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## **20. CLAIMS PROCESSING**

### **A. Claims Processing**

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#### **APPLIES TO:**

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

#### **POLICY:**

- A. All Capitated Providers are delegated the responsibility of claims processing for non-Capitated services and are subject to review by IEHP. IEHP provides oversight of the Capitated Providers by monitoring, reviewing, and measuring claims processing systems and dispute resolution mechanisms to ensure timely and accurate claims processing and dispute resolution.
- B. Contracted providers of service must be given at least 90 days to submit a claim. Non-contracted Medi-Cal providers of service have up to one year from the date of service to submit a claim.
- C. Capitated Providers must identify and acknowledge the receipt of all claims within 2 working days if the claim was received electronically or within 15 working days if a paper claim was received.
- D. Misdirected claims must be forwarded to the appropriate financially responsible entity within 10 working days of receipt.
- E. Capitated Providers must pay or deny all complete (clean) claims for non-contracted providers providing services to Medi-Cal Members within 30 calendar days of receipt of the claim. Complete claims for contracted providers must be paid or denied within 45 working days, or within other contractual timeframes.
- F. Late payment of claims requires payment of interest penalties within 5 working days of the claim payment date.
- G. Overpayments or adjustments must be identified and written notification sent to providers of service within 365 days of the date the original claim was paid. Providers of service must either contest or pay the requested monies within 30 working days of receipt of the notification of overpayment or adjustment.
- H. All Capitated Providers must have a dispute resolution mechanism in place that allows providers of service to file a dispute within 365 days of payment or denial. All disputes must be acknowledged within 2 working days if received electronically and 15 working days if a paper dispute was received. All disputes must be resolved within 45 working days of receipt of the dispute.
- I. All claims must be processed (paid or denied), and disclosures made in accordance with federal and state laws and regulations governing all IEHP Programs, plus all other applicable laws, regulations, and contractual stipulations pertaining to IEHP standards.

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#### **PROCEDURE:**

- A. Capitated Providers must have written procedures for claims processing that are available for review. In addition, Capitated Providers must disclose claims filing instructions, fee schedules and provider dispute filing guidelines, via contract, written notification, Explanation of Benefits (EOB) or Remittance Advice (RA) at the time of payment, denial or adjustment, and/or via a website, as applicable. These written procedures and disclosures must comply with state, federal and IEHP contractual standards and requirements. Such disclosures must also be made available upon request to providers of service, IEHP, or a regulatory agency. For a sample of IEHP's RA, (see Attachment 20-4 in Section 20, "Attachments").
- B. The claims processing systems for Capitated Providers must identify and track all claims and disputes by line of business and/or program, as well as claims related phone calls and inquiries, and be able to produce claims and dispute related reports as outlined in Policy 20H, "Claims and Provider Dispute Reporting."
- C. Contracted providers of service must be given no less than 90 days and no greater than 1 year, from the date of service, to submit claims.
- D. Non-contracted Medi-Cal providers of service must submit claims within 180 days after the month of service to be eligible for full reimbursement. Claims may be submitted up to 1 year from the date of service, subject to the following reductions for any claims received after 180 days:
1. Claims received in the 7<sup>th</sup> through the 9<sup>th</sup> month, after the month of service, are subject to a payment reduction of 25%;
  2. Claims received in the 10<sup>th</sup> through 12<sup>th</sup> month after the month of service are subject to a payment reduction of 50%;
  3. Claims submitted after 1 year from the date of service can be denied;
  4. Timely filing reductions are applied only to non-contracted Medi-Cal providers and on original received claims. They do not apply to subsequent adjustments.
- E. Claims should be filed in accordance with the financially responsible Payor's submission requirements. Claims involving IEHP as the Payor should be submitted to:
- Inland Empire Health Plan  
P.O. Box 10129  
San Bernardino, CA 92423
- Claims involving PCP P4P reimbursement should be filed in accordance with Policy 19C, "Pay for Performance."

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- F. Claims submitted after the filing deadline can be denied unless substantiating documentation for good cause associated with the delay in billing or proof of timely filing is provided. Disputes filed by providers of service subsequent to the denial of the claim for untimely filing must include proof of timely filing as defined below or other substantiating documentation of good cause for the delay in order to be reconsidered for payment. IEHP considers adequate proof of timely filing to be one or more of the following:
1. Claim determination letter or EOB/RA from IEHP or one of IEHP's contracted Capitated Providers (see Attachment 20-4 in Section 20, "Attachments").
  2. Copy of a written request for information or other written claim-related correspondence from IEHP or one of IEHP's Capitated Providers, dated and printed on letterhead or form letter with the date and letterhead clearly identified.
  3. Determination letter from other insurance carriers or other financially responsible entities such as CCS or Medicare, dated and printed on letterhead, in which the date of determination is documented, that demonstrates the provider originally presented the claim within the claims filing timelines permitted by law and/or written contractual agreement from the date of receipt of the determination.
  4. Financial ledgers with multiple claim billings for the date of service in question, including name of the billed party (i.e., IEHP, Capitated Provider, Medicare, HMO, etc.).
  5. Computer generated claim transaction history that includes the billing history of the claim and history of timely and consistent follow-up attempts made to the original billed entity within the timely filing guidelines permitted by law and/or written contractual agreement. Detailed history should include billing dates and/or ledgers that show follow-up dates, contact names, time of calls (if applicable) and/or address to which the claim was sent.
  6. Other documentation that demonstrates good cause for the delay in being able to submit the claim timely.
- G. Capitated Providers must have the systems in place and be able to identify and acknowledge the receipt of each claim, whether or not complete, and disclose the recorded date of receipt in the same manner as the claim was submitted.
1. If the claim was received electronically, acknowledgement must be provided within 2 working days of receipt of the claim.
  2. If the claim was a paper claim, acknowledgement must be provided within 15 working days of receipt of the claim.
- H. Capitated Providers must redirect or deny claims that are not their financial responsibility within 10 working days, as follows:

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1. Claims in which the Capitated Provider has an affiliated network relationship with the financially responsible Payor, including both emergency and non-emergency service claims must be forwarded to the financially responsible entity. This includes IEHP as the health plan when the health plan is the financially responsible Payor.
  2. If the Member cannot be identified or the financially responsible entity is not affiliated with the Capitated Provider's network, the claim should be denied and/or returned to the provider of service advising the billing provider to verify eligibility assignment and to bill the appropriate responsible party.
  3. All forwarded and denied misdirected claims must be tracked and reported as outlined in Policy 20H, "Claims and Provider Dispute Reporting."
- I. Complete (clean) claims are those claims and attachments or other documentation that include all reasonably relevant information necessary to determine Payor liability. To be considered a complete claim, the claim should be prepared in accordance with the National Uniform Billing Committee standards, and should include, but is not limited to the following information:
1. A claim form that contains:
    - a. A description of the service rendered using valid CPT, ICD9, HCPCS, and/or Revenue codes, the number of days or units for each service line, the place of service code and the type of service code;
    - b. Member (patient) demographic information;
    - c. Provider of service name, address, National Provider Identifier (NPI) number and tax identification number;
    - d. Date(s) of service;
    - e. Amount billed;
    - f. Signature of person submitting payment; and
    - g. Other documentation necessary in order to adjudicate the claim, such as medical or emergency room reports, claims itemization or detailed invoice, medical necessity documentation, other insurance payment information and referring provider information (or copy of referral) as applicable
  2. Proof of Member eligibility on the date(s) services were rendered.
  3. Prior authorization documentation, such as an authorization number on the claim, a copy of the authorization form or referral form attached to the claim for services in which authorization is required.

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- J. Incomplete claims or claims that require medical records in order to make a determination of Payor liability, must be coded as “pended” and a request for additional information sent to the provider of service.
1. The Capitated Provider must make at least one request to the provider of service for any reasonably relevant information necessary to process the claims and/or determine Payor liability, including medical records. The request must include a clear, accurate and written explanation of the necessity of the request and must be made within 15 days of receipt of the claim.
  2. If the requested information is received, the Capitated Provider must adjudicate (pay or deny the claim) based on the new information, within 45 working days from the date of receipt of the additional information if a contracted provider, or 30 calendar days if a non-contracted provider.
  3. If the requested information is not received, the claim must be denied in writing within 45 working days from the date of receipt of the claim for a contracted provider or 30 calendar days for a non-contracted provider. The denial must identify the individual or entity that was requested to submit information, the specific documents requested and the reason(s) why the information is necessary to determine Payor liability.
  4. All claims, including pended claims, must be paid or denied within mandated timeframes.
- K. Claims received from contracted providers must be appropriately paid or denied within 45 working days from receipt of a complete claim. Claims from non-contracted providers rendering services to Medi-Cal Members must be paid or denied within 30 calendar days of receipt.
1. This standard is based on the timeframe from the day after the date of receipt of the claim (e.g., date stamp) until the check or denial is mailed to the provider of service, regardless of when the check is dated.
  2. The payment date used to meet timeliness standards is the actual date the check is mailed, deposited into the provider of service’s account, or transferred electronically, regardless of the date on the check. Proof of mailing must be maintained, including a signed attestation of the date of mailing, the check number and the check amount.
  3. The date of receipt is the date the claim is first received by the financially responsible entity as indicated by its date stamp on the claim. In cases of a misdirected claim, the date of receipt is the date the claim is first received by the financially responsible entity. Claims with multiple date stamps should be deemed priority and processed immediately.
- L. Any claim, whether from a contracted or non-contracted provider, that is not paid at billed charges must include an explanation of the adjustment (i.e., contract rate), language

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involving balance billing of the member and the process for filing a dispute of the paid amount, on the EOB/RA (see Attachment 20-4 in Section 20, “Attachments”).

- M. Reimbursement for services rendered to an IEHP Medi-Cal Member by a non-contracted provider is as follows:
1. For outpatient services, the Fee for Service rates specified in the Medi-Cal schedule of reimbursement (RFO500); or
  2. Inpatient Facility claims are paid at the prevailing rate established by Section 6085 of the Federal Deficit Reduction Act (DRA) of 2005, also known as the “Rogers Amendment.” This rate applies regardless of CMAC participation status.
  3. For emergency services, the ER rate listed in the Medi-Cal schedule of reimbursement (RFO500).
  4. For Family Planning claims, the family planning rates listed for the procedure codes and diagnosis billed as outlined in Senate Bill 94, effective January 1, 2008.
- N. An interest penalty must automatically be paid on any claim not paid within the required timeframe, beginning with the first calendar day after the 45 working day period. The 45 working day requirement for the payment of interest applies to both contracted and non-contracted providers. Failure to pay interest due automatically requires a \$10.00 late fee to be paid in addition to any interest due.
1. Automatically means that interest due to the provider of service must be paid within 5 working days of the payment of the claim or dispute resolution determination resulting in payment of additional monies, without the need for any reminder or request by the provider of service.
  2. For claims not paid within the required timeframe, or that are identified as underpaid, interest must be paid for the period of the time that the payment is late or underpaid portion as follows:
    - a. Non-emergency claims, including adjustments - 15% per annum, per claim; or
    - b. Emergency service claims, including adjustments - the greater of \$15 per claim for each 12 month period or portion thereof, on a non-prorated basis; or 15% per annum.
    - c. Interest is due for each **calendar** day exceeding the 45<sup>th</sup> working day, beginning with the first calendar day after the 45<sup>th</sup> working day.
  3. If the amount of interest due on an individual claim is less than \$2.00 at the time the claim is paid, the interest on that claim or other such claims must be paid within 10 days of the close of the month in which the claim was paid.
  4. Depending on the circumstances surrounding the claim or adjustment, interest methodology is as follows:

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- a. New clean claims should calculate interest based on the period of the day after receipt to the date the payment is mailed. Interest accrues for each calendar day beyond 45 working days (if applicable).
  - b. Claim adjustments due to a processing error should calculate interest based on the period of the day after receipt of the initial clean claim to the date the payment is mailed. Interest accrues for each calendar day beyond 45 working days (if applicable).
  - c. Claim adjustments not involving a processing error should calculate interest based on the period of the day after receipt of the additional information that warranted the adjustment to the date the payment is mailed. Interest accrues for each calendar day beyond 45 working days (if applicable).
5. Any and all payments of interest must include a statement specifying the method used to calculate the payment of interest.
- O. Providers of service that file a claim tracer must identify the claim as such. Tracers should not be submitted prior to 60 days from the date the claim was originally submitted to the financially responsible party.
- P. CCS claims or other claims in which there was potential responsibility for payment by another party, and subsequently denied by that party for non-coverage of service, termination of coverage or partial payment which is less than Medi-Cal rates, are considered timely if submitted within contract submission timelines for contracted providers of services, or one year for non-contracted Medi-Cal providers of service from the date services were denied or partially paid, when accompanied by the notice of denial or partial payment. Claims submitted after the above noted timeframes from the date services were denied or partially paid can be denied.
- Q. Payment or notification of denial must be sent to the provider of service within 45 working days of the date a complete claim is received if a contracted provider or 30 calendar days if a non-contracted provider, accompanied by an EOB/RA. The date of payment or notification of denial is the date the payment or notice is actually mailed to the provider of service.
- R. Any claim that is denied, adjusted or contested must include an accurate and clear written explanation of the actions taken. The provider of service and Member, when applicable, must be appropriately notified if a claim is denied within 45 working days of receipt of a complete claim if contracted, or 30 calendar days if non-contracted.
1. All denial notifications, including an EOB/RA, to the provider of service must include mandated language involving balance billing and the right to appeal the denial, including the process for filing a dispute. For a sample of IEHP's RA and disclosure language (see Attachment 20-4 in Section 20, "Attachments").

