

CLAIMS DEFINITIONS

Automatically: The payment of the interest due to the provider shall be made no later than five (5) working days after the payment of the claim without the need for any reminder or request by the provider.

1. If the interest payment is not sent in the same envelope as the claim payment, the IPA shall identify the specific claim or claims for which the interest payment is made, include a statement setting forth the method for calculating the interest on each claim, and document the specific interest payment made for each claim.

2. In the event that the interest due on an individual late claim payment is less than \$2.00 at the time the claim is paid, the IPA may pay the interest on that claim, along with interest on other such claims within ten (10) calendar days after the close of the calendar month in which the claim was paid, provided the IPA includes with the interest payment a statement identifying the specific claims for which the interest is paid, setting forth the method for calculating interest on each claim, and documenting the specific interest payment made for each claim.

Complete Claim: A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides “reasonably relevant information,” “information necessary to determine payer liability” and varies somewhat based on the type of provider.

1. Provider claims for services rendered to a patient who was provided emergency services and care in the United States on or after September 1, 1999, pursuant to section 1371.35(j) of the Health and Safety Code:

(a) A claim or portion thereof, is reasonably contested if the plan has not received the completed claim pursuant to Section 1371.35(c) of the Health and Safety Code, and

(b) Any state-designated data requirements included in statutes or regulations.

2. For institutional providers:

(a) Completed UB 04 data set or its successor format adopted by the National Uniform Billing committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC;

(b) Entities stated as mandatory by NUBC and required by federal statute and regulations; and

(c) Any state-designated data requirements included in statutes or regulations.

3. For physicians and other professional providers:

(a) Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim committee (NUCC) submitted on the designated paper or electronic format;

(b) Current Procedural Terminology (CPT) codes and modifiers and International Classification of diseases (ICD-9CM) codes;

(c) Entries stated as mandatory by NUCC and required by federal statute and regulations; and

(d) Any state-designated data requirements included in statutes or regulations.

4. For pharmacists;

(a) Universal claim form and data set approved by the National Council on Prescription Drug Programs; and

(b) Any state-designated data requirements included in statutes or regulations.

5. For providers not otherwise specified in this policy or the applicable sections of the Code of California Regulations:

(a) A properly completed paper or electronic billing instrument submitted in accordance with the IPA/Medi-Cal Group's reasonable specifications; and

(b) Any state-designated data requirements included in statutes or regulations.

Date of Contest, Date of Denial, or Date of Notice: The date of postmark or electronic mark accurately setting forth the date on which the contest, denial, or notice was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record with proper postage prepaid. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code Section 641.

Date of Payment: The date of postmark or electronic mark accurately setting forth the date when the payment was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the date of payment, when auditing claims payment compliance, the date the check is printed and the date the check is presented for payment may be considered. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code Section 641.7

Date of Receipt: The working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's capitated provider for that claim. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.

For claims received for IPA payment, the IPA ensures compliance with Chapter 1, Section 80.2.1, which states the receipt date of a claim is the date the contractor receives the claim (provided the filing is in a format and contains data sufficiently complete so that the filing qualifies as a claim). The receipt date is used to: determine if the claim was timely filed (see

