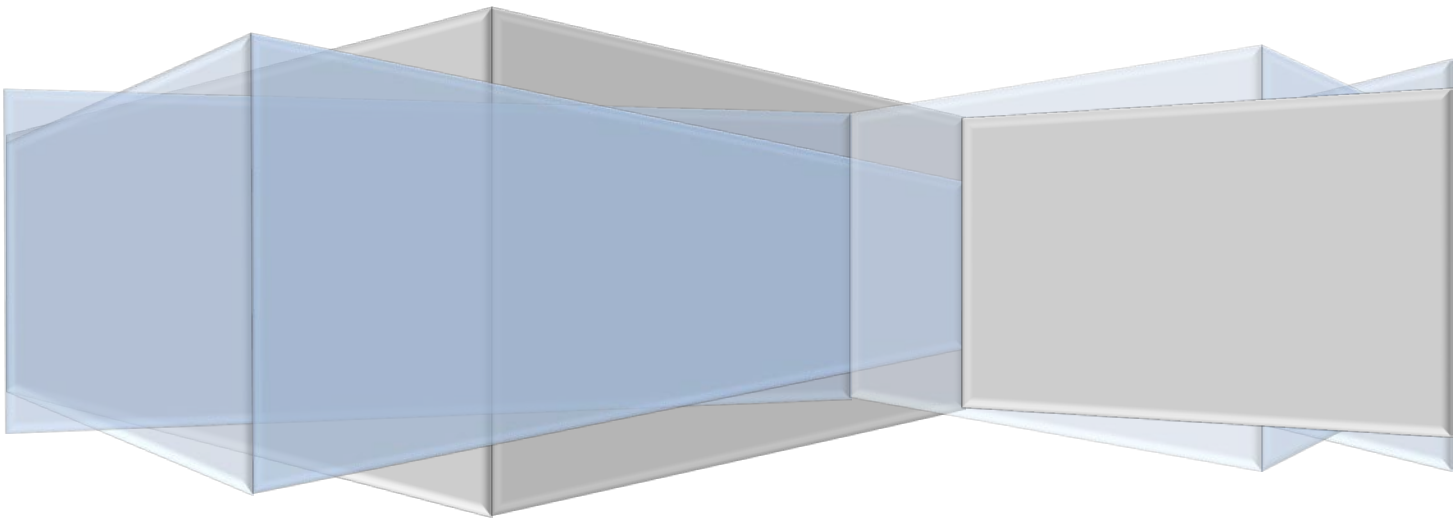

Table of Contents

OMB Approval 0938-1395 (Expires 05/31/2024)

Program Audit Protocol

Purpose

To evaluate performance in the areas outlined in this Program Audit Protocol and Data Request related to Part C Organization Determinations, Appeals and Grievances (ODAG). The Centers for Medicare and Medicaid Services (CMS) performs its program audit activities in accordance with the ODAG Program Audit Data Request and applying the compliance standards outlined in this Program Audit Protocol and the Program Audit Process Overview document. At a minimum, CMS will evaluate cases against the criteria listed below. CMS may review factors not specifically addressed below if it is determined that there are other related ODAG requirements not being met.

Audit Elements Tested

1. Timeliness
2. Processing of Coverage Requests
3. Classification of Requests

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Not Applicable	Universe Integrity Testing	Universe Table 1: Standard and Expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-Service Reconsiderations (RECON) Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C) Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C) Universe Table 5: Part C Standard and Expedited Grievances (GRV_C) Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)	Select 10 cases from each universe, Tables 1 through 6, for a total of 60 cases. Prior to field work, CMS will schedule a webinar with the Sponsoring organization to verify accuracy of data within the universe submissions, and to confirm effectuation of approved requests, for each of the sampled cases. Review all cases selected for universe integrity testing. The integrity of the universe will be questioned if data points specific to the sample case(s) are incomplete, do not match, or cannot be verified by viewing the Sponsoring organization's systems and/or other supporting documentation. Sample selections will be provided to the Sponsoring organization approximately one hour prior to the scheduled webinar.	42 CFR § 422.504(e) 42 CFR § 422.504(f)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Timeliness	1.1	Universe Table 1: Standard and Expedited Pre-Service Organization Determinations (OD)	Conduct timeliness test at the universe level on standard pre-service organization determinations to determine whether the Sponsoring organization provided notification of the determination no later than 14 calendar days after the date the Sponsoring organization received the request. If the Sponsoring organization extended the timeframe, determine whether the Sponsoring organization provided notification of the determination no later than 28 calendar days after the date the Sponsoring organization received the request.	42 CFR § 422.568(b) 42 CFR § 422.631(d)
Timeliness	1.2	Universe Table 1: Standard and Expedited Pre-Service Organization Determinations (OD)	Conduct timeliness test at the universe level on standard organization determination requests for Part B drugs to determine whether the Sponsoring organization provided notification of the determination no later than 72 hours after receipt of the request.	42 CFR § 422.568(b) 42 CFR § 422.629(a)
Timeliness	1.3	Universe Table 1: Standard and Expedited Pre-Service Organization Determinations (OD)	Conduct timeliness test at the universe level on expedited pre-service organization determinations to determine whether the Sponsoring organization provided notification of the determination no later than 72 hours after receipt of the request. If the Sponsoring organization extended the timeframe, determine whether the Sponsoring organization provided notification of the determination no later than 17 calendar days after receipt of the request. For Dual Eligible Special Needs Plans – Applicable Integrated Plans (DSNP-AIP), written notice of the denial must be provided within 3 days of receipt of the request. The additional 3 day allowance to deliver the written notification after providing oral notice does not apply.	42 CFR § 422.572(a) 42 CFR § 422.572(b) 42 CFR § 422.572(c) 42 CFR § 422.631(d)
Timeliness	1.4	Universe Table 1: Standard and Expedited Pre-Service Organization Determinations (OD)	Conduct timeliness test at the universe level on expedited organization determination requests for Part B drugs to determine whether the Sponsoring organization provided notification of the determination no later than 24 hours after the Sponsoring organization received the request.	42 CFR § 422.572(a) 42 CFR § 422.572(c) 42 CFR § 422.629(a)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Timeliness	1.5	Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON)	Conduct timeliness test at the universe level on standard pre-service reconsideration requests to determine whether the Sponsoring organization provided notification of its overturned determination or forwarded its upheld decision to the IRE no later than 30 calendar days after the date the Sponsoring organization received the request. If the Sponsoring organization extended the timeframe, determine whether the Sponsoring organization provided notification of the overturned determination or forwarded its upheld decision to the IRE no later than 44 calendar days after receipt of the request. For DSNP-AIPs, the timeliness assessment will ensure written notification of the upheld reconsideration decision was provided to the enrollee in addition to being forwarded to the IRE no later than 30 calendar days or 44 days with extension after receipt of the request.	42 CFR § 422.590(a) 42 CFR § 422.590(d) 42 CFR § 422.590(f) 42 CFR § 422.633(f)
Timeliness	1.6	Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON)	Conduct timeliness test at the universe level on standard reconsideration requests for Part B drugs to determine whether the Sponsoring organization provided notification of its overturned determination or forwarded its upheld decision to the IRE no later than 7 calendar days after receipt of the request.	42 CFR § 422.590(c) 42 CFR § 422.590(d) 42 CFR § 422.629(a)