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2. Members do not need notification of a denial when services are paid at a lower level than billed (e.g. ED services that have been down coded resulting in payment of the triage fee only), there is no member liability, or the denial is provider specific, such as duplicate claims.
- S. If a Capitated Provider determines that a claim has been overpaid, the provider of service must be notified in writing of the overpayment within 365 days from the date the original claim was paid.
1. The written notice must clearly identify the claim, the name of the Member, the date of service and a clear explanation of the basis upon which the Capitated Provider believes the amount paid was in excess of the amount due, including interest and penalties.
  2. Providers of service have 30 working days from the receipt of the notice of the overpayment to contest or reimburse the overpayment.
    - a. If a provider of service contests the request for overpayment, the provider of service must send a written notice to the Capitated Provider stating the reason why the provider of service believes the claim was not overpaid.
    - b. The contested notice of overpayment must be tracked, resolved and reported as a Provider Dispute, in accordance with Policy 20A1, "Claims Processing: Provider Dispute Resolution Process – Initial Claims Disputes."
- T. Uncontested notices of overpayment can only be offset against a provider of service's future reimbursement when the provider requests the retraction, in writing; or the provider fails to reimburse the monies due within 30 working days and the provider of service's contract allows for the offset. Any offsets must be clearly explained at the time of the offset via the EOB/RA or other written documentation, including identifying the specific overpayment(s). Capitated Providers must establish and maintain a Provider Dispute Resolution Mechanism for all providers of service that meets or exceeds the requirements outlined in Policy 16B1, "Dispute and Appeals Resolution for Providers of Service: Initial Dispute Resolution" and Policy 20A1, "Claims Processing: Dispute Resolution Process – Initial Claims Disputes." In general, the Provider Dispute Resolution Mechanism must include the following:
1. Providers of service have 365 days from the date of the original payment, denial, adjustment or contest, or other last action on a claim (i.e., Provider inquiries), to dispute or appeal the claim decision.
  2. All disputes must be acknowledged within 2 working days of receipt, if received electronically, or within 15 working days if received via paper.
  3. All disputes must be resolved within 45 working days after the date of receipt.
  4. Any dispute resolved in favor of the disputing provider and resulting in additional payment must include interest and penalties as outlined in Policy 20A1, "Claims

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Processing: Dispute Resolution Process – Initial Claims Disputes.” Any payment including interest must be made within 5 working days of the date of the written determination.

5. Any dispute involving an issue of medical necessity or utilization review that is upheld by the Capitated Provider through the dispute mechanism may be submitted to IEHP for secondary review and resolution within 60 working days of the determination date of the dispute from the Provider. Appeals must be submitted to IEHP in accordance with Policy 16B2, “Dispute and Appeals Resolution Process: Health Plan Appeals” and policy 20A2, “Claims Processing: Health Plan Claims Appeals” for appeals involving adjudication of claims or billing matters.
  6. All provider disputes must be reported to IEHP as outlined in Policy 20H, “Claims and Provider Dispute Reporting.” For reporting and monitoring purposes, issues resolved through arbitration are not considered a dispute and are not subject to the requirements noted above.
- U. IEHP’s Provider Call Center is available from 8:00am - 5:00pm, Monday through Friday at (909) 890-2054 or (866) 223-4347 to assist and answer any claim related inquiries.
- Contracted Providers where IEHP is the Payor may also verify claim status on IEHP’s website at [www.iehp.org](http://www.iehp.org).
- V. The responsibility for claims payment as outlined above continues until all claims have been paid/denied for services rendered during the timeframe a Capitated Agreement existed.

| INLAND EMPIRE HEALTH PLAN                       |                        |                   |
|---|------------------------|-------------------|
| <b>Chief Approval:</b> <i>Signature on file</i> | <b>Effective Date:</b> | September 1, 1996 |
| <b>Chief Title:</b> Chief Executive Officer     | <b>Revised Date:</b>   | January 1, 2012   |

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## 20. CLAIMS PROCESSING

### A. Claims Processing

#### 1. Provider Dispute Resolution Process - Initial Claims Disputes

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##### **APPLIES TO:**

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

##### **POLICY:**

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

##### **PROCEDURE:**

- A. Providers must submit all disputes, including claims payment or denial, billing, contracting issues, or those involving UM/medical necessity, in writing to the Payor within 365 days of the last date of action on the claim requiring resolution. If a dispute is received beyond this timeframe, a denial letter is issued, (see Attachment 20-12 in Section 20, “Attachments”). Justification and supporting documentation must be provided with the written dispute.
1. Disputes are categorized as follows, for reporting, tracking and monitoring purposes:
- a. Claims/Billing – any formal written disagreement involving the payment, denial, adjustment or contesting of a claim, including overpayments, payment rates, billing issues or other claim reimbursement decisions.

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## 20. CLAIMS PROCESSING

### A. Claims Processing

#### 1. Provider Dispute Resolution Process - Initial Claims Disputes

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- b. Contract – Any formal written disagreement concerning the interpretation of a contract as it relates to claim payment.
  - c. UM/Medical Necessity – any formal written disagreement concerning the need, level or intensity of health care services provided to Members.
2. Written claims and billing related disputes must be submitted to the Payor in accordance with the dispute filing guidelines issued by the Payor.
- a. For claims or billing disputes involving IEHP as the Payor, disputes must be sent to:

**IEHP Claims Appeal Resolution Unit**

**P.O. Box 10276**

**San Bernardino, CA 92423**

- b. IEHP Provider dispute forms are available upon request and are also available on IEHP's website at [www.iehp.org](http://www.iehp.org).
  - c. Any dispute involving PCP P4P reimbursements should be filed in accordance with Policy 19C, "Pay For Performance."
3. Written disputes must include the Provider name, Provider identification, contact information, original claim number of the claim in dispute, date of service, a clear identification of the disputed item, and a clear explanation of the basis upon which the Provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment, or other action is incorrect.
4. If the dispute is not about a claim/billing, the written request must include a clear explanation of the issue and the providers' position, as outlined in Policy 16B1, "Dispute and Appeal Resolution Process for Providers of Service: Initial Dispute Resolution."
5. If the dispute is filed on behalf of a Member by the Provider, the dispute is considered a Member grievance, subject to the requirements of the Member Grievance Resolution process, as outlined in Policy 16A, "Member Grievance Resolution Process."
- B. Payors must identify and acknowledge in writing the receipt of each dispute, whether or not complete, and disclose the recorded date of receipt as follows:
- 1. If the dispute was received electronically, acknowledgment must be provided within two working days of receipt of the dispute; or
  - 2. If the dispute was received in paper form, acknowledgement must be provided

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## 20. CLAIMS PROCESSING

### A. Claims Processing

#### 1. Provider Dispute Resolution Process - Initial Claims Disputes

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within 15 working days of receipt of the dispute (see Attachment 20-13a & 13b in Section 20, "Attachments").

- C. If a dispute is incomplete, or if the information is in the possession of the practitioner and not readily accessible to the Payor, the Payor may send a written request for information (see Attachment 20-1 in Section 20, "Attachments") that is necessary to resolve the dispute. The Provider has 30 working days to resubmit an amended dispute with the missing information. If requested documentation is not received, a denial letter is issued (see Attachment 20-2 in Section 20, "Attachments").
- D. Payors must make every effort to investigate and take into consideration all information on file or received from the Provider and may further investigate and/or request additional information or discuss the issue with the involved Provider as needed to make a determination.
- E. Payors must send a written notice of the resolution regardless of whether the dispute is upheld or overturned (see Attachment 20-14 & 15 in Section 20, "Attachments"), including pertinent facts and an explanation of the reason for the determination, within 45 working days of the receipt of the dispute. If the written determination results in payment to the disputing Provider, payment must be made within 5 working days of the date of the written determination.
- F. Determinations involving Medi-Cal claims made in favor of the disputing Provider that results in payment of additional monies is subject to interest penalties as follows:
  - 1. If the determination is made to pay additional monies based on information originally provided and/or available at the time the claim was first presented to the financially responsible Payor for adjudication, or a result of a processing error, interest penalties are due as follows:
    - a. Claims not involving emergency services, including adjustments - 15% per annum;
    - b. Claims involving emergency services, including adjustments - the greater of \$15.00 per year or 15% per annum;
    - c. Interest must be paid within 5 working days of the determination to pay. Failure to pay interest automatically requires a \$10.00 late fee, to be paid in addition to any interest due; and
    - d. Interest is calculated on a calendar day basis, beginning with the first calendar day after the 45<sup>th</sup> working day from the original date of receipt of the first claim filed that is being disputed through the day the payment check is mailed.
    - e. If the resolution of a Provider Dispute results in additional payment, IEHP

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### A. Claims Processing

#### 1. Provider Dispute Resolution Process - Initial Claims Disputes

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will automatically include the appropriate interest amount if payment is not issued within the required timeframes.

2. If the determination is made to pay additional monies is based on information obtained subsequent to the initial adjudication decision, such as a request for retro-authorization or is made as a goodwill gesture, interest penalties are not due.
- G. Providers that are dissatisfied with the resolution of any dispute **not** involving claims or billing (i.e. capitation, contracts) may appeal to IEHP as outlined in Policy 16B2, “Dispute and Appeal Resolution Process for Providers of Service: Health Plan Appeals.”
- H. Providers that are dissatisfied with the initial resolution and written determination by the Payor that involves payment or denial decisions on adjudicated claims or billing, including denials for procedures, referrals or services may submit a written appeal of the Payor’s determination to IEHP by following the process outlined in Policy 20A2, “Claims Processing: Health Plan Claims Appeals.”
- I. Providers that are not satisfied with the initial determination by the Payor, AND the determination is related to medical necessity or utilization management, the Provider has the “de novo” right to appeal directly to IEHP within 60 working days of receipt of the written determination by submitting a written request for review as outlined in Policy 16B2, “Dispute and Appeal Resolution Process for Providers of Service: Health Plan Appeals” and Policy 20A2, “Claims Processing: Health Plan Claims Appeals.”
- J. Furthermore, Providers that are dissatisfied with the outcome of a dispute originally filed with the Payor that involves pre-service referral denials or modifications may submit an appeal to IEHP in accordance with Policy 16B3, “Dispute and Appeal Resolution Process for Providers of Service: Provider Appeals of UM Decisions.”
- K. No retaliation can be made against a Provider who submits a dispute in good faith.
- L. Copies of all Provider disputes, and related documentation, must be retained for at least five years. A minimum of the last two years must be easily accessible and available within five days of request from IEHP or regulatory agency.
- M. Payors must track and report all disputes received and submit monthly summary reports to IEHP in accordance with Policy 20H, “Claims Processing: Claims and Provider Dispute Reporting.” A principal officer of the entity must be assigned responsibility for the Dispute Resolution Process and sign as to the validity and accuracy of all dispute related reporting.

| INLAND EMPIRE HEALTH PLAN                       |                        |                 |
|---|------------------------|-----------------|
| <b>Chief Approval:</b> <i>Signature on file</i> | <b>Effective Date:</b> | August 1, 2005  |
| <b>Chief Title:</b> Chief Executive Officer     | <b>Revised Date:</b>   | January 1, 2012 |

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## **20. CLAIMS PROCESSING**

### **A Claims Processing**

#### **2. Health Plan Claims Appeals**

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#### **APPLIES TO:**

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

#### **POLICY:**

- A. “Providers” means any practitioner or professional person, acute care hospital organization, health facility, ancillary provider, or other person or institution licensed by the State to deliver or furnish health care services directly to the Member.
- B. Providers may submit a second level appeal to IEHP if they disagree with the written determination rendered by the financially responsible Payor (contracted Capitated IPAs or Hospitals) for any dispute involving payment, denial, adjustment or contesting of a claim, including overpayments, payment rates, billing issues or other claim reimbursement decisions that they deem were unfairly upheld or underpaid.
- C. Second level appeals to IEHP involving claims or billing must be submitted in writing within six months from the date of determination of the dispute received from the Payor. IEHP reviews provider appeals as an intermediary to determine the appropriateness of the denial.
- D. IEHP will identify and acknowledge appeals within fifteen (15) working days of receipt.
- E. IEHP reviews the appeal to determine the appropriateness of the denial/reduction and renders a decision within 45 working days of receipt of all necessary information.

