



**Technical Assistance Guide
For Assessment of Health Plan
Management of Claims**

Foreword

The Knox Keene Health Care Service Plan Act of 1975, Section 1382, states that the director shall conduct an examination of the fiscal and administrative affairs of any health care service plan, and each person with whom the plan has made arrangements for administrative, management, or financial services, as often as deemed necessary to protect the interest of subscribers or enrollees, but not less frequently than once every five years. The subject areas of the examination are to assess the overall fiscal soundness, financial viability and claim management of each plan, as well as, to verify the plan's compliance with the Knox-Keene Act and related Rules.

This Technical Assistance Guide for Assessment of Health Plan Management of Claims ("Claims TAG") is to be used by the Department of Managed Health Care ("DMHC") to measure health plans' performance against relevant Knox Keene requirements. This document contains procedures performed for assessing a health plan's management of its claims. The DMHC institutes a risk-based approach that requires examiners to exercise their professional judgment to assess the risk inherent in a given plan's operation and determine the scope of the examination taking into consideration the many variables and uniqueness presented in each individual plan. After examiners determine existing or potential risk is present, they may perform some or all of the procedures as described in this document. This Claims TAG is not intended to limit the scope of examination or procedures performed by the DMHC.

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This Claims TAG has been posted to the DMHC website to offer information that plans may find useful when they have questions about the examination process for assessing a health plan's management of its claims. This document is a reference source for the DMHC and its outside contractors and should not be relied upon for any other purpose.

This Technical Assistance Guide for Assessment of Health Plan Management of Claims is a work in process document and as such is designated as a "Draft".

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**Technical Assistance Guide
for
Assessment of Health Plan Management of Claims**

Item	Requirement
CM 001	<p>Structure The health plan has a well-defined and adequate claims management structure that includes appropriate management oversight, allocation of resources, interaction with key functional areas and staffing to ensure the timely and accurate payment of claims.</p>
Statutory & Regulatory Citation(s):	
	<p>CA Health and Safety Code 1317 Emergency services and care shall be provided to any person requesting the services or care, or for whom services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed under this chapter that maintains and operates an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified personnel available to provide the services or care.</p> <p>CA Health and Safety Code 1367(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees.</p> <p>CA Health and Safety Code 1367.01(c) Every health care service plan subject to this section shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section</p> <p>CA Health and Safety Code 1371 A health care service plan, including a specialized health care service plan, shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.</p> <p>CA Health and Safety Code 1371.35 A health care service plan, including a specialized health care service plan, shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is</p>

contested by the plan in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim. The notice that a claim is being denied shall identify the portion of the claim that is denied and the specific reasons for denying the claim. A plan may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the plan pays charges specified in this section.

28 CCR 1300.71(g)

A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

(1) To the extent that a full service health care service plan that meets the definition of an HMO as set forth in paragraph 1300.71(a)(9) also maintains a PPO or POS line of business, the plan shall reimburse all claims relating to or arising out of non-HMO lines of business within thirty (30) working days.

(2) If a specialized health care service plan contracts with a plan that is a health maintenance organization to deliver, furnish or otherwise arrange for or provide health care services for that plan's enrollees, the specialized plan shall reimburse complete claims received for those services within thirty (30) working days.

(3) 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.

(4) 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.

28 CCR 1300.77.4

Every plan shall institute procedures whereby all claim forms received by the plan from providers of health care services for reimbursement on a fee-for-service basis and from subscribers and enrollees for reimbursement are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time, and rapid retrieval of any claim.

Standards in Meeting Statutory & Regulatory Requirements:

1. A claims department is organized to ensure timely payment of claims:
 - A structure exists to ensure proper receipt of a claim
 - A structure exists that allows tracking of claims status
 - A structure exists that allows for the rapid retrieval of claims

 - A structure exists that allows for routing and tracking of pended claims to appropriate departments (provider relations, utilization management, member services)
 - A structure exists that allows for contesting claims

- A structure exists for denying claims
 - A designated and fully licensed medical director is used for all medical necessity determinations
2. Organizational capacity exists to meet statutory requirements of timeliness, reporting and retrieval of information
 - Sufficient space is allocated to the claims department to allow organized tracking of claims and filing and retrieval of documents
 - Telecommunications systems are adequate to allow necessary communication from providers, patients and other departments within the organization
 - Staffing and productivity levels allow for tracking, retrieval and timely payment of claims
 - Information systems handle the demands needed to track, retrieve and pay claims in a timely fashion (reviewed by staff with IT expertise)
 - Medical Director time is sufficient to allow for review of medical necessity while meeting timely payment guidelines
 - Tracking of claims under review for medical necessity to ensure that they are returned and processed within the timely payment guidelines
 3. Administrative capabilities must be in place to ensure:
 - Proper supervision and management
 - Proper training
 - Quality management and audits to ensure compliance with statutory requirement
 4. Other structural elements as needed to fulfill the statutory and regulatory requirements.