OMB Approval 0938-1395 (Expires 05/31/2024)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Timeliness	1.7	Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON)	Conduct timeliness test at the universe level on expedited pre-service reconsideration requests to determine whether the Sponsoring organization provided notification of its overturned decision no later than 72 hours after receipt of the request or forwarded its upheld decision to the IRE no later than 24 hours after affirmation of the determination or no later than 96 hours if the Sponsoring organization failed to provide the enrollee with the results of its reconsideration within the required timeframe. If the Sponsoring organization extended the timeframe, determine whether the Sponsoring organization provided notification of its overturned decision no later than 17 calendar days after receipt of the request or forwarded its upheld decision to the IRE no later than 24 hours after the affirmation of the determination or no later than 18 calendar days if the Sponsoring organization failed to provide the enrollee with the results of its reconsideration within the required timeframe. For DSNP-AIPs, the timeliness test will ensure written notification of the upheld reconsideration decision was also provided to the enrollee no later than 72 hours or 17 calendar days after receipt of the request.	42 CFR § 422.590(e) 42 CFR § 422.590(f) 42 CFR § 422.590(g) 42 CFR § 422.633(f) 42 CFR § 422.634(a)
Timeliness	1.8	Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON)	Conduct timeliness test at the universe level on expedited reconsideration requests for Part B drugs to determine whether the Sponsoring organization provided notification of its overturned decision no later than 72 hours after receipt of the request or forwarded its upheld decision to the IRE no later than 24 hours after affirmation of the determination or no later than 96 hours if the Sponsoring organization failed to provide the enrollee with the results of its reconsideration within the required timeframe. For DSNP-AIPs, the timeliness test will ensure written notification of the upheld reconsideration decision was also provided to the enrollee no later than 72 hours after receipt of the request.	42 CFR § 422.590(e) 42 CFR § 422.590(g) 42 CFR § 422.629(a)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Timeliness	1.9	Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C)	Conduct timeliness test at the universe level on payment organization determinations to determine whether the Sponsoring organization paid or denied claims from non-contracted providers and enrollees no later than 60 calendar days after receipt of the request.	42 CFR § 422.568(c) 42 CFR § 422.520(a)
Timeliness	1.10	Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C)	Conduct timeliness test at the universe level on payment reconsiderations to determine whether the Sponsoring organization paid overturned reconsideration claims from non-contracted providers and enrollees or forwarded its upheld decision to the IRE no later than 60 calendar days after receipt of the request. For DSNP-AIPs, the timeliness assessment will ensure whether the Sponsoring organization paid overturned reconsideration claims from non-contracted providers and enrollees or forwarded its upheld decision to the IRE no later than 30 calendar days after receipt of the request.	42 CFR § 422.590(b) 42 CFR § 422.618(a) 42 CFR § 422.633(f)
Timeliness	1.11	Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C)	Conduct timeliness test at the universe level on standard pre-service IRE cases in which the Sponsoring organization's determination was reversed in whole or in part by the IRE to determine whether the Sponsoring organization effectuated the decision within 14 calendar days after receipt of the notice reversing the determination.	42 CFR § 422.618(b) 42 CFR § 422.634(d)
Timeliness	1.12	Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C)	Conduct timeliness test at the universe level on standard Part B drug request IRE cases in which the Sponsoring organization's determination was reversed in whole or in part by the IRE to determine whether the Sponsoring organization authorized or provided the Part B drug under dispute within 72 hours after receipt of the notice reversing the determination.	42 CFR § 422.618(b) 42 CFR § 422.634(d)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Timeliness	1.13	Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C)	Conduct timeliness test at the universe level on expedited pre-service IRE cases in which the Sponsoring organization's determination was reversed in whole or in part by the IRE to determine whether the Sponsoring organization effectuated the decision within 72 hours after receipt of the notice reversing the determination.	42 CFR § 422.619(b) 42 CFR § 422.634(d)
Timeliness	1.14	Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C)	Conduct timeliness test at the universe level on expedited Part B drug request IRE cases in which the Sponsoring organization's determination was reversed in whole or in part by the IRE to determine whether the Sponsoring organization authorized or provided the Part B drug under dispute within 24 hours after receipt of the notice reversing the determination.	42 CFR § 422.619(b) 42 CFR § 422.634(d)
Timeliness	1.15	Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C)	Conduct timeliness test at the universe level on payment decisions reversed in whole or in part by the IRE to determine whether the Sponsoring organization paid for the service no later than 30 calendar days after receipt of the notice reversing the determination.	42 CFR § 422.618(b) 42 CFR § 422.634(d)
Timeliness	1.16	Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C)	Conduct timeliness test at the universe level on standard and expedited decisions overturned by an ALJ or the MAC to determine whether the Sponsoring organization authorized or provided the service under dispute no later than 60 calendar days after receipt of the notice of determination reversal.	42 CFR § 422.618(c) 42 CFR § 422.619(c) 42 CFR § 422.634(d)
Timeliness	1.17	Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C)	Conduct timeliness test at the universe level on standard and expedited Part B drug request decisions overturned by an ALJ or the MAC to determine whether the Sponsoring organization authorized or provided the Part B drug under dispute no later than 72 hours for standard requests or 24 hours for expedited requests after receipt of the notice of determination reversal.	42 CFR § 422.619(c) 42 CFR § 422.634(d)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Timeliness	1.18	Universe Table 5: Part C Standard and Expedited Grievances (GRV_C)	Conduct timeliness test at the universe level on standard grievances to determine whether the Sponsoring organization notified the enrollee of its decision no later than 30 days after receipt of the grievance. If the Sponsoring organization extended the timeframe, determine whether the Sponsoring organization notified the enrollee of its decision no later than 44 days after receipt of the grievance.	42 CFR § 422.564(e) 42 CFR § 422.630(e)
Timeliness	1.19	Universe Table 5: Part C Standard and Expedited Grievances (GRV_C)	Conduct timeliness test at the universe level on expedited grievances to determine whether the Sponsoring organization responded to the enrollee's grievance no later than 24 hours after receipt of the grievance.	42 CFR § 422.564(f) 42 CFR § 422.630(d)
Timeliness	1.20	Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP).	Conduct timeliness test at the universe level on adverse integrated organization determinations to determine whether the DSNP-AIP notified the enrollee of the decision to terminate, suspend, or reduce services no later than 10 calendar days prior to the action (that is, before the date on which a termination, suspension, or reduction of previously approved services becomes effective).	42 CFR § 422.631(d)
Timeliness	1.21	Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP).	Conduct timeliness test at the universe level on standard integrated reconsideration requests to determine whether the Applicable Integrated Plan provided written notice of its resolution to enrollees no later than 30 calendar days after the date the DSNP-AIP received the request. If the Sponsoring organization extended the timeframe, determine whether the Sponsoring organization provided notice of the resolution no later than 44 calendar days after receipt of the request.	42 CFR § 422.633(f)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Timeliness	1.22	Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)	Conduct timeliness test at the universe level on expedited integrated reconsideration requests to determine whether the DSNP-AIP provided written notice of its resolution to enrollees no later than 72 hours after the date the Applicable Integrated Plan received the request. If the Sponsoring organization extended the timeframe, determine whether the Sponsoring organization provided notice of the resolution no later than 17 calendar days after receipt of the request.	42 CFR § 422.633(f)
Processing of Coverage Requests	2.1	Universe Table 1: Standard and expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C) Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)	Select 30 denied requests from tables 1-3. The number of cases per record layout will vary. Additionally, select 5 denial cases from Table 6. Ensure sample set represents various medical services (e.g., ER services, outpatient hospital, inpatient hospital, urgent care, etc.). For each denial case, review case file documentation for proper notification of the denial decision. If the enrollee identified a representative, review case file to determine if notification was sent to the enrollee's representative. If a provider requested the coverage, review case file to determine if notification of decision was also sent to provider. Sample selections will be provided to the Sponsoring organization approximately one hour prior to the scheduled webinar.	42 CFR § 422.568(d) 42 CFR § 422.568(e) 42 CFR § 422.561 42 CFR § 422.572(a) 42 CFR § 422.590(d) 42 CFR § 422.631(d)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Processing of Coverage Requests	2.2	Universe Table 1: Standard and expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C) Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)	For the sampled cases review case file documentation to ensure a physician or other appropriate health care professional with sufficient medical and other expertise reviewed the determination.	42 CFR § 422.566(d) 42 CFR § 422.590(g) 42 CFR § 422.629(k)
Processing of Coverage Requests	2.3	Universe Table 1: Standard and expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C)	For each sampled denial case, review case file documentation for clinical accuracy.	42 CFR § 422.101(a) 42 CFR § 422.101(b) 42 CFR § 422.100(c)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Processing of Coverage Requests	2.4	Universe Table 1: Standard and expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)	For each sampled case, review case file for documentation to ensure an extension was appropriate.	42 CFR § 422.568(b) 42 CFR § 422.572(b) 42 CFR § 422.590(e) 42 CFR § 422.631(d)
Processing of Coverage Requests	2.5	Universe Table 1: Standard and expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)	For each case sampled, review case file documentation for proper downgrade from an expedited determination request to a standard determination and for proper notification to the enrollee that explains that the MA organization will process the request using the 14-day timeframe for standard determinations, informs the enrollee of the right to file an expedited grievance, informs the enrollee of the right to resubmit a request for an expedited determination with any physician's support, and provides instructions about the grievance process and timeframes.	42 CFR § 422.570(c) 42 CFR § 422.570(d) 42 CFR § 422.584(c) 42 CFR § 422.584(d) 42 CFR §422.631(d) 42 CFR §422.633(e)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Processing of Coverage Requests	2.6	Universe Table 1: Standard and expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON)	For each sampled case, review case file to determine if the Sponsoring organization applied step therapy only to new administrations of Part B drugs using at least a 365-day look back period.	42 CFR § 422.136(a)
Processing of Coverage Requests	2.7	Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)	For each sampled case, review case file to determine if the Applicable Integrated Plan continued benefits to enrollees who filed an appeal involving the termination, suspension, or reduction of a previously authorized service.	42 CFR §422.632
Classification of Requests	3.1	Universe Table 1: Standard and expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C)	Select 10 dismissed requests from Tables 1-3. Review case file documentation to determine if the request was appropriately dismissed or whether it should have been treated as a coverage request or grievance. Sample selections will be provided to the Sponsoring organization approximately one hour prior to the scheduled webinar.	42 CFR § 422.566 42 CFR § 422.578 42 CFR § 422.582 42 CFR § 422.584 42 CFR § 422.590 42 CFR § 423.564 42 CFR § 422.630