#### **PROCEDURE:**

- A. Claims appeals relate to the initial determination of a dispute by the Payor involving the original adjudication decision of a claim or billing issue and are primarily complaints concerning reduced payment or denial of services that were not resolved to the satisfaction of the appealing provider by the responsible Payor.
- B. Inquiries regarding the status of a claim, or requests for intervention by IEHP on behalf of the billing provider in an attempt to get an initial adjudication decision (payment or denial) made on a claim by the Payor, are not considered disputes or appeals and are handled in accordance with Policy 20C1, “Claims Deduction From Capitation: 14-Day Letters.”
- C. A provider who has been denied payment for services or feels that the claim has been underpaid or who has other claims or billing related issues must first file a dispute with the Payor as outlined in Policy 20A1, “Claims Processing: Provider Dispute Resolution Process: Initial Claims Disputes.”

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## 20. CLAIMS PROCESSING

### A Claims Processing

#### 2. Health Plan Claims Appeals

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- D. If IEHP receives an initial claim or billing dispute directly from a provider, IEHP will forward the claim or billing dispute to the Payor for resolution as applicable, and notify the provider.
- E. Upon receipt of an appeal, IEHP will acknowledge by issuing a letter to the provider within 15-working days (see Attachment 20-10a in Section 20, “Attachments”).
- F. Providers that disagree with the written determination of the dispute by the Payor may appeal to IEHP in writing within six months of the date of the written determination.
1. Appeals should be submitted to:

IEHP – Claims Appeal Resolution Unit  
P.O. Box 10276  
San Bernardino, CA 92423-0276
  2. The following information must be included with the written appeal, as applicable:
    - a. Claim Appeal Cover Letter;
    - b. Written Determination from the responsible Payor;
    - c. Claim Form;
    - d. Denial Letter/Explanation of Benefits;
    - e. Transcribed Notes;
    - f. Hardcopy Authorization if Prior Authorization Received;
    - g. If Verbal Authorization Received:
      - 1) Services Authorized;
      - 2) Any Limitations to the Authorization;
      - 3) Name of Person Providing Verbal Authorization; and
      - 4) Date and Time Verbal Authorization Given.(Follow up calls for additional services require the same information.)
    - h. Documentation proving an attempt was made to obtain authorization from the IPA/Hospital should indicate the phone number called, the date and time call was made, and whom the provider spoke to, if applicable.
    - i. If the responsible entity denied the claim due to timeliness, evidence of timely billing or other documentation that substantiates good cause for the delay in billing, that includes but is not limited to the following, must be submitted with the appeal.

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## 20. CLAIMS PROCESSING

### A Claims Processing

#### 2. Health Plan Claims Appeals

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- 1) Claim determination letter or EOB/RA from IEHP or one of IEHP's contracted Capitated Providers.
  - 2) Copy of a written request for information or other written claim-related correspondence from IEHP or one of IEHP's Capitated Providers, dated and printed on letterhead or form letter with the date and letterhead clearly identified.
  - 3) Determination letter from other insurance carriers or other financially responsible entities such as CCS or Medicare, dated and printed on letterhead, in which the date of determination and date of receipt is documented, that demonstrates the provider presented the claim within the claims filing timelines permitted by law and/or written contractual agreement from the date of receipt of the determination.
  - 4) Financial ledgers with multiple claim billings for that day, including name of the billed party (i.e., IEHP, Capitated Provider, Medicare, HMO, etc.).
  - 5) Computer generated claim transaction history that includes the billing history of the claim and history of timely and consistent follow-up attempts made to the original billed entity within the timely filing guidelines permitted by law and/or written contractual agreement. Detailed history should include billing dates and/or ledgers that show follow-up dates, contact names, time of calls (if applicable) and/or address to which the claim was sent.
  - 6) Other documentation that demonstrates good cause for the delay in being able to submit the claim timely.
- j. Any other information to assist IEHP in validating the appropriateness of services rendered.
- G. If the appealing party does not provide the above required documentation, the appeal will be closed and returned to the provider indicating the missing information.
- H. If additional information is needed from the Payor, IEHP will request documentation from the Payor that has reduced payment or denied the services (see Attachment 20-7 – Provider 14 Day Letter in Section 20, “Attachments”). This documentation must be provided within the timeline outlined in Attachment 20-7.
1. If the Payor fails to provide evidence of appropriate medical review, as applicable, the original adjudication decision is overturned based on procedural grounds. IEHP issues a certified letter indicating the Payor is financially liable for the claim in question (see Attachment 20-8 – 14-Day Inappropriate Denial Letter in Section 20, “Attachments”). The Payor has 14 days to pay the claim,

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## 20. CLAIMS PROCESSING

### A Claims Processing

#### 2. Health Plan Claims Appeals

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with appropriate interest and penalties, and provide evidence to IEHP that payment was made. If the Payor does not pay or provide evidence that the claim was paid then IEHP pays the claim on the Payor's behalf and deducts the payment from future payments, including capitation due to the Provider.

- I. Once IEHP receives all necessary documentation, the appeal undergoes review.
- J. Medical and non-medical claims-related dispute appeals are resolved separately:
  - 1. Medical claims-related dispute appeals are forwarded to the IEHP Chief Medical Officer. Medical claims-related appeals involve denials for non-authorized services, denials or down-coding of emergency services, UM/medical necessity decisions, etc.
  - 2. Medical disputes involving current patient care are resolved in accordance with Policy 16B3, "Dispute and Appeal Resolution Process for Providers of Service: Provider Appeals of UM Decisions" and the immediacy of the situation.
- K. IEHP conducts a review of the appeal and renders a decision within 10 days. A written determination of the decision is sent to the appealing party within 45 working days of receipt of the appeal (see Attachment 20-6a in Section 20, "Attachments").
  - 1. If the reduced payment or denial is upheld, the appealing party and Payor are notified in writing of the decision and no further action is taken by IEHP (see Attachment 20-6b in Section 20, "Attachments").
  - 2. If the reduced payment or denial is overturned, the Payor is notified in writing, via certified mail or secure email, of their financial obligation with a copy sent to the appealing provider. IEHP instructs the Payor to pay the claim, including interest and penalties as applicable, within 14 days (see Attachment 20-8 in Section 20, "Attachments"). Interest must be paid as outlined in Policy 20A1, "Claims Processing: Provider Dispute Resolution Process – Initial Claims Disputes."
    - a. If Payor fails to respond to an IEHP inquiry, a demand letter will be issued requiring proof of payment within the timeline outlined in (Attachment 20-6c in Section 20, "Attachments") 14-Day Non-Response letter. If evidence is not provided of claim payment, IEHP will pay the claim on the Payor's behalf and deducts the payment from the next capitation payment.
- L. If, after 14 days, the Payor has not paid the claim, IEHP pays the claim on the Payor's behalf and deducts the payment from future payments, including capitation due to the Payor, as follows:
  - 1. For outpatient services the rates specified in the Medi-Cal schedule of reimbursement (RFO500); or
  - 2. Inpatient Facility claims are paid at the prevailing rate established by Section 6085 of the Federal Deficit Reduction Act (DRA) of 2005, also known as the

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## 20. CLAIMS PROCESSING

### A Claims Processing

#### 2. Health Plan Claims Appeals

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“Rogers Amendment.” This applies to claims from contracted and non contracted facilities; or

3. For emergency services, the ER rate listed in the Medi-Cal schedule of reimbursement (RFO500).
- M. If the provider is still not satisfied with the outcome of the health plan appeal determination, the provider may request the IEHP Peer Review Committee or IEHP CEO and/or Governing Board review the appeal. Appeals for Peer Review must be received within 30 days of receipt of the decision concerning the health plan level appeal. IEHP will acknowledge receipt by issuing a letter to the provider within 15-working days (see Attachment 20-10b in Section 20, “Attachments”). The IEHP Peer Review Committee determines medical issues only. If the decision on the health plan appeal, or by the Peer Review Committee or CEO/IEHP Governing Board, determines the Payor is not financially responsible, and if IEHP paid the claim on their behalf, the payment deduction from capitation is reversed.

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| <b>Chief Title:</b> Chief Executive Officer     | <b>Revised date:</b>   | January 1, 2012 |

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## 20. CLAIMS PROCESSING

### B. Billing of IEHP Members

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#### **APPLIES TO:**

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

#### **POLICY:**

- A. Under the Knox-Keene Act, Health and Safety Code 1379 of the State of California, it is illegal to bill an HMO Member for whom services were provided, except for non-benefit items or non-covered services.
- B. According to State and Federal regulations, it is illegal to bill a Medi-Cal Member for covered medical services. It is also illegal to bill a Member a co-payment amount for any reason or purpose under Medi-Cal managed care.
- C. Providers and practitioners are not allowed and must not bill Medi-Cal Members or attempt collection against a Medi-Cal Member as indicated above.
- D. IEHP monitors Providers to ensure compliance with these regulations.

#### **PROCEDURE:**

- A. When IEHP receives a call from Members stating they are being billed, IEHP determines the Member's responsibility for the services rendered. If it is determined that the services are the responsibility of the Member, the Member is advised accordingly. If it is determined that the services billed are not the responsibility of the Member, IEHP obtains all pertinent information regarding the bill and records it into the tracking database, maxMC. Additionally, IEHP instructs the Member to mail the received bill to IEHP for further research and action.
- B. When IEHP receives the Member's bill, IEHP reviews the information logged and verifies eligibility, benefits and the Member's PCP. If the bill received is not a complete itemized claim, IEHP requests any additional information needed for claims processing and sends all items to the financially responsible Provider with a 14-day letter (see Attachment 20-7 in Section 20, "Attachments").
- C. IEHP sends a letter to the provider of service with a notice that it is illegal to bill the Member for covered services (see Attachment 20-5 in Section 20, "Attachments"). This letter instructs the provider of service to contact IEHP directly.
1. Covered services are outlined in the IEHP Benefit Manual and also include any forms required by IEHP that must be completed by the practitioners pertaining to payment, authorization or reporting of services. Examples of forms that are considered covered services, and for which Members cannot be charged for completing them, include, but are not limited to:
    - Referrals (e.g., WIC referral forms, referrals for specialty services, etc.)
    - PM160s for well-child visits or immunizations

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## 20. CLAIMS PROCESSING

### B. Billing of IEHP Members

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- Assessments, surveys or questionnaires (e.g., Lead testing questionnaire, perinatal assessment forms, etc.)
  - Prescriptions
- D. IEHP allows 7 days for the Member to submit the bill. If the bill is not received within 7 days, the Member is contacted and an additional 7 days is provided to submit the information. If no response is received following the second attempt, IEHP closes the case.
- E. If the provider of service is a participating practitioner, the responsible Provider must intervene and contact the practitioner to ensure that the billing of the assigned Member is discontinued.
- F. If the provider of service continues to charge a member in violation of this policy after being notified to stop, or sends the Member's account to a collections agency, IEHP reserves the right to inform DMHC, DHCS or other regulatory agencies of the violation. In addition, the billing of Members is in violation of the IEHP Agreement and IEHP takes all necessary actions, up to and including termination of the Agreement, to ensure that such actions cease (see Attachment 20-11 in Section 20, "Attachments").
- G. In addition, if the services provided are deemed medically necessary and the Member was sent to collections, IEHP reserves the right to pay the provider of service and reduce the responsible Provider's next monthly capitation check, as applicable.