§70.3), determine the “payment floor” for the claim (see §80.2.1.2), determine the “payment ceiling” on the claim (see §80.2.1.1) and, when applicable, to calculate interest payment due for a clean claim that is not timely processed, and to report to CMS statistical data on claims, such as in workload reports. A paper claim that is received by 5:00 p.m. on a business day, or by closing time if the contractor routinely ends its public business day between 4:00 p.m. and 5:00 p.m., must be considered as received on that date, even if the contractor does not open the envelope until a later date. A paper claim that is received after 5:00 p.m., or after the contractor’s routine close of business between 4:00 p.m. and 5:00 p.m., is considered as received on the next business day. A paper claim is considered as received if it is delivered to the contractor’s place of business by the U.S. Postal Service, picked up from a P.O. box, or is otherwise delivered to the contractor’s place of business by its routine close of business time. If the contractor uses a P.O. box for receipt of mailed claims, it must have its mail picked up from its box at least once per business day unless precluded on a particular day by the emergency closing of its place of business or that of its postal box site. As electronic claim tapes and diskettes that may be submitted by providers or their agents to an FI are also subject to manual delivery, rather than direct electronic transmission, the paper claim receipt rule also applies to establish the date of receipt of claims submitted on such manually delivered tapes and diskettes. Electronic claims transmitted directly to a contractor, or to a clearinghouse with which the contractor contracts as its representative for the receipt of its claims, by 5:00 p.m. in the contractor’s time zone, or by its closing time if it routinely closes between 4:00 p.m. and 5:00 p.m., must likewise be considered as received on that day even if the contractor does not upload or process the data until a later date.

Date of Service: For purposes of evaluating claims submission and payment requirements:

1. For outpatient services and all emergency services and care: the date upon which the provider delivered separately billable health care services to the enrollee;
2. For inpatient services: the date upon which the member was discharged from the inpatient facility. However, the IPA shall accept separately billable claims for inpatient services on at least a bi-weekly basis.

Demonstrable and Unjust Payment Pattern or Unfair Payment Pattern: Any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of 8 provider claims. The following practices, policies and procedures may constitute a basis for a finding that the IPA or IPA/Medi-Cal Group’s capitated provider has engaged in a demonstrable and unjust payment pattern.

1. The imposition of a Claims Filing Deadline inconsistent with this policy in three (3) or more claims over the course of any three (3) month period;
2. The failure to forward at least 95% of misdirected claims consistent with Section “Procedure B” of this policy over the course of any three (3) month period;
3. The failure to accept a late claim consistent with Section “Procedure A.2 at least 95% of the time for the affected claims over the course of any three (3) month period;

4. The failure to request reimbursement of an overpayment of a claim consistent with the provisions of this policy at least 95% of the time for the affected claims over the course of any three-month period;
5. The failure to acknowledge the receipt of at least 95% of claims consistent with Section “Procedure C” of this policy over the course of any three-month period;
6. The failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with Section “Procedure E” of this policy at least 95% of the time for the affected claims over the course of any three-month period;
7. The inclusion of contract provisions in a provider contract that requires the provider to submit medical records that are not Reasonably Relevant Information, for the adjudication of a claim on three (3) or more occasions over the course of any three month period;
8. The failure to establish, upon written request, that requests for medical records more frequently than in three percent (3%) of the claims submitted to IPA or IPA/Medi-Cal Group’s capitated provider by all providers over any 12-month period was Information Necessary to Determine Payer Liability for those claims. The calculation of the 3% threshold and the limitation on requests for medical records shall not apply to claims involving emergency or unauthorized services or where the plan establishes reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices;
9. The failure to establish, upon written request, requests for medical records more frequently than in twenty percent (20%) of the emergency services and care professional provider claims submitted to the IPA or the IPA for emergency room service and care over any 12-month period was Reasonably Necessary To Determine Payer Liability for those claims. The calculation of the 20% threshold and the limitation on requests for medical records shall not apply to claims where the IPA demonstrates reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices;
10. The failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period;
11. The failure to contest or deny a claim, or portion thereof, within the timeframes of this policy at least 95% of the time for the affected claims over the course of any three (3) month period;
12. The failure to provide the Information for Contracting Providers and the Fee Schedule and Other Required Information disclosures required in the Policy Section, paragraph nine of this policy to three (3) or more contracted providers over the course of any three (3) month period;
13. The failure to provide three (3) or more contracted providers the required notice for Modifications to the Information for Contracting Providers and to the Fee Schedule and Other

Required Information consistent with the Policy Section, paragraph nine of this policy over the course of any three month period;