Guidance:

1. The structure includes:
 - Reporting relationships within the organization to a key executive with ultimate accountability and responsibility for claims management functions
 - Appropriate management oversight of the claims operation's:
 - Size
 - Scope of services
 - Complexity of benefit administration
 - Hours of operation
 - Geographic dispersal
2. There is evidence of organizational resources which address the following considerations:
 - Designated budget based on historic and projected needs
 - Work environment for processing, tracking, filing and paying claims
 - Telecommunications systems that meet the volume needs of providers, enrollees, other departments and the claims department
 - Archive/filing systems that allow for secure storage and timely retrieval
 - Computer terminals/software sufficient for each employee to operate, without downtime interfering with meeting statutory requirements (reviewed by staff with IT expertise)
 - Mail handling space and staff that allow for secure, efficient and documented receipt of claims
 - Sufficient staff given membership, percent of claims submitted electronically and percent of claims auto adjudicated
 - Backup for illness, turnover and increased production needs

3. There is documented evidence of timely and appropriate interaction with the following functional areas:
 - Enrollee/customer services
 - Information Systems
 - Utilization Management
 - Medical Director
 - Provider Relations
 - Finance

4. There is adequacy of appropriately trained staff as evidenced through:
 - Documented staffing and productivity levels as compared with industry standards, historic and anticipated claims volumes, and the plan's unique characteristics
 - Orientation & Training programs that ensure that employees are properly trained initially and have ongoing training based on individual staff and organizational needs
 - Current, detailed and accurate job descriptions for all positions

5. There is adequate oversight taking into consideration the plan model and structure through the assessment of:
 - Audit staff (experience and number)
 - Audit methodology (frequency, selection of claims, elements audited, etc.)
 - Audit reports (processor and system level)
 - Staff supervision that allows for handling of questions on a real time basis
 - Internal Audits performed by internal audit staff (where nonclaims internal audit Department exists)

6. No statutory or regulatory instances of non-compliance are noted due to an inadequate organizational or administrative structure, or its capacity.

Individual(s)/Position(s) that may be Interviewed:

- Key Executive with ultimate accountability and responsibility for claims management functions
- Claims Manager
- Claims Supervisor
- Information Technology (IT) Department Manager
- Customer Service Manager
- Medical Director
- UM Director
- Provider relations Director
- Individual Claims Processor
- Director of Internal Audits

Document(s) that may be Reviewed:

- Job descriptions
- Organization Charts
- Meeting minutes
- Staff training manuals/materials
- Policies and procedures
- Telephone system reports
- Pended claims routing criteria and flow
- Claims tracking forms
- Trend analyses
- Internal Audit reports

Level of Compliance:

Met: Statutory/regulatory requirements are met as defined in the Act or Rules

Not Met: Some (or all) statutory/regulatory requirements are not met as defined in the Act or Rules

Item	Requirement
CM 002	<p>Operations The Plan has well documented processes in place to support all key claims functions that ensure the accurate and timely payment of claims in compliance with statutory requirements.</p>
<p>Statutory & Regulatory Citation(s):</p>	
<p>CA Health and Safety Code 1375.1(a)(3)</p>	
<p>(a) Every plan shall have and shall demonstrate to the director that it has all of the following: (3) A procedure for prompt payment or denial of provider and subscriber or enrollee claims, including those telemedicine services, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, covered by the plan.</p>	
<p>CA Health and Safety Code 1370</p>	
<p>Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs.</p>	
<p>CA Health and Safety Code 1363.5</p>	
<p>(a) A plan shall disclose or provide for the disclosure to the director and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for sub-acute care, transitional inpatient care, or care provided in skilled nursing facilities. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request. The disclosure to the director shall include the policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01.</p>	
<p>(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:</p>	
<ol style="list-style-type: none"> (1) Be developed with involvement from actively practicing health care providers. (2) Be consistent with sound clinical principles and processes. (3) Be evaluated, and updated if necessary, at least annually. (4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case. (5) Be available to the public upon request. 	
<p>CA Health and Safety Code 1367.01</p>	
<p>(a) Every health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.</p>	
<p>(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed</p>	

pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

CA Health and Safety Code 1371.35 (c)

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. However, if the plan requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the plan may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. The provider shall provide the plan reasonable relevant information within 10 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the plan requires further information, the plan shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

CA Health and Safety Code 1371.37(a) and (c)

(a) A health care service plan is prohibited from engaging in an unfair payment pattern, as defined in this section.

(c) An "unfair payment pattern," as used in this section, means any of the following:

- (1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that result in payment delays.
- (2) Engaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims.
- (3) Failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Section 1371, 1371.1, or 1371.35.
- (4) Failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.

28 CCR 1300.71(a)(8)

The following practices, policies and procedures may constitute a basis for a finding that the plan or the plan's capitated provider has engaged in a "demonstrable and unjust payment pattern" as set forth in section (s)(4):

- (A) The imposition of a Claims Filing Deadline inconsistent with section (b)(1) in three (3) or more claims over the course of any three-month period;
- (B) The failure to forward at least 95% of misdirected claims consistent with sections (b)(2)(A) and (B) over the course of any three-month period;

- (C) The failure to accept a late claim consistent with section (b)(4) at least 95% of the time for the affected claims over the course of any three-month period;
- (D) The failure to request reimbursement of an overpayment of a claim consistent with the provisions of sections (b)(5) and (d)(3), (4), (5) and (6) at least 95% of the time for the affected claims over the course of any three-month period;
- (E) The failure to acknowledge the receipt of at least 95% of claims consistent with section (c) over the course of any three-month period;
- (F) 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 (d)(1) at least 95% of the time for the affected claims over the course of any three-month period;
- (G) The inclusion of contract provisions in a provider contract that requires the provider to submit medical records that are not reasonably relevant, as defined by section (a)(10), for the adjudication of a claim on three (3) or more occasions over the course of any three month period;
- (H) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in three percent (3%) of the claims submitted to a plan or a plan's capitated provider by all providers over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with the section (a)(2). 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;
- (I) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in twenty percent (20%) of the emergency services and care professional provider claims submitted to the plan's or the plan's capitated providers for emergency room service and care over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with section (a)(2). The calculation of the 20% threshold and the limitation on requests for medical records shall not apply to claims where the plan demonstrates reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices;
- (J) The failure to include the mandated contractual provisions enumerated in section (e) in three (3) or more of its contracts with either claims processing organizations and/or with plan's capitated providers over the course of any three-month period;
- (K) 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;
- (L) The failure to contest or deny a claim, or portion thereof, within the timeframes of section (h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims over the course of any three-month period;
- (M) The failure to provide the Information for Contracting Providers and the Fee Schedule and Other Required Information disclosures required by sections (l) and (o) to three (3) or more contracted providers over the course of any three-month period;
- (N) 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 section (m) over the course of any three month period;
- (O) Requiring or allowing any provider to waive any protections or to assume any obligation of the plan inconsistent with section (p) on three (3) or more occasions over the course of any three month period;
- (P) The failure to provide the required Notice to Provider of Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b) at least 95% of the time for the affected claims over the course of any three-month period;
- (Q) The imposition of a provider dispute filing deadline inconsistent with section 1300.71.38(d) in three (3) or more affected claims over the course of any three-month period;