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## 20. CLAIMS PROCESSING

### C. Claims Deduction From Capitation

#### 1. 14-Day Letter

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##### **APPLIES TO:**

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

##### **POLICY:**

- A. Providers must appropriately pay or deny complete claims for contracted providers of service within 45 working days from original receipt. Non-contracted providers of service must be paid within 30 calendar days. This standard is based on the timeframe from the initial receipt of the claim (date stamped) until the check or denial letter is mailed to the provider of service.
- B. In the event the Provider fails to meet IEHP's claims processing standards as indicated above, IEHP may elect to pay these claims on behalf of the Provider by deducting such payment from the Provider's next monthly capitation check.
- C. The 14-Day letter process is available for unpaid and/or unresponded to claims inquiries for up to 1 year and 60 days after the date of service.

##### **PROCEDURE:**

- A. The 14-Day letter is a tool used by IEHP to expedite payment of any claims that may have fallen outside of the indicated claims processing timelines.
- B. IEHP's 14-Day letter process is available to providers of service under the following circumstances:
  - 1. A provider of service notifies IEHP that no status has been provided on claims submitted to the appropriate Payor for over 45 working days (approximately 60 calendar days) or
  - 2. IEHP identifies a claim that has not been paid within the claims processing timeframes above.
- C. The 14-Day letter process is available for unpaid and/or unresponded to claims inquiries. Providers may avail themselves to the 14-Day letter process for up to 1 year and 60 days after the date of service.
- D. As outlined in Policy 20.A.2, "Claim Processing Health Plan Claims Appeals" providers of service should submit documentation demonstrating an attempt to obtain payment from the Payor. Documentation can be:

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## 20. CLAIMS PROCESSING

### C. Claims Deduction From Capitation

#### 1. 14-Day Letter

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Required:

- ✓ A Clean Claim (CMS 1500/UB-04 form)
  - ✓ Appeal Cover Letter from Provider;
  - ✓ Written Determination from the responsible Payor;
  - ✓ EOB from the responsible entity;
  - ✓ Denial Letter/Explanation of Benefits;
  - ✓ Medical Records
  - ✓ Claim Tracers
  - ✓ Transcribed Notes;
  - ✓ Hardcopy Authorization if Prior Authorization Received;
  - ✓ Phone Logs
  - ✓ Authorization Received:
    - Services Authorized;
    - Any Limitations to the Authorization;
    - Name of Person Providing Verbal Authorization; and
    - Date and Time Verbal Authorization Given.(Follow up calls for additional services require the same information.)
  - ✓ Or any other necessary information that supports the appropriateness of services rendered
- E. Upon receipt of the claim, IEHP verifies Member eligibility on the date of service, and ensures that the claim was sent to the appropriate Payor. If the Member is not eligible with IEHP for the date of service, the request is rejected and a denial letter is issued to the provider of service explaining the reason for the rejection. If the claim was sent to the incorrect Payor, IEHP returns the claim to the provider of service advising them to re-bill the correct Payor (see Attachment 20-3 in Section 20, “Attachments”).
- F. IEHP sends a secure email or mails a certified 14-Day letter to the Provider (see Attachments 20-7 and 20-8 in Section 20, “Attachments”). The 14-Day letter includes a copy of the claim and requests information on the status of the claim, which must be completed by the Provider and returned to IEHP within 14 days from the sent date.
- G. Providers must respond to IEHP with the following claim information: the date the claim was originally received; if it was paid or denied; the date paid or denied; the amount paid; check number of payment; and/or the reason for the denial.
- H. The following are examples of unacceptable responses to the 14-day letter:
1. Not Provider’s Responsibility (IEHP confirms financial responsibility prior to 14-day notification).
  2. Member Not Eligible (IEHP confirms eligibility prior to 14-day notification).

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## 20. CLAIMS PROCESSING

### C. Claims Deduction From Capitation

#### 1. 14-Day Letter

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3. Not Authorized (it is inappropriate to deny a claim due to “No Authorization” as medical review must be performed prior to denial).
- I. In the event the Provider fails to provide an acceptable written response to IEHP within 14 days, or the requested information is returned incomplete, IEHP pays the provider of service directly and deducts the amount paid from the Provider’s monthly capitation check.
1. For outpatient services the rates specified in the Medi-Cal schedule of reimbursement (RFO500); or
  2. Inpatient Facility claims for Emergency services and OB Deliveries are paid at the average California Medical Assistance Commission (CMAC) rate for the geographic region referred to as Combined Statistical Area (CSA) in which the provider is located for the last year reported, as published in the most recent CMAC Annual Report to the Legislature; or
  3. Inpatient facility claims for all other conditions are paid at the prevailing DHCS Interim rate for the facility at the time of service; or
  4. For emergency services, the ER rate listed in the Medi-Cal schedule of reimbursement (RFO500).
- J. Claims capitation deductions are outlined on a detail report, sent with the capitation payment (see Attachment 20-9 in Section 20, “Attachments”).

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## 20. CLAIMS PROCESSING

### D. Claims and Compliance Audits

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#### **APPLIES TO:**

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

#### **POLICY:**

- A. IEHP provides oversight of claims processing by Capitated Providers through monitoring, reviewing, and measuring claims payments and denial processes, provider dispute mechanisms and assessing for demonstrable and unjust payment patterns on an on-going basis.
- B. IEHP audits all Capitated Providers annually or as necessary.
- C. Audits include on-site review and evaluation of specific claims, disputes, adjustments, reports, personnel, written policies and procedures and contracts; management involvement and oversight, claims processing systems and functions, dispute resolution mechanism and regulatory and contractual compliance. These audits are conducted in accordance with IEHP standards and state and federal requirements.
- D. Audited Capitated Providers are required to cure any deficiencies in their systems in order to bring them into contractual and regulatory compliance.

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

#### **PROCEDURES:**

- A. IEHP provides comprehensive oversight of Capitated Providers' delegated responsibilities to process claims and resolve disputes in accordance with contractual and regulatory requirements. IEHP performs this oversight through routine audits and review of monthly and quarterly reporting to IEHP by the Capitated Providers.
- B. Audits ensure Capitated Providers:
1. Are paying and denying claims and resolving provider disputes in accordance with regulatory and contractual requirements.
  2. Have adequate system protocols in place to log, acknowledge, track, monitor and appropriately adjudicate or resolve all claims and disputes received; follow-up and reporting meet IEHP requirements, and that these systems are operating as designed and do not result in unfair payment patterns.
  3. Claims processing systems are adequate to meet the terms of the IEHP contract as well as regulatory requirements.
  4. Have contracts in place with subcontracted providers that meet regulatory

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## 20. CLAIMS PROCESSING

### D. Claims and Compliance Audits

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requirements as they pertain to claims processing and dispute resolution.

5. Are financially viable and are able to manage risks associated with capitation and not presenting undue risk to IEHP or its providers or members.
- C. IEHP monitors the performance of Capitated Providers in between audits through monthly and quarterly reporting. Review of reports enables IEHP to assess compliance with regulatory and contractual requirements, as well as to perform comparative analysis and trends for possible indicators of potential or emerging patterns of unfair payment practices or inability to perform delegated functions.
- D. Capitated Providers must submit the following monthly and quarterly reports to IEHP within specified timeframes, in a format designated by IEHP, as outlined in the IEHP Audit Guide.
1. By the 15<sup>th</sup> of each month, Capitated Providers must submit to IEHP the Monthly Timeliness Report (MTR) for the previous month's activity. The MTR contains information regarding claims processing timeliness and activity and is outlined in Policy 20H, "Claims and Provider Dispute Reporting."
  2. By the 30<sup>th</sup> of the month following the end of the quarter, for the previous quarter, Capitated Providers must submit information regarding disputes and adjustments. The reports due, as outlined in Policy 20H, "Claims and Provider Dispute Reporting", are:
    - a. Quarterly Provider Dispute Resolution (PDR) Report
    - b. Quarterly Provider Dispute by Type/Volume Report
    - c. Quarterly Adjustments Summary Report
    - d. Quarterly Statement of Deficiencies Report
  3. Capitated Providers must also submit to IEHP by November 30th of each year, an Annual Claims Payment and Provider Dispute Report (Annual Report) for the reporting period covering October 1 through September 30, for all lines of business combined, as outlined in Policy 20H, "Claims and Provider Dispute Reporting."
  4. Failure to submit required reports that include all required information in a complete and accurate manner in IEHP's required format, within the indicated timeframes, may result in the Capitated Provider being subjected to a focused audit and negatively impact the Capitated Provider's contract renewal terms.
- E. IEHP audits the claims processing system of each Capitated Provider on an annual basis. Audits may be conducted more frequently (Focused Audits) if circumstances arise that in the judgment of IEHP management requires closer scrutiny including but not limited to the following circumstances:
1. Failure to meet IEHP Financial Viability Standards
  2. Non-compliance with monthly and quarterly self-reporting requirements to IEHP or

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## 20. CLAIMS PROCESSING

### D. Claims and Compliance Audits

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- to DMHC under SB260, or discovery during an audit or through other means, deficiencies that were not self-reported
3. Excessive claims appeals that are overturned by IEHP for denial of payment or underpayment
  4. Excessive number of insufficient or inappropriate responses to 14 -day letters that result in payment by IEHP to the provider of service that is deducted from capitation
  5. Excessive claims grievances, provider disputes, provider inquiries or other information received by IEHP from subcontracted entities or other outside sources
  6. Failure to submit accurate and completed required reports to IEHP within specified timeframes
  7. Failure to meet claims payment standards, dispute resolution standards and other indicators and measures based on IEHP review of periodic reports and other internally and externally available information
  8. Identification of potential or emerging unfair payment patterns or other indicators of possible payment practices that pose undue risk to IEHP and/or its Members or providers based on claims inquiries, grievances and appeals, IEHP review of periodic reports, contracts or other internally or externally available information
  9. Failure to cooperate with IEHP in report resolution, issue resolution or other matters with respect to determination of compliance with IEHP requirements
  10. Change in claims processing system
  11. Change in management oversight, including management services organization (MSO)
- F. IEHP notifies Capitated Providers in writing at least 90 days in advance of the scheduled audit. The notice is explicit in the timeframe being audited, its request for documents and access to Provider staff. For Focused Audits, IEHP reserves the right to give a minimum of three working days prior notice.
1. Routine Audits include off-site and on-site review.
  2. Approximately 60 days prior to the scheduled audit, Capitated Providers must submit the following detailed reports, covering the audit period, to IEHP for review and selection of claims:
    - a. Paid Claims (including identification of emergency and family planning claims)
    - b. Denied Claims (including identification of emergency and family planning claims)
    - c. Closed Overpayments

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## 20. CLAIMS PROCESSING

### D. Claims and Compliance Audits

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- d. Post-Payment Adjustments
  - e. Resolved Disputed Claims
  - f. Interest Paid Claims
  - g. Pre-Audit Questionnaire
3. In addition, the following reports must be provided at the time of the audit for on-site claims selection and/or review. IEHP also reserves the right to request additional reports and/or documents as deemed necessary.
    - a. Received Claims (including identification of emergency service claims, separately subtotaled)
    - b. Pended Claims (including identification of emergency service claims, separately subtotaled)
    - c. Open Claims (including identification of emergency service claims, separately subtotaled)
    - d. Log of Redirected Claims
    - e. Signed Check Mailing/Attestation Log
    - f. Customer Service Inquiry/Call Log
  4. Refer to the IEHP Audit Guide for a detailed description of each report and required reporting elements as well as the pre-audit notification and audit preparation requirements.
- G. IEHP randomly selects claims to audit. The number of claims selected varies depending on the type and scope of the audit and the Provider's total claim volume, and generally covers a 12-month period. For specific information on the number of claims selected by volume, please refer to the IEHP Audit Guide.
1. For routine annual audits, the type of claims selected (for both contracted and non-contracted providers unless noted otherwise) is as follows:
    - a. Paid and Denied Claims
    - b. Emergency Services claims (paid)
    - c. Non-contracted family planning claims, (paid and denied)
    - d. Disputed claims
    - e. Post-Payment Adjustments
    - f. Interest Paid on late paying, adjusted or disputed claims
    - g. Overpayment Refund Requests (refunded, retracted or disputed)
    - h. Pended claims