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Classification of Requests	3.2	Universe Table 5: Part C Standard and Expedited Grievances (GRV_C)	Select 20 grievance sample cases from Table 5. Sample both verbal and written grievances. Target samples that appear to: relate to quality of care; involve multiple issues and do not appear in the organization determination and reconsideration universes; and appear to be misclassified requests. Review case file documentation to determine if proper notification (i.e., written or verbal) was provided. If the Sponsoring organization extended the deadline, review case file for documentation stating how the delay is in the interest of the enrollee. Also review case file for written notification to the enrollee of the reason(s) for the delay. If the enrollee identified a representative, review case file to determine if notification was sent to the enrollee's representative.	42 CFR § 422.564(a) 42 CFR § 422.564(e) 42 CFR § 422.564(f) 42 CFR § 422.564(g) 42 CFR § 422.561 42 CFR §422.630

Program Audit Data Request

Audit Engagement and Universe Submission Phase

Universe Submissions
Sponsoring organizations must submit universe tables 1 - 5, comprehensive of all contracts and Plan Benefit Packages (PBP), identified in the audit engagement letter, in either Microsoft Excel (.xlsx) file format with a header row or Text (.txt) file format without a header row. Sponsoring organizations determined to be an Applicable Integrated Plan (AIP) must submit universe table 6 comprehensive of all contracts and/or PBPs offered as Dual Eligible Special Needs Plans only. Descriptions and clarifications of what must be included in each submission and data field are outlined in the individual universe record layouts below. Characters are required in all requested fields, unless otherwise specified, and data must be limited to the request specified in each record layout. Sponsoring organizations must provide accurate and timely universe submissions within 15 business days of the audit engagement letter date. Submissions that do not strictly adhere to the record layout specifications will be rejected. Sponsoring organizations may however enter the time within universes instead of 'None' if the time is not required per the field description.

Universe Requests

1. Universe Table 1: Standard and Expedited Pre-service Organization Determinations (OD) Record Layout
2. Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Record Layout
3. Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C) Record Layout
4. Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C) Record Layout
5. Universe Table 5: Part C Standard and Expedited Grievances (GRV_C) Record Layout
6. Universe Table 6: Dual Eligible Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)

Universe Record Layout	Scope of Universe Request*
Table 1 Table 2 Table 3 Table 4 Table 5 Table 6	Sponsoring organizations with MA/MAPD enrollment of – • <50,000 enrollees: submit the 12-week period preceding, and including, the date of the audit engagement letter. • ≥50,000 but <250,000 enrollees: submit the 8-week period preceding, and including, the date of the audit engagement letter. • ≥250,000 but <500,000 enrollees: submit the 4-week period preceding, and including, the date of the audit engagement letter. • ≥500,000 enrollees: submit the 2-week period preceding, and including, the date of the audit engagement letter.

***** CMS reserves the right to expand the review period to ensure sufficient universe size.

Please use the guidance below for the following record layout:

Universe Table 1: Standard and Expedited Pre-service Organization Determinations (OD) Record Layout

- Include all pre-service organization determination requests the Sponsoring organization approved, denied or dismissed during the universe request period. The date of the Sponsoring organization's determination (Column ID P) must fall within the universe request period.
- Include all pre-service requests for supplemental services that meet the criteria defined in 42 CFR § 422.100(c)(2).
- Include all pre-service organization determination requests for Part B drugs.
- If a pre-service organization determination includes more than one service, include all of the request's line items in a single row and enter the multiple line items as a single organization determination request.
    - Enter any request denied in whole or in part as denied.
- Enter all fields for a single request in the same time zone. For example, if the Sponsoring organization has systems in EST and CST, all data in a single line item must be in the same time zone.
- Exclude all requests processed as reconsiderations, payments, reopenings, and withdrawals.
    - Exclude all concurrent reviews for inpatient hospital services and inpatient SNF services, and notifications of admissions.
    - Exclude all requests for Value Added Items and Services.

Column ID	Field Name	Field Type	Field Length	Description
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee ID	CHAR Always Required	11	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.

Column ID	Field Name	Field Type	Field Length	Description
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234).
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the Sponsoring organization to provide administrative or health care services to an enrollee under the Part C or D program) that processed the request. Enter None if the Sponsoring organization processed the request.
G	Authorization or Claim Number	CHAR Always Required	40	Enter the associated authorization or claim number for this request. If an authorization or claim number is not available, enter the internal tracking or case number. Enter None if there is no authorization, claim or other tracking number available.
H	Date the request was received	CHAR Always Required	10	Enter the date the request was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01). If a standard request was upgraded to expedited, enter the date the request was upgraded.

