Complete Claims Processing

1. All Complete Claims can be processed as soon as it is received.

2. Complete claims are identified properly by the claims processor when received from the mailroom, already prepared for processing (i.e. date stamped, logged, and data entered or scanned).

3. All claims are noted with the date received, paper claims are manually date stamped with a mechanical date stamp and received dates are monitored to ensure timeliness compliance. In accordance with Chapter 1 Section 80.2.1 Claims received by 5:00 pm (local time) must be considered as received on that date.

4. Complete claims are processed within a reasonable turn-around-time frame to meet the following criteria:

a. Timeliness – Commercial

i. Complete claims are processed within forty-five(45) working days for Commercial from the Date of Receipt. For all lines of business, if a complete claim is not reimbursed by delivery of payment to the providers address of record within timeframes, automatic payment of interest is included with the original payment or is due within 5 working days of the payment of the claim without the need for any reminder or request by the provider. **If interest on a claim is less than $2.00, the interest for that claim may be paid, along with interest on other such claims, within ten (10) calendar days of the close of the calendar month in which the original claim was paid.**

b. Timeliness – Medicare

i. Complete claims are processed within, **thirty (30) calendar days** for Non-Contracted Medicare Providers and within **sixty (60) calendar days** for Contracted Medicare Providers, from the Date of Receipt.

ii. If a complete claim is not reimbursed by delivery of payment to the providers address of record within timeframes, automatic payment of interest is included with the original payment or is due within 5 working days of the payment of the claim without the need for any reminder or request by the provider. If interest on a claim is less than $2.00, the interest for that claim may be paid, along with interest on other such claims, within 10 calendar days of the close of the calendar month in which the original claim was paid.

c. Accuracy – Covered services are paid in conformance with the standard allowances set by the health plan and/or contractual rates with providers.

Denying, Adjusting, or Contesting (Pending) a Claim

1. IPA can contest or deny a claim, or portion thereof, by notifying the provider, in writing.

2. Claims that are not Complete Claims are identified by the claims processor when received from the mailroom, already prepared for processing (i.e. date stamped, logged, and data entered or scanned).

3. In the event that the IPA requests reasonably Relevant Information from a provider in addition to information that the provider submits with a claim, the IPA shall provide a clear, accurate, and written explanation of the necessity for the request.

a. A pended report indicating those claims that are pended shall be generated daily by the Claims Department Manager.

i. For Non-Contracted Medicare Providers, claims pended longer than fifty-five (55) calendar days, the claims processor shall generate a letter.
ii. For Contracted Medicare Providers, claims pended longer than fifty-five (55) calendar days, the claims processor shall generate a letter.
iii. For Non-Contracted Commerical Providers, pend the claim and follow up with provider for the information.

b. When the requested information is received:

i. If the claim is open (still unpaid/not denied for non-receipt), the claims processor shall finalize the claim with the requested information. If the claim is nearing non-compliance, the claims processor shall expedite its processing, including utilizing the assistance of the Claims Supervisor in order to resolve the claim within thirty (30) calendar days for Medi-Cal Program and forty-five (45) working days for Commercial Line of Business.

4. Non-Contracted Commercial providers may also be denied immediately. A Denial Letter is issued immediately, informing the member of their appeal rights.

5. If the IPA subsequently denies the claim based on the provider's failure to provide the requested medical records or other information, any dispute arising from the denial of such claim shall be handled as a provider dispute.

6. Denied, adjusted or contested claims include information on filing a provider dispute, including procedures for obtaining provider dispute forms and the mailing address for submission of the dispute.

7. The IPA shall issue a Integrated Denial Notice (IDN) letter, within 30 days of receipt for any Medicare, Medi-Cal and ERISA clean claim. The IDN letter is sent to the member. The written denial must clearly state the service denied and the specific denial reason. The notice must also inform the enrollee of his or her right to a standard reconsideration and describe the appeal process.

8. IDN letters shall be sent within 60 days of receipt for any non-clean claim. The IDN letter is sent to the member. The written denial must clearly state the service denied and the specific denial reason. The notice must also inform the enrollee of his or her right to a standard reconsideration and describe the appeal process.

9. A request for Information Necessary to Determine Payer Liability from a third party shall not extend the time of reimbursement or the time for contesting or denying claims. Incomplete claims and claims for which Information Necessary to Determine Payer Liability has been requested, which are held or pended awaiting receipt of additional information shall be either contested or denied in writing within the timeframes set forth in this section. The denial or contest shall 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 payer liability.

10. Whenever a denial is made, the currently approved notice or letter format respective to the applicable Health Plan shall be used, including approved denial reasons/codes.