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## 20. CLAIMS PROCESSING

### D. Claims and Compliance Audits

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2. The random claim selections will be forwarded to Capitated Providers 30 days prior to the scheduled audit. For concurrent audits involving more than one entity, IEHP will allow five additional days per additional entity.
  3. IEHP performs the claims review noted above off-site. One day, usually the last day of the scheduled audit, IEHP will perform an on-site visit.
  4. At the time of the on-site visit, IEHP will review current received, open and pend reports (as of the date of the audit), as well as a log of redirected claims, and may select additional claims for review.
  5. IEHP also randomly selects provider contracts for review.
  6. IEHP reserves the right to request additional claims, reports or other documents on-site for review.
  7. For verification and focused audits, the number or type of claims selected for review depends on the nature and issue of the deficiencies identified and may or may not be randomly selected.
- H. One week before the scheduled first day of the audit, Capitated Providers are required to send to IEHP specific supporting documentation for the selected claims or disputes to review. In addition, a signed Checklist must be included with the audit documentation attesting to the completeness of data provided. Please refer to the Audit Guide for a detailed list of the audit documentation for each type of claim reviewed. *Note: If any of the required documentation outlined in the Audit Guide is not available at the time of the audit and cannot be provided upon demand, the claim or dispute will be deemed non-compliant.*
- I. The audit consists of a review of three areas: timeliness, appropriateness and systems. Within each area are a number of measures that must be met in order to fully pass an audit, including regulatory standards pertaining to the processing of claims or dispute resolutions. Each measure is considered a scorable element of the audit under the area assessed. In general, the measures reviewed include those outlined below. Please refer to the Audit Guide for a more comprehensive outline of each element and the relevant measures.
1. Timeliness –
    - a. Timeliness measures include turnaround times for claims, disputes, redirected claims, claims and dispute acknowledgement and other elements in which a specific turnaround time requirement is stipulated by law or IEHP’s contract for the payment of claims and resolution of disputes. Regulatory standards pertaining to potential unfair payment patterns as they pertain to turnaround times and timeliness are also measured under this area. Refer to the IEHP Audit Guide (under timeliness) for the specifics of each element and related measures (i.e., 90% of non-contracted provider claims must be paid within 30 days).
    - b. Timeliness standards for claims are measured from the day after the date of

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## 20. CLAIMS PROCESSING

### D. Claims and Compliance Audits

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receipt as evidenced by the first date the claim is received by the financially responsible entity until the check or denial EOB/RA letter is mailed to the provider of service. In addition to the physical date stamp on the claim, the lag between the billing date on the claim and the date of the receipt is also measured in order to validate the date of receipt. In general, IEHP allows a 90 day lag for non-contracted providers and 180 day for contracted providers.

- c. Timeliness standards for disputes are measured from the day after the date of receipt of the dispute as evidenced by the first date the dispute is received by the financially responsible entity until the resolution letter is mailed to the complainant. When a payment is made, timeliness includes the five working day lag between the date of the resolution letter and the date the check is mailed.
- d. In order to confirm mailed date, IEHP tracks the timeframe between the check date and the date the check is presented for payment by the provider of service. The current standard allows for a 20 day period between the check date and for the funds (e.g., claim check) to clear. This timeframe allows for variances in the mail delivery system and individual office practices for billing and handling accounts receivable.
- e. Signed Proof of mailing of checks must be maintained (check mailing/attestation). IEHP reserves the right to request and review the check mailing/attestation log (or other proof of mailing) as part of any audit to confirm mailing dates and/or to research check clearing patterns.

#### 2. Appropriateness –

- a. Appropriateness measures include elements pertaining to the validity and accuracy of claims adjudication (payment, denial or contest) and dispute resolution and includes, but is not limited to, accuracy and appropriateness of claims payment, including automatic payment of interest as applicable; validity of denial reasons, documentation and written notification; accuracy, validity and appropriateness of adjustments, including applicability and payment of interest and notifications; mandatory disclosures and notification language for denials, adjusted claims and disputes and other regulatory and contractual requirements; accuracy and appropriateness of notifications, resolution and written determination and other regulatory or contractual requirements as it pertains to the resolution of disputes; or other measures that may constitute unfair payment practices.
  - 1) Both overpayment and underpayments are considered non-compliant.
  - 2) Adjustments to correct an underpayment that are made as a result of a review of claims selected for an audit are considered non-compliant. If an adjustment is made as a result of routine operational activities, such

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## 20. CLAIMS PROCESSING

### D. Claims and Compliance Audits

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as a provider inquiry, the adjustment is compliant. If a selected claim is adjusted during the period between the time the selection is received and the date of the audit due to routine activities, proof must be provided to support the adjustment, such as claim notes or a fax. Otherwise, that adjustment will be considered non-compliant.

- b. When a dispute involves payment of interest, interest is calculated from the day after the date of receipt of the original claim that is being disputed until the date the check is mailed to the provider of service on the adjusted payment.
3. Systems
- a. The Systems portion of the audit includes both scored and non-scored elements.
  - b. The scored elements are those measures that assess regulatory standards that cannot be captured as timeliness or appropriates, such as those pertaining to mandatory contract provisions or potential unfair payment patterns such as failure to provide required disclosures.
  - c. The non-scored elements pertain to an assessment of the Capitated Provider's internal control and processes with respect to claims processing and dispute resolution mechanisms, and includes but is not limited to claims processing and provider dispute resolution documentation; policies and procedures; template forms and letters; contractual provisions that are not designated a specific standard through regulatory or contractual requirements; staff interviews; review of inventory control methodology, logging, tracking and control; review of methodology for logging, tracking, and control, including outcome, of provider of service claims and dispute related phone calls, reporting capabilities; internally or externally available information specific to provider compliance including periodic Capitated Provider reporting to IEHP; and a physical walk-through of the claims department before and/or after the audit.
- J. IEHP may conduct a preliminary verbal exit interview with the Capitated Provider at the end of the audit to discuss preliminary results, areas of concern, need for and timing of corrective actions to rectify noted system deficiencies and the timeframe for the next audit.
- K. During the course of or subsequent to the audit, if IEHP suspects fraud, the claims auditor submits his/her findings to IEHP's Fraud Prevention Committee.
- L. Capitated Providers must meet all measurements (elements) under each area, as outlined in the IEHP Audit Guide at the thresholds noted below, in order to pass the audit. The overall score assigned to the audit, which is used for performance evaluation purposes, is based on the total number of elements met as a percent of the total number of elements measured.
- 1. A passing score is assigned when all of the elements are met.

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## 20. CLAIMS PROCESSING

### D. Claims and Compliance Audits

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2. A Conditional Pass is assigned when claims compliance is 95%, but all elements were not met (up to 4 elements not met). Repeatedly missing one or more of the same elements over the course of 2 consecutive audits will result in Non-Compliance.
  3. A non-compliant score is assigned when claims compliance is between 80% and 94% and 5 to 8 elements were not met. Repeatedly missing one or more of the same elements over the course of 2 consecutive audits will result in Non-Compliance.
  4. A failing score is assigned when any of the following occur:
    - a. 9 or more elements are missed
    - b. Less than 80% of the claims are compliant
    - c. Any suspected illegal, fraudulent or abusive practices or violation of regulatory requirements that could result in sanctionable actions by a regulatory agency is identified during the audit
    - d. Repeated non-compliance with one or more of the same standards over the course of 3 or more consecutive audits. In this situation, a failing score will continue to be assigned until such time as a passing score has been achieved.
  5. Failure of the audit is deemed a breach of contract and subjects the Capitated Provider to a cure process, including but not limited to submission of a CAP, a 2% monthly capitation deduction, weekly monitoring and possible contract termination as outlined below.
  6. For more specific information on the actual scoring of the audit, the elements within each area noted below and actions taken for non-compliance or failure, please refer to the IEHP Audit Guide.
- L. Within 30 days of the last day of the audit (usually the on-site visit), IEHP sends a preliminary audit report to the Capitated Provider documenting the outcome of the audit, findings and recommended corrective actions. Capitated Providers have 2 weeks to review the preliminary report and notify IEHP of corrections.
- M. Within 15 days of receipt of the Capitated Provider's response to the preliminary report, IEHP sends a Final Findings Report and Corrective Action Plan Request (CAPR).
- N. The CAPR lists IEHP's findings with respect to deficiencies, along with specific recommendations to bring the Capitated Provider into contractual compliance. Capitated Providers are required to respond in writing to the CAPR by submitting a CAP within the timeframe specified by IEHP, generally 30 days from the date of the Final Findings Report. The CAP should discuss in detail how the Capitated Provider has modified its claims processing system to address the findings of the CAPR. If the CAP caused changes to the Provider's written policies and procedures and work flow charts, copies of this information must be submitted along with the CAP.

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## 20. CLAIMS PROCESSING

### D. Claims and Compliance Audits

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- O. IEHP evaluates and issues a letter of acceptance or rejection of submitted CAPs within 30 days of receipt.
1. If the CAP is accepted, IEHP issues a letter of acceptance.
  2. If a CAP is rejected, the reasons, along with recommendations as to how the CAP should be changed, are included in the rejection letter.
  3. Capitated Providers must submit a revised CAP within 15 days after the IEHP rejection letter is issued. IEHP evaluates the revised CAP within 15 days of receipt.
    - a. If acceptable, an acceptance letter is issued.
    - b. If rejected, the matter is referred to IEHP's Oversight Committee.
- P. Failure to provide an adequate CAP within required timeframes is treated as a contractual breach and may result in the Capitated Provider being subject to a 2% reduction of their capitation payment or possible contract termination until such time as an acceptable CAP is received. Untimely or inadequate CAPs may also impact the Capitated Provider's contract renewal terms.
- Q. CAP verification audits are performed whenever a Capitated Provider fails an annual or focused claims audit and/or to verify implementation of corrective actions for non-compliant audits.
1. The number and type of claims selected for a CAP verification audit may vary depending on the nature and scope of the deficiencies noted during the annual or focused audit.
  2. Capitated Providers failing an annual audit are allowed up to two CAP verification audits to demonstrate contractual compliance. Capitated Providers failing a focused audit are allowed one CAP verification audit in order to demonstrate contractual compliance.
  3. Capitated Providers who fail the final CAP verification audit as outlined in item 3 above, are subject to contract termination.
  4. Capitated Providers passing their CAP verification audit will be scheduled for their next annual audit approximately 6 months from the date of the last CAP verification audit and every 12 months thereafter.
- R. Capitated Providers passing their annual audit are scheduled for the next annual audit approximately 12 months from the date of the last audit and every 12 months thereafter; subject to the focused or verification audit provisions noted herein.
- S. Capitated Providers can submit a rebuttal to dispute the result of an audit through the IEHP Rebuttal process by submitting a written rebuttal to IEHP as outlined in The Audit Guide.
- T. Capitated Providers that receive an audit score that results in contract conversion/termination may request that IEHP's outside auditor, a contracted CPA firm, conduct an audit to confirm

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## 20. CLAIMS PROCESSING

### D. Claims and Compliance Audits

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or overturn said audit scores. The timeframe reviewed for the confirmation audit will be the same timeframe initially audited. In the event the results are upheld, contract termination/conversion will be initiated and the Capitated Provider is responsible for paying the outside auditors fees.

| INLAND EMPIRE HEALTH PLAN                       |                        |                   |
|---|------------------------|-------------------|
| <b>Chief Approval:</b> <i>Signature on file</i> | <b>Effective Date:</b> | September 1, 1996 |
| <b>Chief Title:</b> Chief Executive Officer     | <b>Revised Date:</b>   | January 1, 2012   |

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## **20. CLAIMS PROCESSING**

### **E. Disputes Between Contracted Relationships**

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#### **APPLIES TO:**

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

#### **POLICY:**

- A. IPAs, PCPs and/or IEHP are responsible for authorizing medical care.
- B. The IEHP IPA Capitated Agreement binds the IPA and its physicians to use the designated assigned Hospital as the exclusive provider for all Hospital Services, as applicable.
- C. In the event that a particular service is not available at the assigned Hospital the IPA must coordinate with the Hospital, if Capitated, or IEHP for per diem contracted Hospitals, to provide care for the Member at a mutually agreed upon facility.
- D. In the event of an emergency, the IPA must inform the Hospital, if Capitated, or IEHP for per diem contracted Hospitals, that care is being rendered at another facility.
- E. Members cannot be transferred when Member refuses to be transferred.