- (R) The failure to acknowledge the receipt of at least 95% of the provider disputes it receives consistent with section 1300.71.38(e) over the course of any three-month period;
- (S) The failure to comply with the Time Period for Resolution and Written Determination enumerated in section 1300.71.38(f) at least 95% of the time over the course of any three-month period; and
- (T) An attempt to rescind or modify an authorization for health care services after the provider renders the service in good faith and pursuant to the authorization, inconsistent with section 1371.8, on three (3) or more occasions over the course of any three-month period.

28 CCR 1300.71 (a)(2) and (c)

(a) (2) "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 payer liability" as defined in section (a)(11) and:

(A) For emergency services and care provider claims as defined by section 1371.35(j):

- (i) the information specified in section 1371.35(c) of the Health and Safety Code; and
- (ii) any state-designated data requirements included in statutes or regulations.

(B) For institutional providers:

- (i) the completed UB 92 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;
- (ii) entries stated as mandatory by NUBC and required by federal statute and regulations; and
- (iii) any state-designated data requirements included in statutes or regulations.

(C) For dentists and other professionals providing dental services:

- (i) the form and data set approved by the American Dental Association;
- (ii) Current Dental Terminology (CDT) codes and modifiers; and
- (iii) any state-designated data requirements included in statutes or regulations.

(D) For physicians and other professional providers:

- (i) 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;
- (ii) Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD-9CM) codes;
- (iii) entries stated as mandatory by NUCC and required by federal statute and regulations; and
- (iv) any state-designated data requirements included in statutes or regulations.

(E) For pharmacists:

- (i) a universal claim form and data set approved by the National Council on Prescription Drug Programs; and
- (ii) any state-designated data requirements included in statutes or regulations.

(F) For providers not otherwise specified in these regulations:

- (i) A properly completed paper or electronic billing instrument submitted in accordance with the plan's or the plan's capitated provider's reasonable specifications; and
- (ii) any state-designated data requirements included in statutes or regulations.

(c) The plan and the plan's capitated provider shall identify and acknowledge the receipt of each claim, whether or not complete, and disclose the recorded date of receipt as defined by section 1300.71(a)(6) in the same manner as the claim was submitted or provide an electronic means, by phone, website, or another mutually agreeable accessible method of notification, by which the provider may readily confirm the plan's or the plan's capitated provider's receipt of the claim and the recorded date of receipt as defined by 1300.71(a)(6) as follows:

(1) In the case of an electronic claim, identification and acknowledgement shall be provided within two (2) working days of the date of receipt of the claim by the office designated to receive the claim, or

(2) In the case of a paper claim, identification and acknowledgement shall be provided within fifteen (15) working days of the date of receipt of the claim by the office designated to receive the claim.

(A) If a claimant submits a claim to a plan or a plan's capitated provider using a claims clearinghouse, the plan's or the plan's capitated provider's identification and acknowledgement to the clearinghouse within the timeframes set forth in subparagraphs (1) or (2), above, whichever is applicable, shall constitute compliance with this section.

28 CCR 1300.77.4

Every plan shall institute procedures whereby all claim forms received by the plan from providers of health care services for reimbursement on a fee-for-service basis and from subscribers and enrollees for reimbursement are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time, and rapid retrieval of any claim.

Standards in Meeting Statutory & Regulatory Requirements:

1. A Claims Department must have policies and procedures in place to ensure that its operations will pay claims in a fair, just and timely fashion
 - Defined processes to ensure the standards for meeting submission requirements of a complete claim.
 - Defined processes to ensure the timely flow of claims through the organization should be documented with policies and procedures
 - Defined processes to ensure accurate and complete payment should be documented with policies and procedures
 - Defined processes to determine uncontested claim status should be documented with policies and procedures
 - Defined processes to pay interest due should be documented with policies and procedures
2. A Claims Department must have policies and procedures in place to ensure that retrospective review of claims for medical necessity (See glossary for definition of medical necessity):
 - Follows accepted clinical practice
 - Is available to the public
 - Consistently applied
3. A Claims Department must have policies and procedures in place to ensure the acknowledgement of claims, whether or not complete, and disclose the recorded date of receipt.
 - For electronic claims, within two (2) working days of the date of receipt
 - For paper claims, within fifteen (15) working days of the date of receipt
 - For claims submitted through a claims clearinghouse, the plan's or the plan's capitated provider's identification and acknowledgement to the clearinghouse within the timeframes for either electronic (2 working days) or paper claims (15 working days) whichever is applicable
4. Other processes, procedures and policies as needed to fulfill the statutory and regulatory requirements.