Column ID	Field Name	Field Type	Field Length	Description
I	Time the request was received	CHAR Always Required	8	For all expedited requests and standard Part B drug requests, enter the time the request was received. Submit in HH:MM:SS military time format (e.g., 23:59:59). If a standard request was upgraded to expedited, enter the time the request was upgraded. Enter None for standard service requests and dismissed requests.
J	Part B Drug Request?	CHAR Always Required	1	Enter: • Y for Yes • N for No
K	AOR/Equivalent notice Receipt Date	CHAR Always Required	10	Enter the date the Appointment of Representative (AOR) form or equivalent written notice was received by the Sponsoring organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no AOR or equivalent written notice was received or required.
L	AOR/Equivalent notice Receipt Time	CHAR Always Required	8	For all expedited requests and standard Part B drug requests, enter the time the Appointment of Representative (AOR) form or equivalent written notice was received by the Sponsoring organization. Submit in HH:MM:SS format (e.g., 23:59:59). Enter None for standard service requests or if no AOR or equivalent written notice was received or required.
M	Request Determination	CHAR Always Required	9	Enter: • Approved • Denied • Dismissed

Column ID	Field Name	Field Type	Field Length	Description
N	Was the request processed as Standard or Expedited?	CHAR Always Required	1	Enter the manner by which the request was processed: • S for Standard • E for Expedited
O	Was a timeframe extension taken?	CHAR Always Required	1	Enter: • Y for Yes • N for No
P	Date of Determination	CHAR Always Required	10	Enter the date of the determination. Submit in CCYY/MM/DD format (e.g., 2020/01/01). For dismissed requests, enter the date the Sponsoring organization dismissed the request.
Q	Time of Determination	CHAR Always Required	8	For all expedited requests and standard Part B drug requests, enter the time of the determination. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard service requests and dismissed requests.
R	Date oral notification provided to enrollee	CHAR Always Required	10	Enter the date oral notification was provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no oral notification was provided.
S	Time oral notification provided to enrollee	CHAR Always Required	8	For all expedited requests and standard Part B drug requests, enter the time oral notification was provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard service requests, dismissed requests, or if no oral notification was provided.
T	Date written notification provided to enrollee	CHAR Always Required	10	Enter the date written notification of determination was provided to enrollee. Do not enter the date a letter is generated or printed. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no written notification was provided.

Column ID	Field Name	Field Type	Field Length	Description
U	Time written notification provided to enrollee	CHAR Always Required	8	For all expedited requests and standard Part B drug requests, enter the time written notification of determination was provided to enrollee. Do not enter the time a letter was generated or printed. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard service requests, dismissed requests, or if no written notification was provided.
V	Who made the request?	CHAR Always Required	3	Enter who made the request: • E for enrollee • ER for enrollee's representative or purported representative • CP for requests by a contract provider/facility • NCP for requests by a non-contract provider/facility
W	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service or item requested and why it was requested (if known). For denials, also provide an explanation of why the pre-service request was denied. For dismissed requests, provide the reason for dismissal.
X	Was an expedited request made but processed as standard?	CHAR Always Required	4	Enter: • Y for Yes if an expedited request was received but downgraded to standard • None for all other requests (e.g. the request was received as expedited and processed as expedited, the request was received as standard)
Y	Was the request denied for lack of medical necessity?	CHAR Always Required	4	Enter: • Y for Yes • N for No • None if the request was approved or dismissed.

Please use the guidance below for the following record layout:

Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Record Layout

- Include all pre-service reconsideration requests the Sponsoring organization approved, denied, auto-forwarded to the IRE or dismissed during the universe request period. The date of the Sponsoring organization's determination (Column ID P) must fall within the universe request period.
- Include all pre-service reconsideration requests for supplemental services that meet the criteria defined at 42 CFR § 422.100(c)(2).
- Include all pre-service reconsideration requests for Part B drugs.
- If a pre-service reconsideration includes more than one service, include all of the request's line items in a single row and enter multiple line items as a single reconsideration request. Enter any request denied in whole or in part as denied.
- Enter all fields for a single request in the same time zone. For example, if the Sponsoring organization has systems in EST and CST, all data in a single line item must be in a single time zone.
- Exclude all requests processed as organization determinations, payment requests, reopenings, and withdrawals.
- Exclude all requests for concurrent reviews for inpatient hospital and inpatient SNF services, and notifications of admissions.
- Exclude all requests for Value Added Items and Services.

Column ID	Field Name	Field Type	Field Length	Description
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee ID	CHAR Always Required	11	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.

Column ID	Field Name	Field Type	Field Length	Description
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234).
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the Sponsoring organization to provide administrative or health care services to an enrollee under the Part C or D program) that processed the request. Enter None if the Sponsoring organization processed the request.
G	Authorization or Claim Number	CHAR Always Required	40	Enter the associated authorization or claim number for this request. If an authorization or claim number is not available, enter the internal tracking or case number. Enter None if there is no authorization, claim or other tracking number available.

Column ID	Field Name	Field Type	Field Length	Description
H	Date the request was received	CHAR Always Required	10	Enter the date the reconsideration request was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01). If a standard request was upgraded to expedited, enter the date the request was upgraded. If the Sponsoring organization obtained information establishing good cause after the 60-day filing timeframe, enter the date the Sponsoring organization received the information establishing good cause.
I	Time the request was received	CHAR Always Required	8	For all expedited requests, enter the time the reconsideration request was received. Submit in HH:MM:SS military time format (e.g., 23:59:59). If a standard request was upgraded to expedited, enter the time the request was upgraded. If the Sponsoring organization obtained information establishing good cause after the 60-day filing timeframe, enter the time the Sponsoring organization received the information establishing good cause. Enter None for standard and dismissed requests.

Column ID	Field Name	Field Type	Field Length	Description
J	Part B Drug Request?	CHAR Always Required	1	Enter: • Y for Yes • N for No
K	AOR/Equivalent Notice Receipt Date	CHAR Always Required	10	Enter the date the Appointment of Representative (AOR) form or equivalent written notice was received by the Sponsoring organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no AOR or equivalent written notice was received or required.
L	AOR/Equivalent Notice Receipt Time	CHAR Always Required	8	For all expedited requests, enter the time the Appointment of Representative (AOR) form or equivalent written notice was received by the Sponsoring organization. Submit in HH:MM:SS format (e.g., 23:59:59). Enter None for standard requests or if no AOR or equivalent written notice was received or required.
M	Request Determination	CHAR Always Required	9	Enter: • Approved • Denied • Dismissed
N	Was the request processed as Standard or Expedited?	CHAR Always Required	1	Enter the manner by which the request was processed: • S for Standard • E for Expedited
O	Was a timeframe extension taken?	CHAR Always Required	1	Enter: • Y for Yes • N for No
P	Date of Determination	CHAR Always Required	10	Enter the date of the determination. Submit in CCYY/MM/DD format (e.g., 2020/01/01). For dismissed requests, enter the date the Sponsor dismissed the request.