14. Requiring or allowing any provider to waive any protections or to assume any obligation of the plan inconsistent with this policy on three (3) or more occasions over the course of any three month period;

15. The failure to provide the required Notice to Provider of Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b) of the Health and Safety Code at least 95% of the time for the affected claims over the course of any three-month period;

16. The imposition of a provider dispute filing deadline inconsistent with PR.1 Provider Complaint Policy in three (3) or more affected claims over the course of any three-month period;

17. The failure to acknowledge the receipt of at least 95% of the provider disputes it receives consistent with PR.1 Provider Complaint Policy over the course of any three-month period;

18. The failure to comply with the Time Period for Resolution and Written Determination enumerated in PR.1 Provider Complaint Policy at least 95% of the time over the course of any three-month period; and

19. An attempt to rescind or modify an authorization for health care services after the provider renders service in good faith and pursuant to the authorization, inconsistent with section 1371.8 of the Health and Safety Code, on three (3) or more occasions over the course of any three-month period.

Evidence Code Section 641: Letter received in ordinary course of mail. A letter correctly addressed and properly mailed is presumed to have been received in the ordinary course of mail. Information Necessary to Determine Payer Liability: The minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, comply with any governmental information requirements. Management Services Organization (MSO): Management Company for IPA/Medi-Cal Groups.

OIG Excluded Providers

The Office of the Inspector General (OIG) maintains a sanction list that identifies those individuals found guilty of fraudulent billing, misrepresentation of credentials, etc. The MA organizations employing or contracting with health providers have a responsibility to check the sanction list with each new issuance of the list, as they are prohibited from hiring, continuing to employ, or contracting with individuals named on that list. The MA organizations should check the Office of the Inspector General (OIG) Web site at http://www.oig.hhs.gov/fraud/exclusions/list_of_excluded.html for the listing of excluded providers and entities. The OIG has a limited exception that permits payment for emergency services provided by excluded providers under certain circumstances. See 42 CFR 1001.1901. Opt-Out Providers. If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of 2 years. The only

exception to that rule is for emergency and urgently needed services where a private contract had not been entered into with a beneficiary who receives such services. See 42 CFR 405.440. An MA organization must pay for emergency or urgently needed services furnished by a physician or practitioner to an enrollee in their MA plan who has not signed a private contract with a beneficiary, but may not otherwise pay opt-out providers. Information on providers who opt-out of Medicare may be obtained from the local Medicare Part B carrier. The MA organization must check this list on a regular basis.

(Source: 42 CFR 422.204(b)(4) and 42 CFR 422.220)

Reasonably Relevant Information: “The minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the IPA or IPA/Medi-Cal Group’s capitated provider’s liability, if any, to comply with any governmental information requirements.

Reconsideration - A party or, upon providing oral or written notice to the enrollee, a physician who is treating an enrollee and acting on the enrollee’s behalf, may request a standard reconsideration by filing a written request with the Medicare health plan. Except in the case of an extension of the filing time frame, a party must file the request for reconsideration within 60 calendar days from the date of the notice of the organization determination. If a request for reconsideration is filed beyond the 60 calendar day timeframe and good cause for late filing is not provided, the Medicare health plan will forward the request to the independent review entity for dismissal.

Reimbursement of a Provider Claim: Commercial

1. For contracted providers with a written contract, the agreed upon contract rate;
2. For contracted providers without a written contract and non-contracted providers, the payment of the reasonable and customary value for the health care service rendered based upon statistically credible information that is updated at least annually and takes into consideration:
 - a. the provider’s training, qualifications, and length of time in practice;
 - b. the nature of the services provided;
 - c. the fees usually charged by the provider;
 - d. prevailing provider rates charged in the general geographic area in which the services were rendered;
 - e. other aspects of the economics of the Medi-Cal provider’s practice that are relevant; and
 - f. any unusual circumstances in the case;

Working Days: Monday through Friday, excluding Federally recognized holidays.