Guidance:

The following processes are addressed in policies and procedures:

1. Claim submission requirements are documented with attention to both electronic and paper submissions
2. Claims flow throughout organization is documented in a reproducible fashion, with attention to:
 - Timeliness: bottlenecks to claims flow
 - Accuracy: Sources of error
 - Monitoring and tracking of claims referred to other areas including but not limited to medical claims review, COB and TPL
3. Categorization of claims, pursuant to 28 CCR 1300.71(a)(2), is documented to allow appropriate payment of uncontested claims
 - Clean v. “non clean” claims are well defined
 - Categories that receive special handling as defined by the organization
 - Processing procedures for all claims categories
4. The Application of payment rules and criteria are documented:
 - Adjustment of payment due to changes in coding and other edits in place
 - Determination of contract rates
 - “Reasonable and Customary” amounts
 - DRG’s, CPT and ICD-9, HCPC coding, revenue codes
 - Medicare allowable
 - Overrides
 - Application of stop loss or reinsurance
5. Turnaround time requirements for “clean vs. non-clean” claims are documented for key processes
 - Handling of requests for information from providers and members
 - Handling of Denials
 - Handling of Appeals
 - Coordination of benefits
6. Retrospective review of claims is documented by policies and procedures that:
 - Are based on clinical principles or guidelines, as applicable.
 - Are available to the enrollees, providers, and the public, upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested.
7. QA, Audit and Compliance processes are documented and updated at least annually
8. Privacy, confidentiality and security requirements are appropriately documented
9. Staff Training is in place to ensure compliance with policies and procedure by all personnel
10. No statutory or regulatory instances of non-compliance are noted due to inadequate processes, procedures, or policies.

Individual(s)/Position(s) that may be Interviewed:

- Claims Manager
- Claims Supervisor
- Audit QA staff

- Staff analysts
- Compliance Officer
- Appeals Department
- Medical Director
- Training Department
- IT Department
- Individual Claims Processor

Document(s) that may be Reviewed:

- Flowcharts
- Policies and procedures on payment and processing of claims
- Policies & procedures on handling and processing clean vs. non clean claims
- Sample reports
- Policies and procedures on application of edits
- Policies and procedures on overrides and COB
- Policies and procedures on payment rules
- Audit policies & procedures/protocols
- Coding reference materials
- Training materials

Level of Compliance:

Met: Statutory/regulatory requirements are met as defined in the Act or Rules

Not Met: Some (or all) statutory/regulatory requirements are not met as defined in the Act or Rules

Item	Requirement
CM 003	<p>Performance Standards Performance standards have been established that include the accuracy and timeliness of payments in a manner consistent with mandated requirements.</p>
	<p>Statutory & Regulatory Citation(s):</p> <p>CA Health and Safety Code 1367.01(h)(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law.</p> <p>CA Health and Safety Code 1371 A health care service plan, including a specialized health care service plan, shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.</p> <p>CA Health and Safety Code 1371.35 (a) A health care service plan, including a specialized health care service plan, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the complete claim by the health care service plan. However, a plan may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial. A plan may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the plan pays those charges specified in subdivision (b).</p> <p>(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the respective 30- or 45-working days after receipt, the plan shall pay the greater of fifteen dollars (\$15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working day period. A health care service plan shall automatically include the</p>

fifteen dollars (\$15) per year or interest due in the payment made to the claimant, without requiring a request therefore.

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. However, if the plan requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the plan may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. The provider shall provide the plan reasonable relevant information within 10 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the plan requires further information, the plan shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

28 CCR 1300.71(a)(8)

The following practices, policies and procedures may constitute a basis for a finding that the plan or the plan's capitated provider has engaged in a "demonstrable and unjust payment pattern as set forth in section (s)(4):

- (A) The imposition of a Claims Filing Deadline inconsistent with section (b)(1) in three (3) or more claims over the course of any three-month period;
- (B) The failure to forward at least 95% of misdirected claims consistent with sections (b)(2)(A) and (B) over the course of any three month period;
- (C) The failure to accept a late claim consistent with section (b)(4) over at least 95% of the time for the affected claims over the course of any three-month period;
- (D) The failure to request for reimbursement of an overpayment of a claim inconsistent with the provisions of sections (b)(5) and (d)(3), (4), (5) and (6) at least 95% of the time for the affected claims over the course of any three month period;
- (E) The failure to acknowledge the receipt of at least 95% of claims consistent with section (c) over the course of any three-month period;
- (F) 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 (d)(1) at least 95% of the time for the affected claims over the course of any three-month period;
- (G) The inclusion of contract provisions in a provider contract that requires the provider to submit medical records that are not reasonably relevant, as defined by section (a)(10), for the adjudication of a claim on three (3) or more occasions over the course of any three month period;
- (H) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in three percent (3%) of the claims submitted to a plan or a plan's capitated provider by all providers over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with the section (a)(2). 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;

(I) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in twenty percent (20%) of the emergency services and care professional provider claims submitted to the plan's or the plan's capitated providers for emergency room service and care over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with section (a)(2). The calculation of the 20% threshold and the limitation on requests for medical records shall not apply to claims where the plan demonstrates reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices;

(J) The failure to include the mandated contractual provisions enumerated in section (e) in three (3) or more of its contracts with either claims processing organizations and/or with plan's capitated providers over the course of any three-month period;

(K) 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;

(L) The failure to contest or deny a claim, or portion thereof, within the timeframes of section (h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims over the course of any three-month period;

(M) The failure to provide the Information for Contracting Providers and the Fee Schedule and Other Required Information disclosures required by sections (l) and (o) to three (3) or more contracted providers over the course of any three-month period;

(N) 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 section (m) over the course of any three month period;

(O) Requiring or allowing any provider to waive any protections or to assume any obligation of the plan inconsistent with section (p) on three (3) or more occasions over the course of any three month period;

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

(Q) The imposition of a provider dispute filing deadline inconsistent with section 1300.71.38(d) in three (3) or more affected claims over the course of any three-month period;