Column ID	Field Name	Field Type	Field Length	Description
Q	Time of Determination	CHAR Always Required	8	For all expedited requests, enter the time of the determination. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard and dismissed requests.
R	Date oral notification provided to enrollee	CHAR Always Required	10	Enter the date oral notification was provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None for dismissed requests or if no oral notification was provided.
S	Time oral notification provided to enrollee	CHAR Always Required	8	For all expedited requests, , enter the time oral notification was provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard requests, dismissed requests, or if no oral notification was provided.
T	Date written notification provided to enrollee	CHAR Always Required	10	Enter the date written notification was provided to enrollee. Do not enter the date a letter is generated or printed. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no written notification was provided.
U	Time written notification provided to enrollee	CHAR Always Required	8	For all expedited requests, enter the time written notification was provided to enrollee. Do not enter the time a letter is generated or printed. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard requests, dismissed requests, or if no written notification was provided.

Column ID	Field Name	Field Type	Field Length	Description
V	Date reconsidered determination effectuated in the system	CHAR Always Required	10	Enter the date the reconsidered determination was effectuated in the system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if the determination was denied or dismissed.
W	Time reconsidered determination effectuated in the system	CHAR Always Required	8	For all expedited requests, enter the time the reconsidered determination was effectuated in the system. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard cases, dismissed cases, or if the request was denied.
X	Date forwarded to IRE	CHAR Always Required	10	Enter the date the request was forwarded to the IRE. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if the enrollee was notified of the approved reconsideration or if the request was not forwarded to the IRE.
Y	Time forwarded to IRE	CHAR Always Required	10	For all expedited requests, enter the time the request was forwarded to the IRE. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None if the enrollee was notified of the approved reconsideration, if the request was not forwarded to the IRE, or for standard requests.

Column ID	Field Name	Field Type	Field Length	Description
Z	Who made the request?	CHAR Always Required	3	Enter the person who made the request: • E for enrollee • ER for enrollee's representative or purported representative • CP for requests by a contract provider/facility • NCP for requests by a non-contract provider/facility
AA	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service or item requested and why it was requested (if known). For denials, also provide an explanation of why the pre-service request was denied. For dismissed requests, provide the reason for dismissal.
AB	Was an expedited request made but processed as standard?	CHAR Always Required	4	Enter: • Y for Yes if an expedited request was received but downgraded to standard • None for all other cases (e.g. the request was received as expedited and processed as expedited, the request was received as standard, or the request was dismissed).
AC	Was the initial organization determination request denied for lack of medical necessity?	CHAR Always Required	1	Enter: • Y for Yes • N for No

Please use the guidance below for the following record layout:

Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C) Record Layout

- Include all payment organization determinations and payment reconsiderations the Sponsoring organization approved, denied or dismissed from non-contract providers, enrollees, and non-contract pharmacies during the universe request period.

  Submit payment organization determinations (claims) based on the date the claim was paid (Column O) or notification of the denial to the provider (if provider submitted the claim - Column Q) or enrollee (if the enrollee submitted the claim – Column P). Submit payment reconsiderations based on the date the overturned reconsideration was paid or, for upheld reconsiderations, submit based on the date the case was forwarded to the IRE. Submit dismissed requests based on the date of the decision to dismiss (Column N).
- Include all payment requests for Part B drugs if applicable.
- Include all payment requests for supplemental services that meet the criteria defined at 42 CFR § 422.100(c)(2).
- If a payment organization determination or reconsideration includes more than one service, include all of the request's line items in a single row and enter the multiple line items as a single organization determination or reconsideration request.
  - Enter any request denied in whole or in part as denied.

  Enter all fields for a single case in the same time zone. For example, if the Sponsoring organization has systems in EST and CST, all data in a single line item must be in a single time zone.
- Exclude all payment requests processed as:
  - duplicate claims,
  - payment adjustments,
  - reopenings,
  - withdrawals, and
  - retrospective reviews.
- Exclude all requests for Value Added Items and Services.
- Exclude any payment requests that were denied due to:
  - invalid billing codes,
  - eligibility (i.e., enrollees who were not enrolled on the date of service, providers not accepting assignment), or
  - recoupment of payment, including pending determination of other primary insurance such as automobile, worker's compensation, etc.

Column ID	Field Name	Field Type	Field Length	Description
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.

Column ID	Field Name	Field Type	Field Length	Description
C	Enrollee ID	CHAR Always Required	11	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234).
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the Sponsoring organization to provide administrative or health care services to an enrollee under the Part C or D program) that processed the request. Enter None if the Sponsoring organization processed the request.
G	Authorization or Claim Number	CHAR Always Required	40	Enter the associated authorization or claim number for this request. If an authorization or claim number is not available, enter the internal tracking or case number. Enter None if there is no authorization, claim or other tracking number available.

Column ID	Field Name	Field Type	Field Length	Description
H	Date the request was received	CHAR Always Required	10	Enter the date the payment request was received. If the Sponsoring organization obtained information establishing good cause after the 60-day filing timeframe, enter the date the Sponsoring organization received the information establishing good cause. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
I	AOR/Equivalent notice Receipt Date	CHAR Always Required	10	Enter the date the Appointment of Representative (AOR) form or equivalent written notice was received by the Sponsoring organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None for dismissed requests or if no AOR or equivalent written notice was received or required.
J	Waiver of Liability (WOL) Receipt Date	CHAR Always Required	10	Enter the date the WOL form was received for non- contracted provider payment appeals. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None for ODs, enrollee submitted requests, or if a WOL was never received.
K	Was it a clean claim?	CHAR Always Required	4	Enter: • Y for clean claim • N for unclean claim • None for payment reconsiderations
L	Was the request processed as an OD or Recon?	CHAR Always Required	5	Enter the manner by which the request was processed: • OD • Recon

Column ID	Field Name	Field Type	Field Length	Description
M	Request Determination	CHAR Always Required	9	Enter: • Approved • Denied • Dismissed
N	Date of Determination	CHAR Always Required	10	Enter the date of the determination. Submit in CCYY/MM/DD format (e.g., 2020/01/01). This is the date the determination was entered in the system and may be the same as the date claim was paid. For dismissed requests, enter the date the Sponsoring organization dismissed the request.
O	Date claim/reconsideration was paid	CHAR Always Required	10	Enter the date the claim/reconsideration was paid. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if payment was not provided, if the request was denied, or if the request was dismissed.
P	Date written notification provided to enrollee	CHAR Always Required	10	Enter the date written notification was provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no written notification was provided.
Q	Date written notification provided to provider	CHAR Always Required	10	Enter the date written notification was provided to provider. Do not enter the date a letter is generated or printed. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no written notification was provided or if the enrollee submitted the request.

Column ID	Field Name	Field Type	Field Length	Description
R	Date forwarded to IRE	CHAR Always Required	10	Enter the date the reconsideration request was forwarded to the IRE. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None for organization determination requests, or if the reconsideration request was approved, dismissed, or not forwarded to the IRE.
S	Who made the request?	CHAR Always Required	3	Enter who made the request: • E for enrollee • ER for enrollee's representative or purported representative • NCP for requests by a non-contract provider/pharmacy
T	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service or item requested and why it was requested (if known). For denials, also provide an explanation of why the payment organization determination or payment reconsideration request was denied. For dismissed requests, please provide the reason for dismissal.
U	Was the initial organization determination request denied for lack of medical necessity?	CHAR Always Required	4	Enter: • Y for Yes • N for No • None if the request was approved or dismissed.