11. In the event of a denial of a request for payment from a non-contracted provider, the IPA shall notify the provider of the specific denial reason(s) and provide a description of the appeals process.

12. A non-contracted provider may file an appeal only if a Waiver of Liability statement has been completed. By signing the waiver, the non-contracted provider waives any rights to balance billing the member for covered services.

14. Per IPA policy, a Member (including his or her authorized representative) may to appeal denials within 60 days from the date of the original denial. Upon receipt of the appeal, the IPA shall, within 48 hour, forward the appeal to the applicable Health Plan.

Reimbursement of the Overpayment of Claims

1. If the IPA determines that it has overpaid a claim, within three-hundred and sixty-five (365) days of such payment, it shall notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service and include a clear explanation of the basis upon which the IPA believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

2. If the provider contests the IPA/Medi-Cal Group's notice of reimbursement of the overpayment of a claim, the provider, within thirty (30) Working Days of the receipt of the notice of overpayment of a claim, shall send written notice to the IPA stating the basis upon which the provider believes that the claim was not over paid. The IPA shall receive and process the contested notice of overpayment of a claim as a provider dispute pursuant to the IPA Provider Complaint Policy.

3. If the provider does not contest the IPA/Medi-Cal Group's notice of reimbursement of the overpayment of a claim, the provider shall reimburse the IPA within thirty (30) Working Days of the receipt by the provider of the notice of overpayment of a claim.

4. The IPA may only offset an uncontested notice of reimbursement of the overpayment of a claim against a provider's current claim submission when: (i) the provider fails to reimburse the IPA within the timeframe above and (ii) the provider has entered into a written contract with specifically authorizing the IPA to offset an uncontested notice of overpayment of a claim from the current claim submissions. In the event that an overpayment of a claim or claims is offset against a provider's current claim or claims pursuant to this section, the IPA shall provide the provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

"Complete Claims" Processing Guidelines for California

Title 28 California Code of Regulations (CCR)	Federal Code of Regulations – Title 42	2003 Practice Management Info Corp. Book
Claim Document Completion and Submission		
Section 1300.71 (a)(2)(B)(i)(ii) *AB1455 Page 2 Lines 12-18* For institutional providers: the completed UB92 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; entries stated as mandatory by NUBC and required by federal statute and regulations; and any state-designated data requirements included in statutes or regulations. *Section 1300.71 (a)(2)(D)(i)* *AB1455 Page 2 Line 23; Page 3 Lines 1-3* For physicians and other professional providers: the 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;	*Part 424 Subpart C Section 424.30 through 424.40* • Institutional Providers • Must be on UB92 claim form. • Professional Providers • Must be on CMS 1500 claim form • Can't submit more than six lines of service on one claim • For referred and/or ordered Services the name of the referring or ordering physician and the NPI or UPIN numbers must be present in box 17 and 17A	*Pages 278-310* Includes item by item instructions for completion of CMS-1500 claim form.

"Complete Claims" Processing Guidelines for California

Title 28 California Code of Regulations (CCR)	Federal Code of Regulations – Title 42	2003 Practice Management Info Corp. Book
Coding Requirements		
Section 1300.71 (a)(2)(D)(ii) *AB 1455 Page 3 Lines 4-5* Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD-9CM) codes; *Section 1300.71(a)(2)(D)(iii)* *AB 1455 Page 3 Lines 6-8* entries stated as mandatory by NUCC and required by federal statute and regulations; and any state-designated data requirements included in statutes or regulations	*Part 424 Subpart C Section 424.32 (1), Section 424.32 (2), and Section 424.34 (4)* • Must have appropriate coding • CPT Level I codes • Appropriate CPT and/or HCPCS modifiers • HCPCS National Level II Codes • HCPCS Local Level III Codes • ICD-9-CM	*Pages 120-131, 291 and 298-299* "Medicare requires that all claims contain codes for patient diagnoses and for procedures provided. The coding systems used for these purposes are…" • CPT Level I Codes (ref. Pp. 120 and 298-299) • HCPCS Codes (ref. Pp. 120-124 and 298-299) • ICD-9-CM Codes (ref. Pp. 124-131 and 291)

Title 28 California Code of Regulations (CCR)	Federal Code of Regulations – Title 42 S	2003 Practice Management Info Corp. Book
Clean/Contested Claims		
Section 1300.71 (a)(11) *AB 1455 Page 2 Lines 3-6: Page 9 Lines11-23* "Complete claim" means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: "reasonably relevant information" as defined by section (a)(10) " information necessary to determine payor liability" as defined in section (a)(11). "Reasonably relevant information" means 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 plan's or the plan's capitated provider's liability, if any, and to comply with any government information requirements. (11) "Information necessary to determine payer liability" means 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, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.	*Part 447 Subpart A Section 447.45 (2)(b)* • Develops parameters for a clean claim • Develops parameters for what constitutes a contested claim.	*Pages 261-277 and 305* • Claims returned as unprocessable (ref. Pp. 261-276) • Most Common Reasons for Claim Rejection (ref. P. 277) • Other Tips for Filing Claims (ref. P. 305)