#### **PROCEDURE:**

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

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## 20. CLAIMS PROCESSING

### E. Disputes Between Contracted Relationships

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**Inland Empire Health Plan  
Attention: Claims Appeal Resolution Unit  
Post Office Box 10276  
San Bernardino, CA 92423**

4. Hospitals may send the practitioner a letter informing them that the claim has been forwarded to the IPA for payment; however a denial should not be sent to the practitioner.
5. The IPA must pay the claim for these hospital services unless the IPA feels the services provided were emergent or that the service was justified. In the event of the latter the IPA should submit the claim with the appropriate supporting documentation to IEHP at the above address with a letter of appeal explaining their position. The appeal must be submitted to IEHP within 365 days of the denial or payment.
6. IEHP will follow the procedures outlined in Policy 20A2, "Claims Processing: Health Plan Claims Appeals," in determining the appropriateness of the appeal and whose financial responsibility it is to pay the claim.
7. Payment will be issued by the responsible party as outlined in Policy 20A2, "Claims Processing: Health Plan Claims Appeals."

| <b>INLAND EMPIRE HEALTH PLAN</b>                |                        |                   |
|---|------------------------|-------------------|
| <b>Chief Approval:</b> <i>Signature on file</i> | <b>Effective date:</b> | September 1, 1996 |
| <b>Chief Title:</b> Chief Executive Officer     | <b>Revised date:</b>   | January 1, 2011   |

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## 20. CLAIMS PROCESSING

### F. Coordination of Benefits

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal 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 health plan or insurer.
- B. IEHP is always the Payor of last resort for Medi-Cal Members and all other coverages are primary. State and federal law require practitioners to bill a health insurance carrier prior to billing IEHP or the State. CCS is the primary Payor if a Medi-Cal Member utilizes services for CCS eligible conditions.

#### **PROCEDURE:**

##### **State Programs**

- A. IEHP pays 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 Medi-Cal Member has other insurance coverage, or entitlement, excluding tort liability of a third party (see Policy 20G, “Third Party Liability” for TPL information), Providers should utilize other coverage as primary and IEHP as the Payor of last resort; therefore, Providers should bill these carriers first, before paying for services from their capitation payment.
- C. Providers retain any monies collected through COB, in addition to any capitation received.
- D. Medi-Cal Members with only Medicare Part B coverage have an annual calendar year deductible of \$168. There is also a copayment requirement of 20% of the Medicare allowable amount.
- E. Providers who are assigned Medi-Cal Members with Medicare Part B coverage receive the capitation amounts outlined in the IEHP Capitated Agreement and are financially responsible for the amounts not covered under Medicare. Reimbursement for such services, when combined with the Medicare reimbursement, should not exceed the maximum Medi-Cal allowable.
- F. Providers who are assigned Medi-Cal Members are responsible for no more than the Medi-Cal schedule of reimbursement. If the primary insurance payment exceeds the full Medi-Cal reimbursement rate, Provider is not financially responsible for any additional amount.

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## 20. CLAIMS PROCESSING

### F. Coordination of Benefits

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| INLAND EMPIRE HEALTH PLAN                       |                        |                   |
|---|------------------------|-------------------|
| <b>Chief Approval:</b> <i>Signature on file</i> | <b>Effective Date:</b> | September 1, 1996 |
| <b>Chief Title:</b> Chief Executive Officer     | <b>Revised Date:</b>   | January 1, 2011   |

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## 20. CLAIMS PROCESSING

### G. Third-Party Liability

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**APPLIES TO:**

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

**POLICY:**

- A. Capitated Providers must not make a claim for recovery of the value of covered services rendered to a Medi-Cal 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.
- B. DHCS has sole lien rights for such recoveries. Providers must assist IEHP in identifying such cases to DHCS and must respond to any DHCS or IEHP generated request for claims information within 30 days of receipt of such request.

**PROCEDURE:**

- A. Providers must identify and notify the IEHP Claims Department of cases in which an action of a third party could result in recovery of funds by the Medi-Cal Member.
- B. IEHP must report such cases to DHCS within 10 days of discovery.
- C. If IEHP requests payment information and/or copies of paid invoices/claims for Covered Services to a Medi-Cal Member, Providers must deliver the requested information to DHCS within 30 days of request.

| INLAND EMPIRE HEALTH PLAN                       |                        |                   |
|---|------------------------|-------------------|
| <b>Chief Approval:</b> <i>Signature on file</i> | <b>Effective date:</b> | September 1, 1996 |
| <b>Chief Approval:</b> Chief Executive Officer  | <b>Revised date:</b>   | January 1, 2012   |

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## 20. CLAIMS PROCESSING

### H. Claims Reporting

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#### **APPLIES TO:**

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

#### **POLICY:**

- A. IEHP provides oversight of claims processing by Capitated Providers through monitoring of Capitated Providers' claims payments and denial processes, provider dispute mechanisms and assessing for demonstrable and unjust payment patterns on an on-going basis.
- B. As part of the monitoring process and to comply with state and federal regulatory requirements, Capitated Providers are required to submit Claims Payment and Dispute Mechanism Reports to IEHP.
- C. Failure to submit required reports within the indicated timeframes may result in the Provider being subjected to a focused audit which may negatively impact the Provider's contract renewal terms and may lead to contract termination or conversion.

#### **PROCEDURE:**

- A. Capitated Providers' claims processing systems must be able to identify, track and report all claims and provider disputes, by line of business (i.e., Medi-Cal, Healthy Families, Healthy Kids, etc.) and produce the following ad hoc reports as outlined in the IEHP Audit Guide, Section I, "Performance Monitoring."
1. Received Claims – all claims received for a specified period regardless of status.
  2. Paid Claims – all claims paid for services rendered to Members.
  3. Denied Claims – all claims denied for services rendered to Members. (Note: IEHP considers denied claims to be all claims adjudicated in which the total dollars paid is \$0.00. This includes all claims denied for non-contracted and contracted providers, such as duplicates or non-authorized services, as well as those in which the Member may be liable).
  4. Pended/Contested Claims – claims pended and/or contested for development or in which a determination to pay or deny cannot be made without further information. Examples include claims forwarded for medical review, contested claims and written requests for additional information sent.
  5. Claims Inventory – all claims received and open (i.e. received, however a check or denial has not been issued), whether or not entered in the claims system. Reports should be able to be run at summary level, provider level or claim level.
  6. Claims Overpayments – all claims in which an overpayment has been identified and requests for reimbursement have been sent to the rendering provider.

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## 20. CLAIMS PROCESSING

### H. Claims Reporting

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7. Claims Adjustments – all claims in which a post-payment adjustment has been made due to internal audits, disputes or appeal resolutions, inquiries, retroactive contract or rate adjustments, etc.
  8. Claims Aging – all claims in-house, by age.
  9. Provider Disputes – all claims, billing, contract, UM/medical necessity and other disputes received from providers of service.
    - a. Claims/Billing – any formal written disagreement involving the payment, denial, adjustment, or contesting of a claim, including overpayments, payment rates, billing issues or other claim reimbursement decisions
    - b. Contract – any formal written disagreement concerning the interpretation, implementation, renewal or termination of a contractual agreement
    - c. UM/Medical Necessity – any formal written disagreement concerning the need, level or intensity of health care services provided to Members
  10. Interest Paid – any claim in which interest was paid, including late paying claims, disputes or adjustments
  11. Redirected Claims – all misdirected claims forwarded to another payor or denied to the provider of service, whether or not entered in the claims system.
  12. Emergency Services Claims – all claims received, regardless of status, for emergency services. Emergency services are defined as claims with a place of service ‘23’ or revenue code ‘450’.
  13. Denied Claims by Type/Volume – number of claims denied by type (reason).
  14. Paid Claims by Date/Volume – number of claims paid by check run date.
  15. Pended Claims by Type/Volume – number of claims pended by type (reason).
  16. Disputed Claims by Type/Volume – number of resolved disputes claims by reason code (i.e., underpayment of contract rate).
  17. Check Mailing/Attestation – an accounting of all checks mailed per check run whether scheduled or not
  18. Customer Service Calls – an accounting of all incoming claim or dispute related phone calls from providers of service, including claims status calls.
- B. IEHP requires Capitated Providers to submit monthly, quarterly and annual reports to self-report compliance with contractual and regulatory standards pertaining to claims and dispute processing. Each report must be submitted in IEHP’s required format, using IEHP provided templates and/or designated format as delineated in the IEHP Audit Guide.

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## 20. CLAIMS PROCESSING

### H. Claims Reporting

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- C. By the 15<sup>th</sup> of each month, Capitated Providers must submit to IEHP the Monthly Claims Timeliness Summary Report (MTR) for the previous month's activity, as outlined in the Audit Guide.
1. Each line of business should be separately tracked and reported.
  2. Each report must be reviewed and include a signed attestation as to the accuracy and validity of the report by a Designated Principal Officer. If the Designated Principal Officer is different for claims and Provider disputes, both parties must sign the monthly report.
  3. Refer to the Audit Guide for detailed specifications for each report and additional monthly reporting requirements and information.
- D. On a quarterly basis, Capitated Providers must submit reports for disputes and adjustments for review and evaluation as outlined below.
1. The required reports are:
    - a. Quarterly Provider Dispute Resolution (PDR)
    - b. Statement of Deficiencies
    - c. Adjustment Summary Report
    - d. Resolved Disputes by Type/Volume
  2. All quarterly reports are due to IEHP by the 30th of the month following the end of the quarter (i.e., the quarterly report for the period 10/1/11 through 12/31/11 would be due January 30, 2012) and must be signed by the designated principal officer
  3. Refer to the Audit Guide for detailed specifications for each report and additional quarterly reporting requirements and information.
- E. On an annual basis, Capitated Providers must submit an Annual Claims Payment and Provider Dispute Mechanism Report (Annual Report) to IEHP summarizing the disposition of all claims and provider disputes received by the Capitated Provider for all lines of business combined.
1. The Annual Report must be submitted to IEHP no later than November 30th of each year, for the reporting period covering October 1 through September 30 and must be signed by the Designated Principal Officer attesting to the accuracy and validity of the reported information.
  2. Refer to the Audit Guide for detailed specifications for each report and additional annual reporting requirements and information.
- F. As outlined in Policy 20D, "Claims and Compliance Audits", as well as the Audit Guide, Capitated Providers must also generate the following reports for the designated audit

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## 20. CLAIMS PROCESSING

### H. Claims Reporting

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period, for review and claims selection (detailed specifications are outlined in the Audit Guide):

1. Paid Claims Report, including separate identification of emergency service claims and family planning claims (see the Audit Guide for definitions of emergency services and family planning claims)
  2. Denied Claims Report, including separate identification of emergency service and family planning claims
  3. Overpayments Report
  4. Adjustments Report
  5. Resolved Disputed Claims Report
  6. Interest Paid Claims Report
  7. Pended Claims Report (covering all unresolved pended claims on day of audit), including identification of the pend reason as well as identification and count of emergency claims and non-emergency services claims
  8. Claims Inventory Report (covering all open claims on day of audit), including separate identification and count of emergency claims
  9. Claims Received Report (covering all claims received in the last 90 days of the audit period, regardless of status)
  10. Log of Redirected Claims
  11. Claims Inquiry/Customer Call Log (covering last 90 days of the audit period), including reason for the call and outcome.
  12. Signed Check Mailing/Attestation Log (covering all checks issued for IEHP Members during the audit period), including check number, check amount and date mailed.
- G. As outlined in the Audit Guide, IEHP reviews all reports for on-going monitoring of compliance with regulatory and contractual requirements, as well as to identify possible trends or patterns that may be indicators, alone or in conjunction with other information obtained by IEHP (i.e., provider inquiries), of potential unfair payment practices or other issues that may trigger out-of-cycle corrective actions. Such action includes but is not limited to:
1. Increased reporting and monitoring
  2. Submission of a Corrective Action Plan (CAP) or a
  3. Focused audit.