Please use the guidance below for the following record layout:

Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C) Record Layout

- Include all reconsiderations fully or partially overturned by the IRE, ALJ, or MAC requiring an effectuation as pre-service or post-service (payment) that were received from the IRE, ALJ, or MAC during the universe request period. The date of the Sponsoring organization's receipt of the overturn decision (Column ID J) must fall within the universe request period.
- Exclude any cases that were dismissed or upheld by the IRE, ALJ, or MAC.

Column ID	Field Name	Field Type	Field Length	Description
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee ID	CHAR Always Required	11	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234).
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).

Column ID	Field Name	Field Type	Field Length	Description
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the Sponsoring organization to provide administrative or health care services to an enrollee under the Part C or D program) that processed the request. Enter None if the Sponsoring organization processed the request.
G	Authorization or Claim Number	CHAR Always Required	40	Enter the associated authorization or claim number for this request. If an authorization or claim number is not available, enter the internal tracking or case number. Enter None if there is no authorization, claim or other tracking number available.
H	Type of reconsideration case	CHAR Always Required	9	Enter the type of reconsideration case submitted to IRE/ALJ/MAC: • Standard • Expedited • Payment For pre-service cases, enter Standard or Expedited. For post-service cases, enter Payment.
I	Review Entity	CHAR Always Required	3	Enter the entity that overturned the decision: • IRE • ALJ • MAC

Column ID	Field Name	Field Type	Field Length	Description
J	Date the overturned decision was received	CHAR Always Required	10	Enter the date the overturned decision was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
K	Time the overturned decision was received	CHAR Always Required	8	For expedited requests and Part B drug requests, enter the time the overturned decision was received. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for Standard (pre-service) and Payment reconsideration cases.
L	Part B Drug Request?	CHAR Always Required	1	Enter: • Y for Yes • N for No
M	Date overturned decision or payment effectuated in the system	CHAR Always Required	10	Enter the date overturned decision effectuated in the system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if the overturned decision was not effectuated.
N	Time overturned decision or payment effectuated in the system	CHAR Always Required	8	For expedited requests and Part B drug requests, enter the time the overturned decision was effectuated in the system. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard service requests and payment reconsideration cases, or if the overturned decision was not effectuated.

Please use the guidance below for the following record layout:

Universe Table 5: Part C Standard and Expedited Grievances (GRV_C) Record Layout

- Include all grievances the Sponsoring organization responded to during the universe request period. The date of the Sponsoring organization's notification (Column ID Q or S) must fall within the universe request period.
- Grievances with multiple issues must be entered as a single line item, unless the Sponsoring organization issued separate notifications.
- Exclude all grievances that were withdrawn and dismissed during the universe request period.
- Exclude complaints filed only within the Complaints Tracking Module (CTM) in HPMS. If a complaint was processed both within the CTM and was also received as a grievance, exclude the CTM complaint but include the grievance as processed by the Sponsoring organization.
- Sponsoring organizations determined to be an applicable integrated plan as defined by 42 CFR § 422.561 should populate the universe with grievances related to Medicare coverage only.

Column ID	Field Name	Field Type	Field Length	Description
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee ID	CHAR Always Required	11	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234).

Column ID	Field Name	Field Type	Field Length	Description
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the Sponsoring organization to provide administrative or health care services to an enrollee under the Part C or D program) that processed the grievance. Enter None if the Sponsoring organization processed the grievance.
G	Date the grievance was received	CHAR Always Required	10	Enter the date the grievance was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
H	Time the grievance was received	CHAR Always Required	8	Enter the time the grievance was received. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard cases.
I	AOR/Equivalent notice Receipt Date	CHAR Always Required	10	Enter the date the Appointment of Representative (AOR) form or equivalent written notice was received by the Sponsoring organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no AOR or equivalent written notice was received or required.

Column ID	Field Name	Field Type	Field Length	Description
J	AOR/Equivalent notice Receipt Time	CHAR Always Required	8	For expedited grievances, enter the time the Appointment of Representative (AOR) form or equivalent written notice was received by the Sponsoring organization. Submit in HH:MM:SS format (e.g., 23:59:59). Enter None for standard grievances or if an AOR or equivalent written notice was not received or required.
K	How was the grievance received?	CHAR Always Required	7	Enter the method of receipt of the grievance: • Oral • Written
L	Was the grievance processed as Standard or Expedited?	CHAR Always Required	1	Enter how the grievance was processed: • S for Standard • E for Expedited
M	Category of the issue	CHAR Always Required	50	Enter the category of the grievance as assigned by the Sponsoring organization. Enter based on the Sponsoring organization's internal labeling system.
N	Grievance Description	CHAR Always Required	1,800	Enter a description of the grievance.
O	Was this processed as a quality of care grievance?	CHAR Always Required	1	Enter: • Y for Yes • N for No
P	Was a timeframe extension taken?	CHAR Always Required	1	Enter: • Y for Yes • N for No
Q	Date oral notification provided to enrollee	CHAR Always Required	10	Enter the date oral notification was provided to the enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no oral notification was provided.

OMB Approval 0938-1395 (Expires 05/31/2024)

Column ID	Field Name	Field Type	Field Length	Description
R	Time oral notification provided to enrollee	CHAR Always Required	8	Enter the time oral notification was provided to the enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard grievances, or if no oral notification was provided.
S	Date written notification provided to enrollee	CHAR Always Required	10	Enter the date written notification was provided to enrollee. Do not enter the date a letter is generated or printed. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if a written notification was not provided.
T	Time written notification provided to enrollee	CHAR Always Required	8	Enter the time written notification was provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard cases, or if written notification was not provided.
U	Who made the request?	CHAR Always Required	2	Enter who made the request: • E for enrollee • ER for enrollee's representative or purported representative

Please use the guidance below for the following record layout:

Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP) Record Layout

- The AIP record layout must be submitted by all Sponsoring organizations determined to be an applicable integrated plan as defined by 42 CFR § 422.561 and have been notified by CMS of their status.
- Include all integrated organization determination cases ***where a previously approved service is being reduced, suspended, or terminated by the DSNP-AIP***. The date the DSNP-AIP notified the enrollee must fall within the universe request period (Column ID H).
- Populate this Table with requests involving Medicare-coverable benefits only.
- Exclude all pre-service cases.

Column ID	Field Name	Field Type	Field Length	Description
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee ID	CHAR Always Required	11	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non- intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11- digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234).
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).

Column ID	Field Name	Field Type	Field Length	Description
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the Sponsoring organization to provide administrative or health care services to an enrollee under the Part C or D program) that processed the request. Enter None if the Sponsoring organization processed the request.
G	Authorization or Claim Number	CHAR Always Required	40	Enter the associated authorization or claim number for this request. If an authorization or claim number is not available, enter the internal tracking or case number. Enter None if there is no authorization, claim or other tracking number available.
H	Date DSNP-AIP notified enrollee of its decision to reduce, suspend or terminate services	CHAR Always Required	10	Enter the date the DSNP-AIP notified the enrollee of the reduction, suspension, or termination. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
I	Effective date of reduction, suspension, or termination of services	CHAR Always Required	10	Indicate the intended date of action (that is, the date on which reduction, suspension, or termination became effective). Submit in CCYY/MM/DD format (e.g., 2020/01/01).
J	Was the decision appealed?	CHAR Always Required	1	Enter: • Y for Yes • N for No If 'N' is entered, populate all remaining fields with None.