(R) The failure to acknowledge the receipt of at least 95% of the provider disputes it receives consistent with section 1300.71.38(e) over the course of any three-month period;

(S) The failure to comply with the Time Period for Resolution and Written Determination enumerated in section 1300.71.38(f) at least 95% of the time over the course of any three-month period; and

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

Standards in Meeting Statutory & Regulatory Requirements:

1. There are performance standards established for:
 - Misdirected claims sent to the appropriate payor or delegate within 10 days
 - Acceptance of late claims accompanied by provider dispute and demonstration of good cause for the delay
 - Appropriate written notice of overpayment within 365 days of date of payment
 - Acknowledgement of receipt of claims
 - Accurate, clear written explanations of specific reasons for denying, adjusting or contesting a claim
 - Correct payment, including all interests and penalties, for complete claims
 - Contesting or denying any portion of a claim within 30 days (HMO 45 days)

- Providing notice of dispute resolution to providers
 - Acknowledgment of receipt of provider disputes
 - Resolve and make a written determination in provider disputes within 45 days of receipt
 - Claims filing deadlines that are not less than 90/180 days for contracted/non-contracted providers
 - Claims filing deadlines for secondary payors that are not less than 90 days from notice/denial/contest from primary payor
 - Failing to include mandated contract provisions in delegated payors (claims processing organizations and capitated groups)
 - Failing to provide Fee Schedule, Required Information and any Modifications for Contracting Providers
 - Not requiring a provider to waive protections or assume plan obligations
 - Dispute filing deadlines of not less than 365 days
 - Attempts to rescind or modify authorizations
2. There are performance standards established for requests of medical records:
 - Contract provisions requiring submission of medical records that are not reasonably relevant
 - For non-emergent authorized claims (except for fraud, misrepresentation, unfair billing cases or incomplete claims as defined in Section 1371.35)
 - For emergent claims (except for fraud, misrepresentation, unfair billing cases or incomplete claims as defined in Section 1371.35)
 3. There are other performance standards as needed to fulfill the statutory and regulatory requirements.
 4. The Plan measures against the performance standards at least every three consecutive months.

Guidance:

1. The health plan has established the following performance standards to meet statutory and regulatory requirements:
 - Turnaround times for “clean” and “non clean” claims
 - Turnaround times for claims referred for to other areas (i.e. medical review, COB and TPL or other activities within the organization)
 - Claims payment standards including:
 - Misdirected claims
 - Correct processing of claims
 - Claims filing deadlines and acceptance of late claims
 - Overpayment notification
 - Acknowledgement of receipt of claims and provider disputes
 - Benefit determination and explanation
 - Notice and process of dispute resolution
 - Contracting
 - Providing required information to providers
 - Interpretation
 - Claims control including payment and denial deadlines
 - Data entry
 - Call center usage and service parameters
 - Identification of third party liability and coordination of benefits
 - Prior authorization processing including requests for medical records
 - Handling of emergency room claims including requests for medical records
 - Claims pricing and adjudication
 - Reporting and financial transactions

- Reference file updates
 - Productivity
 - Customer satisfaction
2. The Plan measures performance against key standards for any three consecutive months.
 3. No statutory or regulatory instances of non-compliance are noted due to a lack of performance standards in any area.

Individual(s)/Position(s) that may be Interviewed:

- Claims Manager
- Claims Supervisor
- Customer Service
- Provider Relations
- Compliance Officer
- Individual Claims Processor (Randomly selected)
- IT Department

Document(s) that may be Reviewed:

- Total claim volumes
 - Emergent
 - Authorized
- Policies and procedures
- Performance standards
- Quarterly reports of performance against standards
- Requests for medical records
 - Should be less than 3% of all non emergent authorized claims (fraud, misrepresentation or unfair billing cases excepted) over any 12-month period
 - Should be less than 20% of emergencies (except for fraud, misrepresentation, unfair billing cases or incomplete claims as defined in Section 1371.35) over any 12-month period
 - Should be less than 20% of emergency claims (except for fraud, misrepresentation, unfair billing cases or incomplete claims as defined in Section 1371.35) over any 12-month period
- Claims files

Probe sample of 50 contracted claims and a separate sample of 50 noncontracted claims to include sufficient examples to evaluate for a demonstrable and unjust payment pattern or unfair payment pattern including

 - Misdirected claims sent to the appropriate payor or delegate within 10 working days
 - Acceptance of late claims accompanied by provider dispute and demonstration of good cause for the delay
 - Appropriate written notice of overpayment within 365 days of date of payment
 - Acknowledgement of receipt of claims
 - Accurate, clear written explanations of specific reasons for denying, adjusting or contesting a claim
 - Correct payment, including all interests and penalties, for complete claims within 30 working days (45 working days for an HMO)
 - Contesting or denying any portion of a claim within 30 working days (45 working days for an HMO)
 - Providing notice of dispute resolution to providers

- Acknowledgment of receipt of provider disputes within 2 working days for electronic and 15 working days for paper provider disputes
- Resolve and make a written determination in provider disputes within 45 working days of receipt

And, no instances of:

- Claims filing deadlines that are less than 90/180 days for contracted/non-contracted providers
- Claims filing deadlines for secondary payors that are less than 90 days from notice/denial/contest from primary payor
- Failing to include mandated contract provisions
- Failure to provide Fee schedule, required information and any modifications for contracted providers
- Requiring a provider to waive protections or assume plan obligation
- Dispute filing deadlines of less than 365 days
- Attempts to rescind or modify authorizations

IF > 95% compliance with these areas

THEN, no further sampling of claims;

OTHERWISE, based on calculation of the compliance rate from the probe sample, additional claims to produce a total sample size necessary for 90% confidence as to compliance rate.