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## 20. CLAIMS PROCESSING

### H. Claims Reporting

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

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

| INLAND EMPIRE HEALTH PLAN                       |                        |                  |
|---|------------------------|------------------|
| <b>Chief Approval:</b> <i>Signature on file</i> | <b>Effective date:</b> | February 1, 2004 |
| <b>Chief Title:</b> Chief Executive Officer     | <b>Revised date:</b>   | January 1, 2012  |

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## 20. CLAIMS PROCESSING

### Attachments

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| <u>ATTACHMENT</u> | <u>DESCRIPTION</u>                                       | <u>POLICY CROSS REFERENCE</u> |
|-------------------|--|-------------------------------|
| 20-1              | PD Request Additional Information Letter                 | 20A1,                         |
| 20-2              | PD Denial-Requested Information Not Received Letter      | 20A1,                         |
| 20-3              | 14-Day Rejection Letter                                  | 20C1                          |
| 20-4              | IEHP Remittance Advice                                   | 20A                           |
| 20-5              | Letter to Provider Regarding Billing of Covered Services | 20B                           |
| 20-6a             | Appeal Response Letter                                   | 20A2,                         |
| 20-6b             | Appeal Decision Upheld Letter                            | 20A2                          |
| 20-6c             | 14-Day Non-Response Letter                               | 20A2                          |
| 20-7              | Provider 14 Day Letter                                   | 20A2, 20B, 20C1               |
| 20-8              | 14-Day Inappropriate Denial Letter                       | 20A2, 20C1                    |
| 20-9              | Capitation Payment Deduction                             | 20C1                          |
| 20-10a            | Provider Appeal Acknowledgement Letter                   | 20A2                          |
| 20-10b            | Provider Appeal Acknowledgement Letter                   | 20A2                          |
| 20-11             | Balance Bill Medi-Cal Member Letter                      | 20B                           |
| 20-12             | Provider Dispute Denial – Late Submission Letter         | 20A1                          |
| 20-13a            | PD Bulk Acknowledgment Letter                            | 20A1                          |
| 20-13b            | PD Bulk Acknowledgment Letter – 2 <sup>nd</sup> Level    | 20A1                          |
| 20-14             | PD Original Claim Determination Upheld Letter            | 20A1                          |
| 20-15             | PD Payment Adjustment Made Letter                        | 20A1                          |

**D05 - SINGLE DISPUTE ACKNOWLEDGEMENT LETTER  
WITH REQUEST FOR ADDITIONAL INFORMATION**

Date:

Provider Name:  
Attention: Billing Department  
Provider Address:  
Provider City, State Zip:

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

Dear Provider:

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

- **List specific item of information needed for dispute**

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

IEHP, Claim Appeals Resolution Unit  
P.O. Box 10276  
San Bernardino, CA 92423-0276

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

Sincerely,

Claim Appeals Resolution Specialist  
Inland Empire Health Plan

**DISPUTE CLOSURE LETTER FOR NON RECEIPT  
OF ADDITIONAL INFORMATION**

Date:

Provider Name:  
Attention: Billing Department  
Provider Address:  
Provider City, State Zip:

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

Dear Provider:

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

- [INSERT WHAT HAD BEEN REQUESTED FROM D05 LETTER]

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

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

Sincerely,

Claim Appeals Resolution Specialist  
Inland Empire Health Plan

{{(Date)}}

{{(Provider Name)}}

{{(Address)}}

{{(City, State Zip)}}

Member Name:

Member ID Number:

Date of Service:

IEHP Claim Number:

Dear Billing Department:

Inland Empire Health Plan (IEHP) has received your Dispute or Appeal on the above referenced claim on {{(Date)}}. After careful review, it has been determined that this claim is neither a dispute nor an appeal for the following reason:

<Letter Comments>

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

Sincerely,

Claims Appeal Resolution Specialist  
Inland Empire Health Plan

*C52/Diamond Initials*

Inland Empire Health Plan  
Remittance Advice

Dr. Bob Blob  
1234 Practice Place  
#A  
Healthy City, CA 98765

Check Date: 4/1/2009  
Check Amt.: \$\*\*\*\*\*25.00  
Check No.: 373522  
Page No.: 1  
0.00

| Member#                           | Line of Business         | DOB        | Patient Name          | Provider Name | Received Date | Service Date From | Service Date To | Proc Mod | Qty | Amount Billed | Amount Allowed | Not Covered | Copay Amount | Deduct Amount | Withhold Amount | Net Paid | S T | Reason | Deduct Copay | Deduct OthCarr | Adjust |
|-----------------------------------|--------------------------|------------|-----------------------|---------------|---------------|-------------------|-----------------|----------|-----|---------------|----------------|-------------|--------------|---------------|-----------------|----------|-----|--------|--------------|----------------|--------|
| 200010005431-00<br>E902345678 001 | IEHP Medicare DualChoice | 12/09/1953 | Mary H. Lamb          | Dr. Mary Blob | 02/27/09      | 10/28/08          | 10/28/08        | 88141 P  | 1.0 | 25.00         | 0.00           | 25.00       | 0.00         | 0.00          | 0.00            | 0.00     | C   | CAPSV  |              |                |        |
|                                   | Patient Acct# S3154      |            | Claim Totals          |               |               |                   |                 |          |     | 25.00         | 0.00           | 25.00       | 0.00         | 0.00          | 0.00            | 0.00     |     |        |              |                |        |
|                                   |                          |            | Member Totals         |               |               |                   |                 |          |     | 25.00         | 0.00           | 25.00       | 0.00         | 0.00          | 0.00            | 0.00     |     |        |              |                |        |
| 200010005431-00<br>E902345678 001 | Medi-Cal                 | 12/09/1953 | Mary H. Lamb          | Dr. Mary Blob | 02/27/09      | 10/28/08          | 10/28/08        | 88141 P  | 1.0 | 25.00         | 25.00          | 25.00       | 0.00         | 0.00          | 0.00            | 25.00    | P   | P4P    |              |                |        |
|                                   | Patient Acct# S3154      |            | Claim Totals          |               |               |                   |                 |          |     | 25.00         | 25.00          | 0.00        | 0.00         | 0.00          | 0.00            | 25.00    |     |        |              |                |        |
|                                   |                          |            | Member Totals         |               |               |                   |                 |          |     | 25.00         | 25.00          | 0.00        | 0.00         | 0.00          | 0.00            | 25.00    |     |        |              |                |        |
|                                   |                          |            | Provider Totals       |               |               |                   |                 |          |     | 50.00         | 25.00          | 25.00       | 0.00         | 0.00          | 0.00            | 25.00    |     |        |              |                |        |
|                                   |                          |            | Vendor Account Totals |               |               |                   |                 |          |     | 50.00         | 25.00          | 25.00       | 0.00         | 0.00          | 0.00            | 25.00    |     |        |              |                |        |

Inland Empire Health Plan  
Remittance Advice

Dr. Bob Blob  
1234 Practice Place  
#A  
Healthy City, CA 91234

Check Date: 4/1/2009  
Check Amt.: \$\*\*\*\*\*25.00  
Check No.: 373522  
Page No.: 2  
0.00

\*\* Summary Page \*\*

Total Number Of Claims 2  
Total Number Of Claims Lines 2  
Total Payment Amount \$25.00

Explanations Code Legend

-----  
CAPSY CAPITATED SERVICE  
P4P PAY FOR PERFORMANCE PROGRAM

ST Code Legend IInformational, PPayable, DDenied, AAdjustment, HClaim Received & In Process

Please Note

Medi-Cal, Healthy Families, Healthy Kids, Commercial members

- \* Under the Knox-Keene Act, Health and Safety Code 1379 of the State of California and Title 22 of the California Code of Regulations, the patient to whom services were provided is not liable for any portion of the bill, except non-benefit items or non-covered services.
- \* In compliance with AB1455, if you disagree with your payment you may contact IEHP Claims Customer Service at (888) 322-6693. You may also file a Provider Dispute within 365-days from the claim determination date. Disputes should be submitted to IEHP Provider Disputes P.O. Box 10276, San Bernardino, CA 92423. Please visit [www.iehp.org](http://www.iehp.org) to obtain a Provider Dispute Resolution form online.
- \* In accordance with our agreement, negative balances will be offset against future claims to be paid to you.

Withhold Amount

- \* By statute enacted in February 2008 (in response to the California budget crisis) effective July 1, 2008 Medi-Cal has reduced payments to specific provider types by 10% with a corresponding reduction to Medi-Cal Managed Care Plans. Due to this legislative mandate, IEHP has reduced payments to all providers referenced in the statute by 10%.

IEHP Medicare Dual Choice members

- \* If you disagree with the outcome of a claim, you may submit an appeal within 60-days from the payment or denial date. Upon receipt, IEHP will review the appeal and issue a written determination within 60-days of receipt. Payment appeals should be mailed to IEHP Medicare Dual Choice Claim Appeals, P.O. Box 10276, San Bernardino, CA 92423. For more information, please contact IEHP Claims Services at (888) 322-6693.

Legal Notice

- \* Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil and criminal penalties.
- \* Please assist IEHP in preventing possible benefit abuse. Request another form of identification from the Member in addition to the IEHP card.

{{(Date)}}

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

Re:                   {{(Members Name)}}  
Acct:                {{(Number)}}  
ID#:                 {{(IEHP ID Number)}}  
Date of Service:   {{(Date)}}

To Whom It May Concern:

It has come to the attention of Inland Empire Health Plan that you are billing the above referenced Member for medical services rendered on {{(Date)}}. Our records indicate that this Member was active on this date.

The Member has been billed inappropriately. The financial responsibility for this claim is assigned to the Member's Medical Group:

«HOSP/IPA»  
«DEPARTMENT»  
«ADDRESS»  
«CITY», «ST» «ZIP»

Please update your records and submit your claim to the appropriate payer. Should you have any further questions, call the responsible payer for clarification regarding billing practices or contact the Provider Call Center at (909) 890-2054 or (866) 223-4347.

Sincerely,

Claims Appeal Resolution Specialist  
Inland Empire Health Plan

*MB09/Diamond Initials*

{{(Date)}}

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

Member Name:       {{(Member Last Name, First Name)}}  
Member ID Number: {{(ID #)}}  
Pt. Acct. No.:       {{(Patient Account Number)}}  
Date of Service:     {{(Date)}}  
Amount Billed:       {{(Dollar Amount)}}  
IEHP Claim Number: {{(Claim Number)}}

Dear Billing Department:

Inland Empire Health Plan (IEHP) has completed processing the appeal on the above mentioned service(s) provided by you. Enclosed is a copy of the response IEHP received from the responsible capitated payor in our network.

If you require a check tracer or additional information, please contact the capitated payor, {{(name of payor)}} at {{(payors phone number)}}.

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

Sincerely,

Claims Appeal Resolution Specialist  
Inland Empire Health Plan

{{Date}}

<IPA/HOSPITAL>  
Attention: Billing Department  
<Address>  
<City, State Zip>

Member Name: <Member Last Name, First Name>  
Member ID Number: <ID #>  
Pt. Acct. No.: <Patient Account Number>  
Date of Service: <Date>  
IEHP Claim Number: <Claim Number>

Dear Billing Department:

Inland Empire Health Plan (IEHP) has received a request from you to review a denial or reduction for services rendered to the above referenced claim.

<Letter Comments>

This decision was based on the information provided by you. If you disagree with this decision, you may appeal through the IEHP Provider Appeals process by submitting such request in writing to the IEHP Medical Director. Written requests must be signed by appropriate medical personnel when the dispute involves medical decision making. Submit your request with a copy of this letter and supporting documentation to

Inland Empire Health Plan, Claims Appeals Resolution Unit  
Post Office Box 10276  
San Bernardino, California 92423.