Column ID	Field Name	Field Type	Field Length	Description
K	Who made the request?	CHAR Always Required	4	Enter who made the plan level appeal: • E for enrollee • ER for enrollee's representative or purported representative • CP for requests by a contract provider/facility • NCP for requests by a non-contract provider/facility Enter None if the decision was not appealed as indicated by N in column ID J.
L	Date the appeal was received	CHAR Always Required	10	Enter the date the request was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if the decision was not appealed as indicated by N in column ID J.
M	AOR/Equivalent notice receipt date	CHAR Always Required	10	Enter the date the Appointment of Representative (AOR) form or equivalent written notice was received by the Sponsoring organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None for dismissed requests, if no AOR or equivalent written notice was received or required, or if the decision was not appealed as indicated by N in column ID J.
N	Was the appeal processed as Standard or Expedited?	CHAR Always Required	4	Enter the manner by which the appeal was processed: • S for Standard • E for Expedited Enter None if the decision was not appealed as indicated by N in column ID J.

Column ID	Field Name	Field Type	Field Length	Description
O	Was appeal made under the expedited timeframe but processed by the plan under the standard timeframe?	CHAR Always Required	4	Yes (Y)/No (N) indicator of whether the request was received as expedited but was downgraded and processed under the standard timeframe (e.g., based on the DSNP-AIP deciding that the expedited plan level appeal was unnecessary). Enter None if the request was received as a standard request or if the decision was not appealed as indicated by N in column ID J.
P	Was a timeframe extension taken?	CHAR Always Required	4	Yes (Y)/No (N) indicator of whether the DSNP-AIP extended the timeframe to make the appeal decision. Enter None if the decision was not appealed as indicated by N in column ID J.
Q	Did the enrollee request continuation of benefits?	CHAR Always Required	4	Yes (Y)/No (N) indicator of whether the enrollee requested continuation of benefits. Enter None if someone other than the enrollee requested continuation of benefits or if the decision was not appealed as indicated by N in column ID J.
R	Were the benefits under appeal provided to the enrollee during the plan level appeal process?	CHAR Always Required	4	Yes (Y)/No (N) indicator of whether the benefits under appeal were provided to the enrollee during the reconsideration process. Enter None if no request for continuation of benefits was made or if the decision was not appealed as indicated by N in column ID J.

Column ID	Field Name	Field Type	Field Length	Description
S	Request Disposition	CHAR Always Required	9	Enter: • Approved • Denied • Dismissed Enter None if the decision was not appealed as indicated by N in column ID J.
T	Date of DSNP- AIP decision	CHAR Always Required	10	Date of the DSNP-AIP decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if the decision was not appealed as indicated by N in column ID J.
U	Date oral notification provided to enrollee	CHAR Always Required	10	Date oral notification provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no oral notification provided or if the decision was not appealed as indicated by N in column ID J.
V	Date written notification provided to enrollee/provider	CHAR Always Required	10	Date written notification provided to enrollee, or if applicable the non-contract provider. Do not enter the date when a letter is generated or printed within the DSNP-AIP's organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no written notification was provided or if the decision was not appealed as indicated by N in column ID J.

Column ID	Field Name	Field Type	Field Length	Description
W	Date reconsidered determination effectuated in the DSNP-AIP system	CHAR Always Required	10	Date reconsidered determination effectuated in the DSNP-AIP 's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None for denials and or if the decision was not appealed as indicated by N in column ID J.
X	Date forwarded to IRE if denied or untimely	CHAR Always Required	10	Date the AIP forwarded request to the IRE if request for Medicare service was denied or processed untimely. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if approved or not forwarded to IRE or if the decision was not appealed as indicated by N in column ID J.
Y	If request denied, date services were terminated, reduced, suspended	CHAR Always Required	10	Enter the date the services were terminated, reduced, suspended. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if the reconsideration was approved or if the decision was not appealed as indicated by N in column ID J.

Audit Field Work Phase

Supporting Documentation Submissions

Each case will be evaluated to determine whether the Sponsoring organization is compliant with its Part C contract requirements. To facilitate this review, the Sponsoring organization must have access to, and the ability to save and upload screenshots of, supporting documentation and data relevant for a particular case, including, but not limited to:

- Original pre-service or payment (i.e., claim or reimbursement request) or reconsideration request.
  - If request was received via fax/mail/email, copy of original request including date/time stamp of receipt.
  - If request was received via phone, copy of Customer Service Representative (CSR) notes and/or documentation of call including date/time stamp of call and call details.
  - If a request was received via a chat feature that is available on the sponsoring organization's website, copy of the transcript.
  - If request was received from a representative or NCP (payment reconsiderations), copy of the AOR or equivalent written notice/WOL received.
- Letters, emails or documentation confirming the Sponsoring organization's receipt of the request:
  - If request was received via fax/mail/email, copy of original request.
  - If request was received via phone, copy of CSR notes and/or documentation of call.
- Description of the service/benefit requested from the provider/physician or the enrollee.
- Notices, letters, call logs or other documentation showing the Sponsoring organization requested additional information (if applicable) from the requesting provider/physician, including type of communication. If the request was made via phone call, copy of the call log detailing what was communicated to the physician/provider.
- All supplemental information submitted by the requesting provider/physician or enrollee.
  - If information was received via fax/mail/email, copy of original request.
  - If information was received via phone, copy of CSR notes and/or documentation of call.
- Documentation of case review steps including name and title of final reviewer; clinical criteria that supports rationale for denial; any reference to CMS guidance, Federal Regulations, clinical criteria, peer reviewed literature (where allowed), and Sponsoring organization documents (e.g., EOC); or any other documentation used when considering the request.
- Documentation of effectuation including approval in organization determinations/reconsiderations systems and evidence of effectuation in Sponsoring organization's claims adjudication system.
- Documentation showing approval notification to the enrollee and/or their representative and physician/provider, as applicable.
  - Copy of the written decision letter;
  - If oral notification was given, copy of CSR notes and/or documentation of call.
- Records indicating that payments were made/issued such as EFT records.
- Documentation showing denial notification to the enrollee and/or their representative and provider/physician, if applicable:
  - Copy of written decision letter;
  - If oral notification was given, copy of CSR notes and/or documentation of call.

- Documentation showing reconsideration denial notification to the enrollee and/or their representative and provider/physician, if applicable:
  - Copy of written decision letter;
  - If oral notification was given, copy of CSR notes and/or documentation of call.
- If applicable, all documentation to support the Sponsoring organization's decision to process an expedited request under the standard timeframe, including any pertinent medical documentation, and any associated notices provided to the enrollee and the requesting provider/physician.
- If applicable, providing timely notification of dismissed requests to enrollees or another party, and informing enrollees and other parties about the right to request IRE review of the dismissed request since Sponsoring organizations will no longer automatically forward such reconsideration cases to the IRE for review.
- ANOC/EOC to support application of Step Therapy to Part B drugs
- For reconsiderations, all documentation outlined for both the original determination and the reconsideration.
- If reconsidered case was untimely, include the following:
  - Documentation showing the Sponsoring organization auto-forwarded the request to the IRE.
- Copy of overturn notice from IRE/ALJ/MAC.
- Copy of effectuation notice sent to IRE.
- Initial Complaint and any other supplemental documentation explaining the issue:
  - If complaint was received via fax/mail/email, copy of original complaint including date/time stamp of receipt;
  - If complaint was received via phone, copy of CSR notes and/or documentation of call including date/time of call and call details.
- Where applicable, copy of all notices, letters, call logs, or other documentation showing when the Sponsoring organization acknowledged receipt of the grievance to the enrollee, and/or requested additional information from the enrollee and/or their representative, including the date and time of the acknowledgement. If the request was made via phone call, copy of the CSR notes and/or documentation of call, as well as what was communicated to the enrollee.
- Documentation of all supplemental information submitted by enrollee and/or their representative:
  - If information was received via fax/mail/email, copy of documentation provided including date/time stamp of receipt;
  - If information was received via phone, copy of CSR notes and/or documentation of call including date/time of call and call details.
- Documentation showing the steps the Sponsoring organization took to resolve the issue and a description of the final resolution. Documentation showing the steps the Sponsoring organization took to resolve the issue may include, but is not limited to, appropriate correspondence with other departments within the organization; referral to the Sponsoring organization's fraud, waste, and abuse department; and outreach to providers.
- Documentation showing the Sponsoring organization's investigation, follow-up steps, and description of the final grievance outcome. Include all notices, letters, and enrollee communications.
- Documentation showing resolution notification to the enrollee and/or their representative:
  - Copy of the written decision letter sent and documentation of date/time letter was printed and mailed.