Statistical sampling to determine sample size is as follows:

A. Attribute Sampling (Discovery Sampling)

I. Define the sampling objective:

Attribute sampling is used to estimate whether (yes or no) an event (attribute) has occurred, how many times an event occurred and/or, the frequency (how often) an event occurred throughout a given population. For example, attribute sampling is often performed to determine whether or not claims were processed correctly by answering the following question: Are claims being paid correctly based on the terms of the provider contract?

II. Define the population to be sampled:

Determine exactly what items or characteristics must be reflected in the sample according to the sampling objectives. For example, claims that were adjudicated from February 1, 2004 through April 30, 2004.

III. Determine the sampling plan and criteria.

A. Estimate the expected error rate in the population.

B. Randomly select and test 50 samples to estimate the expected error rate in the population. The maximum error rate is 50% (the Plan failed to pay all 50 sample claims correctly).

The expected error rate (p) = # of errors in the 50 samples / 100
Precision (5%) and confidence level (95%)

Confidence level is the probability that the value/errors in a sample of the population characteristics under study will not differ from the true value/error of the population by more than a stated amount (precision).

Precision is the range (ordinarily expressed as a plus or minus given number of percentage points) within which the true answer concerning the population characteristics under study (errors, for example) should fall at a specified confidence level.

IV. Determine the "statistically" representative sample size.

Statistical formulas or tables (based on definition of the population and determination of the sampling criteria) are used to determine the appropriate sample size. The following is an example for the sample size when the population is over 10,000:

Confidence Interval	95.00%	OR	1.96 σ	OR	$1.96 \sqrt{\frac{pq}{n}}$
Precision Interval	5.00%				
Population Parameters	p	OR	50.00% [a]		
	q	OR	1-p		
	1.96σ	=	5.00%		
	$1.96 \sqrt{\frac{pq}{n}}$	=	.05		
	$\sqrt{\frac{pq}{n}}$	=	.026		
	$\frac{pq}{n}$	=	.000651		
	$\frac{.50(1-.50)}{n}$	=	.000651		
	$\frac{.50(.50)}{n}$	=	.000651		
	$\frac{.25}{n}$	=	.000651		
	.000651 n	=	.2500		
	n	=	384.16		

[a] Population parameter calculated as:

# of claims in First 50 sample denied in error	50	=	50.00%
# of claims in First 50 sample	10		

If the population is under 5,000, calculate the sample size using the statistical formula stated above. Compare that amount to the sample size listed below and use the lesser of the two sample sizes:

Population Size	Sample Size
50	45
100	64
500	87
1,000	90
2,000	92
2,001-10,000	93

V. Choose a selection technique.

The primary desired outcome of statistical sampling is to select a sample that is truly representative of the population. This is done by letting each member of the population have an equal chance of being selected (random sampling).

VI. Evaluate the Results to determine compliance.

If 100 out of the total 385 claims were paid incorrectly, one can conclude that with 95% confidence (+ or - 5% error), $100/385 = 25.97\%$ of the claims were paid incorrectly.

B. Variable Stratifying Sampling

I. Define the sampling objective:

Variable sampling is used to estimate dollar or other quantitative characteristics of the population. For example, variable sampling is often performed to determine whether IBNR lags are reliable by estimating a percentage of over or under payment of claims to extrapolate to the IBNR lags.

II. Define the population to be sampled:

Determine exactly what items or characteristics must be reflected in the sample according to the sampling objectives. For example, it's recommended to include (at a minimum) the most recent six months of paid claims data for testing IBNR lags.

III. Determine the sampling plan and criteria.

A. Precision (5%) and confidence level (95%)

Confidence level is the probability that the value/errors in a sample of the population characteristics under study will not differ from the true value/error of the population by more than a stated amount (precision).

Precision is the range (ordinarily expressed as a plus or minus given number of percentage points) within which the true answer concerning the population characteristics under study (errors, for example) should fall at a specified confidence level.

B. Stratified Sampling

The main purpose of stratification is to increase the accuracy of the estimates of the population parameters of interest. Done properly, the accuracy of the parameter estimates in each of the strata is also increased.

In stratified selection, the units in the population are subdivided into mutually exclusive groups or strata prior to selection of the sample units. It is not necessary that each strata contain the same number of units. In fact, in some situations, unequal numbers in each strata may be required to truly improve precision.

The stratification principle states: to maximize the precision of the estimator of the population parameter of interest, 1) construct strata so that strata averages are as different as possible and 2) strata variances are as small as possible.

IV. Determine the "statistically" representative sample size.

Statistical formulas are used to determine the appropriate sample size, as follows:

Confidence Interval 95.00% OR 1.96 σ

Precision Interval 5.00%

Population Parameters A_i - # of claims in strata i

B_i - standard deviation for strata i

C – Total Paid in the Population

$$\text{Sample Size } n = \frac{\sum(A_i + B_i)^2 * 1.96}{\sum(A_i + B_i)^2 * 1.96 + (5\% * C)}$$

$$\text{Sample Size by Strata } n_i = \frac{A_i + B_i}{\sum(A_i + B_i)} * n$$

As 30 is the minimum acceptable sample size for each stratum, the sample size of each stratum (with the exception of that stratum which will be tested at 100% will need to be increased to 30 if the strata do not have sample size of 30 or more.

V. Choose a sample selection technique.

The primary desired outcome of statistical sampling is to select a sample that is truly representative of the population. This is done by letting each member of the population have an equal chance of being selected (random sampling).