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

Sincerely,

Claims Appeal Resolution Specialist  
Inland Empire Health Plan

*C12b/Diamond Initials*

{{(Date)}}

{{(Provider Name)}}

Attention: Billing Department

{{(Address)}}

{{(City, State Zip)}}

Dear Claims Manager:

Inland Empire Health Plan's (IEHP) Claims Department previously requested information from you regarding the below referenced claim. IEHP has not received the required proof of payment within the 14-day timeframe in accordance with IEHP Policy 20A2. The policy indicates, "If the Payor does not pay or provide evidence that the claim was paid then IEHP pays the claim on the Payor's behalf and deducts the payment from future payments, including capitation due to the Provider".

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

|                  |  |               |  |
|------------------|--|---------------|--|
| Claim Number:    |  | Provider:     |  |
| Member Name:     |  | Date Paid:    |  |
| IEHP ID:         |  | Amount Paid:  |  |
| Pt. Acct. No.:   |  | Check Number: |  |
| Date of Service: |  | Date Mailed:  |  |

If you have any questions, please contact the IEHP Provider Call Center at (909) 890-2054 or (866) 223-4347.

Sincerely,

Claims Appeal Resolution Specialist  
Inland Empire Health Plan

cc: *Provider of Service*

*C30a/Diamond Initials*

<Date>

**Due Date:**

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

Dear Claims Manager:

Please provide payment or denial information for the claim listed below. Attached is a copy of the original claim for your review. Return this **fully completed** letter within fourteen (14) calendar days to: Inland Empire Health Plan, Claims Department, P.O. Box 10276, San Bernardino, CA. 92423 or Fax to: 909-890-5747.

| <b>Incomplete responses or responses received after fourteen (14) calendar days will be subject to capitation deduction from your next monthly capitation payment.</b>  |  |                               |  |
|---|--|-------------------------------|--|
| 1. Your response <b>must</b> indicate whether claim is paid or denied.<br>2. <b>Pending, No Auth,</b> and <b>Not Eligible</b> are inappropriate responses. IEHP has verified the Member's eligibility.                          |  |                               |  |
| <b>THESE RESPONSES WILL RESULT IN CAPITATION DEDUCTION.</b>   |  |                               |  |
| 3. If denial letter is being issued as a result of this inquiry, a copy of the letter must accompany your response.<br>4. Provide written documentation (EOB, Auth Limitations, TANN Log, etc.) to substantiate your responses. |  |                               |  |
| <i><b>IEHP Completes</b></i>  |  | <i><b>Payer Completes</b></i> |  |
| Claim Number:   |  | Original Date Rec'd:          |  |
| Member Name:  |  | Date Paid:                    |  |
| IEHP ID:  |  | Amount Paid:                  |  |
| Pt. Acct. No.:  |  | Check Number:                 |  |
| Date of Service:  |  | Date Denial Sent:             |  |
| Amount Billed:  |  | Denial Reason:                |  |
|   |  | Person Responding:            |  |
|   |  | Person's Phone #:             |  |
| <i><b>IEHP notes:</b></i><br>Comments:  |  |                               |  |
| <i><b>Payer notes:</b></i>  |  |                               |  |
| <b>DENIAL REASONS (Please circle response)</b>  |  |                               |  |
| 1. Carve out (type _____ )  |  | 4. Non-Emergent               |  |
| 2. Non-covered benefit (type _____ )  |  | 5. Other: _____               |  |
| 3. IPA Retro-Reviewed and service is not medically indicated.   |  | _____                         |  |

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

Sincerely,

Claims Appeal Resolution Specialist  
Inland Empire Health Plan

C07/Diamond Initials

{{(Date)}}

**Due Date:**

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

Dear Claims Manager:

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

<Letter Comments>

|                           |  |                      |  |
|---------------------------|--|----------------------|--|
| Claim Number:             |  | <b>Date Paid:</b>    |  |
| Member Name:              |  | <b>Amount Paid:</b>  |  |
| IEHP ID:                  |  | <b>Check Number:</b> |  |
| Pt. Acct. No.:            |  | <b>Date Mailed:</b>  |  |
| Date of Service:          |  | <b>Signed:</b>       |  |
| Amount Billed:            |  |                      |  |
|                           |  |                      |  |
| <b>Person Responding:</b> |  | <b>Phone:</b>        |  |
| Comments:                 |  |                      |  |

Please complete this form and return it to the IEHP Claims Department. You may mail to Inland Empire Health Plan, Attention Claims Department. P.O. Box 10276, San Bernardino, CA 92423 or Fax to: 909-890-5747.

Payment is due within 14 calendar days. If you fail to provide proof of payment within 14 calendar days, the claim will be subject to capitation deduction from your next capitation payment. If you have any questions, or concerns, please contact the IEHP Provider Call Center at (909) 890-2054 or (866) 223-4347.

Sincerely,

Claims Appeal Resolution Specialist  
 Inland Empire Health Plan

## Capitation Payment Deduction

**INLAND EMPIRE HEALTH PLAN  
 Claims Department  
 Claims Capitation Deductions Detail by IPA/Hospital**

Total Deductions for:

| PROVIDER OF SERVICE | MEMBER LAST NAME | MEMBER FIRST NAME | DATE OF SERVICE | IEHP ID | CLAIM# | CODE BILLED | MOD | QTY | AMOUNT BILLED | AMOUNT PAID | EOB CODE |
|---------------------|------------------|-------------------|-----------------|---------|--------|-------------|-----|-----|---------------|-------------|----------|
|                     |                  |                   |                 |         |        |             |     |     |               |             |          |
| #Error              |                  |                   |                 |         |        |             |     |     | #Error        | #Error      |          |

**INLAND EMPIRE HEALTH PLAN**  
**Claims Department**  
**Claims Capitation Deductions Detail by IPA/Hospital**

Total Deductions for:

| PROVIDER OF SERVICE | MEMBER LAST NAME | MEMBER FIRST NAME | DATE OF SERVICE | IEHP ID | CLAIM# | CODE BILLED | MOD | QTY | AMOUNT BILLED | AMOUNT PAID | EOB CODE |
|---------------------|------------------|-------------------|-----------------|---------|--------|-------------|-----|-----|---------------|-------------|----------|
| Grand Total         |                  |                   |                 |         |        |             |     |     | #Error        | #Error      |          |

<Date>

<Provider Name>

<Provider Address>

<Provider City, State, Zip>

Member Name: <Member Name>

Member ID Number: <Member Id #>

Patient Acct #: <Member Acct #>

Date of Service: <Date of Service>

IEHP Claim Number: <Claim #>

Dear Billing Department:

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

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

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

Sincerely,

Claims Appeal Resolution Specialist  
Inland Empire Health Plan

<Date>

<Provider Name>

<Provider Address>

<Provider City, State and Zip>

Member Name: <Member Name>

Member ID Number: <IEHP ID #>

Patient Acct #: <Patient Acct #>

Date of Service: <Date of Service>

IEHP Claim Number: <Claim #>

Dear Billing Department:

Inland Empire Health Plan (IEHP) has received your 2nd level Appeal on the above referenced claim on <Date>. You will be notified of the decision made within 45 working days from the day that IEHP received this Appeal.

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

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

Sincerely,

Claims Appeal Resolution Specialist  
Inland Empire Health Plan

{{(Date)}}

**Via Certified Mail:**  
**Due:**

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

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

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

To Whom It May Concern:

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

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

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

“To comply with these federal requirements, Medi-Cal has imposed certain limitations on provider reimbursement. Under section 14019.3, subdivision (c), “[u]pon presentation of the Medi-Cal card or other proof of eligibility, the provider shall submit a Medi-Cal claim for

reimbursement ....” **“Any provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility ... shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or any person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services.”** (§ 14019.4, subd. (a).)<sup>ii</sup>

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

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

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

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

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

Thank you for your anticipated cooperation.

Sincerely,  
*{(CARS Name)}*  
Claims Appeal Resolution Specialist  
Inland Empire Health Plan

<sup>i</sup> *Olszewski v. Scripps Health*, 30 Cal.4th 798, 812 (2003) (emphasis added).

<sup>ii</sup> *Id.* at 813 (emphasis added). Also see Title 22, Calif. Code of Regulations, § 51002(a).

<sup>iii</sup> For emergent services, the prohibition against balance billing is also set forth in Title 28, Calif. Code of Regulations, § 1300.71.39(a).

<sup>iv</sup> California Department of Health Services, *Medi-Cal Provider Agreement*, DHS 6208 (1/06) (“DHS Provider Agreement”), sec. 20 (emphasis in original).

<sup>v</sup> See Calif. Welf. & Inst. Code, sec. 14123(a); DHS Provider Agreement, sec. 25(b)(1).

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**CLAIMS DISPUTE RESOLUTION  
Late Submission**

Date:

Provider Name:  
Attention: Billing Department  
Provider Address:  
Provider City, State Zip:

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

Dear Provider:

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

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

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

Sincerely,

Claim Appeals Resolution Specialist  
Inland Empire Health Plan

Date:

Provider Name:  
Attention: Billing Department  
Provider Address:  
Provider City, State Zip:

Member Name:  
Date of Service:  
Total Billed Amount:  
Claim # (s): *See Attached Report*  
PDR Date Received: *See Attached Report*

Dear Provider:

Inland Empire Health Plan (IEHP) received a claim dispute(s) regarding the claim referenced above. The dispute will be reviewed and a resolution will be sent. If you have not received a response or resolution within 45 working days from the date of receipt, please contact the IEHP Provider Relations Team at (909) 890-2054 or (866) 223-4347. Please use the claim number to reference the claim.

Sincerely,

Claim Appeals Resolution Specialist  
Inland Empire Health Plan

C50

Acknowledged: {{Date}}

Provider: {{Provider Name}}

| Claim Number | Member Name | Pt. Account Number | IEHP ID Number | DOS | Dispute Rcvd Date |
|--------------|-------------|--------------------|----------------|-----|-------------------|
|              |             |                    |                |     |                   |
|              |             |                    |                |     |                   |
|              |             |                    |                |     |                   |

Revision: 02/17/11

Date:

Provider Name:  
Attention: Billing Department  
Provider Address:  
Provider City, State Zip:

Member Name:  
Date of Service:  
Total Billed Amount:  
Claim # (s): *See Attached Report*  
PDR Date Received: *See Attached Report*

Dear Provider:

Inland Empire Health Plan (IEHP) has received your 2<sup>nd</sup> Level Dispute(s) regarding the claim referenced above. The dispute will be reviewed and a resolution will be sent. If you have not received a response or resolution within 45 working days from the date of receipt, please contact the IEHP Provider Relations Team at (909) 890-2054 or (866) 223-4347. Please use the claim number to reference the claim.

Sincerely,

Claim Appeals Resolution Specialist  
Inland Empire Health Plan

C50A

Acknowledged: {{Date}}

Provider: {{Provider Name}}

| Claim Number | Member Name | Pt. Account Number | IEHP ID Number | DOS | Dispute Rcvd Date |
|--------------|-------------|--------------------|----------------|-----|-------------------|
|              |             |                    |                |     |                   |
|              |             |                    |                |     |                   |
|              |             |                    |                |     |                   |

Revision: 02/17/11

## CLAIMS DISPUTE RESOLUTION Original Claim Determination Upheld

Date:

Provider Name:  
Attention: Billing Department  
Provider Address:  
Provider City, State Zip:

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

Dear Provider:

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

- The claim is the financial responsibility of the member's IPA.
- The member was not eligible at the time medical services were rendered.
- The medical services received are not a covered benefit under the health plan.
- Contracted rate paid and no additional amount is due.
- No invoice received.
- Medical services were not authorized.
- Member has other primary insurance.
- Additional information requested was never received.
- Other:

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

Sincerely,

Claim Appeals Resolution Specialist  
Inland Empire Health Plan

**CLAIMS DISPUTE RESOLUTION  
Adjustment/Payment Made**

Date:

Provider Name:  
Attention: Billing Department  
Provider Address:  
Provider City, State Zip:

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

Dear Provider:

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

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

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

Payment may include applicable interest or penalties due.

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

Sincerely,

Claim Appeals Resolution Specialist  
Inland Empire Health Plan

D03/Diamond Initials