  - If oral notification was given, copy of CSR notes and/or documentation of call including date/time stamp.
- Documentation that supports a Sponsoring organizations record layout population (e.g. mailroom policies).

Sponsoring organizations are expected to submit supporting documentation within two business days of the request.

Root Cause Analysis Submissions
Sponsoring organizations may be required to provide a root cause analysis using the Root Cause Template provided by CMS. Sponsoring organizations have two business days from the date of the request to respond.

Impact Analysis Submissions
When non-compliance with contract requirements is identified on audit, Sponsoring organizations must submit each requested impact analysis, comprehensive of all contracts and Plan Benefit Packages (PBP) identified in the audit engagement letter, in either Microsoft Excel (.xlsx) file format with a header row or Text (.txt) file format without a header row using one of the universe record layouts above, as specified by CMS. The Sponsoring organization must include all requests impacted by the issue of non-compliance during the impact analysis request period. Sponsoring organizations must provide accurate and timely impact analysis submissions within 10 business days of the request. Submissions that do not strictly adhere to the record layout specifications will be rejected.

Verification of Information Collected: CMS may conduct integrity tests to validate the accuracy of all universes, impact analyses, and other related documentation submitted in furtherance of the audit. If data integrity issues are noted, Sponsoring organizations may be required to resubmit their data.

Att 20 - Payment Organization Determinations and Reconsiderations (PYMT_C)

A	B	C	D	E	F	G	H	I	J	K	L
Enrollee First Name	**Enrollee Last Name**	**Enrollee ID**	**Contract ID**	**Plan Benefit Package (PBP)**	**First Tier, Downstream, and Related Entity.**	**Authorization or Claim Number**	**Date the Request was Received**	**AOR/Equivalent notice Receipt Date**	**Waiver of Liability (WOL) Receipt Date**	**Was it a Clean Claim?**	**Was the request processed as an OD or Recon?**
First name of the enrollee.	Last name of the enrollee.	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.	The contract number of the organization. ***Note: H5355 identifies the CMC line of business***	Enter the PBP. ***Note: IEHP's assigned PBP is 001***	Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the sponsoring organization to provide administrative or health care services to an enrollee under the Part C or D program) that processed the request. Enter None if the sponsoring organization processed the request.	Enter the associated authorization or claim number for this request. If an authorization or claim number is not available, enter the internal tracking or case number. Enter None if there is no authorization, claim or other tracking number available.	Enter the date the payment request was received. If the sponsoring organization obtained information establishing good cause after the 60-day filing timeframe, enter the date the MMP received the information establishing good cause. Submit in CCYY/MM/DD format (e.g., 2020/01/01).	Enter the date the Appointment of Representative (AOR) form or equivalent written notice was received by the Sponsoring organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None for dismissed requests or if no AOR or equivalent written notice was received or required.	Enter the date the WOL form was received for noncontracted provider payment appeals. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter **None** for ODs, enrollee submitted requests, or if a WOL was never received.	Enter **Y** for clean claim, **N** for unclean claim, or **None** for payment reconsiderations.	The manner by which the request was processed. Enter **OD** or **Recon**

M	N	O	P	Q	R	S	T
Request Determination	**Date of Determination**	**Date Claim/Reconsideration was paid**	**Date Written Notification Provided to Enrollee**	**Date Written Notification Provided to Provider**	**Date forwarded to IRE**	**Who made the request?**	**Issue Description and Type of Service**
Status of the request. Valid values are: **Approved**, **Denied** or **Dismissed**	Enter the date of the determination. Submit in CCYY/MM/DD format (e.g., 2020/01/01). This is the date the determination was entered in the system and may be the same as the date claim was paid. For dismissed requests, enter the date the Sponsoring organization dismissed the request.	Enter the date the claim/reconsideration was paid. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter **None** if payment was not provided, if the request was denied, or if the request was dismissed.	Enter the date written notification was provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter **None** if no written notification was provided.	Enter the date written notification was provided to provider. Do not enter the date a letter is generated or printed. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter **None** if no written notification was provided or if the enrollee submitted the request.	Enter the date the payment appeal was forwarded to the IRE. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter **None** for organization determination requests, or if the reconsideration request was approved, dismissed, or not forwarded to the IRE	Who made the request. Enter **E** for enrollee, **ER** for enrollee's representative or purported representative, or **NCP** for requests by a non-contract provider/pharmacy.	Provide Procedure Code followed directly by a dash (-) with no space, followed directly by the description. If there are multiple services, list them all here as specified above delimited by a comma. For denials, also provide an explanation of why the determination or request was denied. For dismissed requests, provide the reason for dismissal.

U
Was the initial Organization Determination request denied for lack of medical necessity?
Enter **Y** for Yes, **N** for No or **None** if the request was approved or dismissed.

November 10, 2021

Member Name:
IEHP ID #:
Patient Account #:
Claim #:
Total Billed Amount:
Date Received:

Dear Provider:

Inland Empire Health Plan is in receipt of your appeal regarding a denied claim(s) for services provided to the above member on 00/00/0000.

As a non-contracted provider, you have the right to file a standard appeal for a denied claim only after you have completed the attached waiver of liability statement, which indicates that you will not bill the member regardless of the outcome of the appeal.

If you wish to proceed with the appeal request, please complete the enclosed Waiver of Liability Statement within sixty (60) calendar days along with your supporting documentation and submit to:

IEHP Medicare Dual Choice
Attn: Provider Claims Appeals
P.O. Box 40
Rancho Cucamonga, CA 91729
Fax Number: (909) 890-5747

IEHP will initiate the review of your appeal request once we have received once we have received a properly executed signed Waiver of Liability. Request for appeals from non-contracted providers, where the appropriate document is not received within sixty (60) calendar days, will be dismissed.

Please reference the claim and case numbers listed above on any correspondence to ensure that all information is considered prior to making a final determination.

If you have any questions or need additional assistance, please contact the Provider Relations team at (909) 890- 2054.

Sincerely,

Claims Appeals Resolution Specialist
Inland empire Health Plan

Enclosure: Waiver of Liability Statement

IEHP Medicare Dual Choice
WAIVER OF LIABILITY STATEMENT

Enrollee's Name _____ Medicare/HIC Number _____

Provider Name _____ Dates of Service _____

Health Plan _____

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.

Physician Signature _____ Date _____

Enclosure: Waiver of Liability Statement