"Complete Claims" Processing Guidelines for California

Title 28 California Code of Regulations (CCR)	Federal Code of Regulations – Title 42	2003 Practice Management Info Corp. Book
Payment		
Section 1300.71 (g)(4) *AB 1455 Page 18 Lines 13-16* Every plan contract with a provider shall include a provision stating that except for applicable co-payments and deductibles, a provider shall not invoice or balance bill a plan's enrollee for the difference between the provider's billed charges and the reimbursement paid by the plan or the plan's capitated provider for any covered benefit. *AB 1455 Page 18 Lines 7 – 12* If a non-contracted provider disputes the appropriateness of a plan's or a plan's capitated provider's computation of the reasonable and customary value, determined in accordance with section (a)(3)(B), for the health care services rendered by the non-contracted provider, the plan or the plan's capitated provider shall receive and process the non-contracted provider's dispute as a provider dispute in accordance with section 1300.71.38.	*Part 414 Subpart B Section 414.48 (a)(b)* • Non-contracted Physicians must accept payment in full less any copayments or deductibles. • Non-contracted physician may no longer balance bill a member. • To dispute the reasonable and customary fee received, the Non-contracted provider must submit an appeal through the health plan's provider dispute resolution process	PMIC doesn't address this.

Title 28 California Code of Regulations (CCR)	Federal Code of Regulations – Title 42	2003 Practice Management Info Corp. Book
Surgical Guidelines		
AB 1455 Page 2 Lines 22- describes what constitutes a 'complete' claim which states that the information required on the CMS1500 or the NUBC is a requirement. On the CMS1500 form, the requirements in box 24 (d) requires the use of CPT/HPCS numbers and box 23 requires the use of ICD-9 codes. This pertains to all of the procedures that would have any of the billing code numbers.	Part 414 Subpart B Section 414.40 (1)(3) **Global Major Surgery** • Includes preoperative, intraoperative, and postoperative care of 90 days **Global Minor Surgery** • Includes visit, surgery, and postoperative care of 10 days • Includes minor surgeries, nonincisional procedures, and endoscopy procedures **Multiple Procedures Reduction Rule** *Part 414 Subpart B Section 414.40 (3)* • Multiple surgery performed by the same physician on the same patient during the same operative session • Highest valued procedure allowed at 100% second highest through the fifth highest valued procedure allowed at 50% • Operative report required when more than five procedures are performed at once, payment decision at the carrier's discretion	*Pages 131-138* CPT specifically defines the Surgical Package to include: • Local or topical anesthesia (including digital blocks, etc) • One Evaluation and Management code on date immediately prior to or on date of procedure • Immediate post-op care • Writing orders • Evaluation of patient post-anesthesia • Typical post-op follow up care Reference Surgery Guidelines at front of Surgery section of current CPT published by AMA) *Page 138* "Payment is made at 100% of the fee schedule amount for the highest valued procedure and 50% … for the 2nd through 5th procedures… Use the multiple procedures modifier, '-51' on the secondary and tertiary procedures."

Title 28 California Code of Regulations (CCR)	Federal Code of Regulations – Title 42	2003 Practice Management Info Corp. Book
Surgical Guidelines (Con't)		
	Multiple Endoscopies • Major endoscopic procedure allowed at 100% • Family Base code allowable amount is deducted from the fee schedule amount for each additional covered endoscopic procedure from that family **Bilateral Procedures** *42 Part 414 Subpart B Section 414.40 (3)* • Defined as performed on the same anatomic site on opposite sides of the body through separate incision **Professional & Technical Components** *Part 414 Subpart B Section 414.40 (2)* **Unbundling** • Unbundling activities may be considered potentially fraudulent as they inflate costs **Up coding** • Charging a higher level of service than was actually rendered may be considered potentially fraudulent	*Page 139-140* "When more than one endoscopic procedure from the same family is billed, special endoscopic pricing rules apply" This section specifies endoscopic pricing rules. *Page 177* "Bilateral procedures are identical procedures…performed on the same anatomic site but on opposite sides of the body…Each procedure should be performed through its own separate incision… Medicare will pay 150% of the amount allowed for a unilateral procedure." *Pages 169-172 and 416-418* • Use of CCI and CCI edits (ref. Pp. 169-172) • Unbundling (ref. Pp. 416-417) • Upcoding (ref. Pp. 416-418)