VI. Evaluate the Results.

D_i - total dollar error in strata i
 T_i – total dollar paid in strata i
 T – total dollars paid in the population

$$\text{Percentage error in strata i } (p_i) = \frac{D_i}{T_i}$$

$$\text{Dollar Error Extrapolated} = p_i * T$$

$$\text{Impact on Total Paid Claims} = \sum(p_i * T)$$

Level of Compliance:

Met: Statutory/regulatory requirements are met as defined in the Act or Rules

Not Met: Some (or all) statutory/regulatory requirements are not met as defined in the Act or Rules

Item	Requirement
CM 004	<p>Audits and Controls There is a defined process and evidence of regular oversight/quality assurance audits for the Claims Department.</p>
<p>Statutory & Regulatory Citation(s):</p>	
<p>CA Health and Safety Code 1367.01(j) Every health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.</p> <p>CA Health and Safety Code 1370 Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs.</p>	
<p>Standards in Meeting Statutory & Regulatory Requirements:</p>	
<ol style="list-style-type: none"> 1. The Claims Quality Management/Audit system must include the evaluation of: <ul style="list-style-type: none"> • Complaints • Trends • Problem Identification • Corrective actions • Performance measurements 2. The actions and results of the program should be communicated to the appropriate contracting providers and health plan employees. 3. The Claims Quality Management/Audit system should be designed to detect and correct any instances of statutory or regulatory non-compliance. 	
<p>Guidance:</p>	
<ol style="list-style-type: none"> 1. There is a defined process and evidence of regular oversight/quality assurance audits for: <ul style="list-style-type: none"> • Procedural error rates <ul style="list-style-type: none"> ○ Matching to prior authorization for service ○ Timeliness of payment ○ Benefits application ○ Appropriate application/interpretation of contract • Financial error rates <ul style="list-style-type: none"> ○ Under and overpayment ○ Net error ○ Fraud • Customer Service issues, complaints and appeals, provider dispute resolutions 2. Based on data that includes trend analysis, problems with claims payment are identified for corrective action <ul style="list-style-type: none"> • Corrective action plans are implemented to correct identified problems • Appropriate plan personnel and contracted providers are notified 	

- Repeat measurement is performed, and corrective action taken until the problem is corrected
3. There is evidence that compliance to statutory and regulatory compliance is part of the Claims Quality Management/Audit plan.
- Availability of current statutes and regulations to key personnel, with an active management of revision control
 - Sufficient resources devoted to compliance issues.

Individual(s)/Position(s) that may be Interviewed:

- Claims Manager/Supervisor
- Audit staff
- Customer Service
- Quality Assurance Personnel
- IT Department

Document(s) that may be Reviewed:

- Policies and procedures for audits and quality assurance activities
- Audit reports
- Complaints analyses
- Appeals analyses
- Provider dispute resolution analyses
- Member satisfaction surveys
- Provider satisfaction surveys
- Corrective actions

Level of Compliance:

Met: Statutory/regulatory requirements are met as defined in the Act or Rules

Not Met: Some (or all) statutory/regulatory requirements are not met as defined in the Act or Rules

Item	Requirement
CM 005	<p>Reporting Capabilities The health plan produces timely, accurate and relevant reports regarding the timeliness and accuracy of claims payments.</p>
<p>Statutory & Regulatory Citation(s):</p>	
	<p>28 CCR 1300.71(q)(1) Within 60 days of the close of each calendar quarter, the plan shall disclose to the Department in a single combined document: (A) any emerging patterns of claims payment deficiencies; (B) whether any of its claims processing organizations or providers failed to timely and accurately reimburse 95% of its claims (including the payment of interest and penalties) consistent with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28; and (C) the corrective action that has been undertaken over the preceding two quarters.</p> <p>28 CCR 1300.77.4 Every plan shall institute procedures whereby all claim forms received by the plan from providers of health care services for reimbursement on a fee-for-service basis and from subscribers and enrollees for reimbursement are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time, and rapid retrieval of any claim. Although any categories for status-determination held unobjectionable by the Director may be used, for the purposes of this section, the following status-determination categories, as a group, shall be presumptively reasonable: (1) to be processed, (2) processed, waiting for payment, (3) pending, waiting for approval for payment or denial, (4) pending, waiting for additional information, (5) denied, (6) paid, and, if appropriate, (7) other. These procedures shall involve the use of either a claims log, claims numbering system, electronic data processing records, and/or any other method held unobjectionable by the Director.</p> <p>28 CCR1300.77.2 (a) Each plan subject to Subdivision (b) of Section 1377 shall calculate the estimate of incurred and unreported claims pursuant to a method held unobjectionable by the Director. Such method may include a lag study as defined and illustrated in Subsection (c), an actuarial estimate as defined in Subsection (d), or other reasonable method of estimating incurred and unreported claims. The amount required by Section 1300.77.1 to be accrued in the plan's books and records must equal the estimated total of all claims incurred but not yet received as of the end of the month as calculated in working papers, schedules or reports prepared in support of the unobjectionable lag study, actuarial estimate, or other method of estimating incurred and unreported claims. (b) Working papers which support the incurred and unreported claims calculation shall be maintained as part of the records of the plan. Lag study working papers shall include a detailed allocation of all claims received each month to the various months in which the services were performed. Actuarial estimate working papers must detail all underlying assumptions and calculations in establishing the actuarial rate. Any other method used to determine the amount of incurred and unreported claims must be supported by adequate working papers, schedules or reports which detail all aspects of the incurred and unreported calculation.</p>

Standards in Meeting Statutory & Regulatory Requirements:

1. The Plan has an accounting system which permits the determination of:
 - The date of receipt of any claim,
 - The status of any claim including those claims received in an area other than in the Claims Department and those sent to another department within the organization
 - The dollar amount of unpaid claims at any time
 - The rapid retrieval of any claim including:
 - Claims to be processed
 - Claims processed waiting for approval for payment or denial
 - Claims pending waiting for additional information
 - Claims denied
 - Claims paid
 - Claim checks waiting for signature
2. The Plan reports within 60 days of the close of each quarter:
 - Trends of emerging patterns in claims payment deficiencies identified by report or audit
 - The rate of accuracy and timeliness in aggregate claims payment, and for capitated medical groups and claims processing organizations
3. The Plan generates all reports needed for statutory and regulatory compliance
4. The Plan has a designated individual(s) who is/are accountable for receiving and responding to internal audit, production and system reports

Guidance:

1. There is evidence that the plan has reporting capabilities such that it is capable of generating critical management reports, which address the following:
 - Claims inventory
 - Claims to be processed
 - Claims processed waiting for payment
 - Claims pending, waiting for approval for payment or denial
 - Claims pending, waiting for additional information
 - Claims denied
 - Claims paid
 - Claim checks waiting for signature
 - Suspended claims backlog
 - Timeliness of Payment
 - Aged claims
 - Percent of complete, uncontested claims paid, modified or denied within 30 working days (45 days for an HMO)
 - By claims processing organization or capitated medical group
 - Accuracy of payments
2. The Plan accounts for claims that have been incurred but not yet reported:
 - Lag studies, which show the allocation of all claims, received (or paid, many plans used paid data as approved by the Department) each month to the various months in which the services were performed.
 - Actuarial estimate working papers must detail all underlying assumptions and calculations in establishing the actuarial rate.

3. The Plan identifies within 60 days of the close of each quarter:
 - Any emerging pattern of claims payment deficiencies
 - Any claims processing area or delegate with less than a 95% compliance with the timely and accurate payment of claims identified by report or audit
4. The Plan has documented and is able to report corrective actions taken in order to ensure prompt and accurate payment of claims
5. All reports necessary for regulatory and statutory compliance are produced in a timely and accurate manner

Individual(s)/Position(s) that may be Interviewed:

- Claims Manager
- Claims Supervisor
- IT Department Manager
- Finance Analyst/Actuary

Document(s) that may be Reviewed:

- Claims inventory
- Aged claims reports
- Timeliness reports
- Suspended claims inventories
- Error reports
- IBNR (lag) reports and methodology
- Evidence of stop loss coverage and reinsurance
- Reports of claims denials
- Reports of appeals (percent overturned)
- Audit results/reports
- Committee minutes

Level of Compliance:

Met: Statutory/regulatory requirements are met as defined in the Act or Rules

Not Met: Some (or all) statutory/regulatory requirements are not met as defined in the Act or Rules

Item	Requirement
CM 006	<p>Information Systems</p> <p>The Plan has Information Systems in place to ensure accurate and timely claims payment.</p>
	<p>Statutory & Regulatory Citation(s):</p> <p>CA Health and Safety Code 1367.02(c)(d) (c) Each plan that uses economic profiling shall, upon request, provide a copy of economic profiling information related to an individual provider, contracting medical group, or individual practice association to the profiled individual, group, or association. In addition, each plan shall require as a condition of contract that its medical groups and individual practice associations that maintain economic profiles of individual providers shall, upon request, provide a copy of individual economic profiling information to the individual providers who are profiled. The economic profiling information provided pursuant to this section shall be provided upon request until 60 days after the date upon which the contract between the plan and the individual provider, medical group, or individual practice association terminates, or until 60 days after the date the contract between the medical group or individual practice association and the individual provider terminates, whichever is applicable.</p> <p>(d) For the purposes of this article, "economic profiling" shall mean any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.</p> <p>28 CCR 1300.71(a)(2) "Complete claim" means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: "reasonably relevant information" which is the minimum amount of information necessary to adjudicate the claims as defined by section (a)(10), "information necessary to determine payer liability" which is the minimum amount of information necessary, in the possession of third parties, required by a claims adjudicator to adjudicate the claim as defined in section (a)(11) and:</p> <p>(A) For emergency services and care provider claims as defined by section 1371.35(j): (i) the information specified in section 1371.35(c) of the Health and Safety Code; and (ii) any state-designated data requirements included in statutes or regulations.</p> <p>(B) For institutional providers: (i) the completed UB 92 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; (ii) entries stated as mandatory by NUBC and required by federal statute and regulations; and (iii) any state-designated data requirements included in statutes or regulations.</p> <p>(C) For dentists and other professionals providing dental services: (i) the form and data set approved by the American Dental Association; (ii) Current Dental Technology Terminology (CDT) codes and modifiers; (iii) any state-designated data requirements included in statutes or regulations.</p> <p>(D) For physicians and other professional providers: (i) 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; (ii) Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD-9CM) codes; (iii) entries stated as mandatory by NUCC and required by federal statute and regulations;</p>

and

(iv) any state-designated data requirements included in statutes or regulations.

(E) For pharmacists:

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

(ii) any state-designated data requirements included in statutes or regulations.

(F) For providers not otherwise specified in these regulations:

(i) A properly completed paper or electronic billing instrument submitted in accordance with the plan's or the plan's capitated provider's reasonable specifications; and

(ii) any state-designated data requirements included in statutes or regulations.

(3) "Reimbursement of a Claim" means:

(A) For contracted providers with a written contract, including in-network point-of-service (POS) and preferred provider organizations (PPO): the agreed upon contract rate;

(B) For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph(C) below: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration:(1) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing non-contracted provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case; and

(C) For non-emergency services provided by non-contracted providers to PPO and POS enrollees: the amount set forth in the enrollee's Evidence of Coverage.

28 CCR 1300.71(a)(6)

"Date of receipt" means 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.

28 CCR 1300.71(b)(2)

If a claim is sent to a plan that has contracted with a capitated provider that is responsible for adjudicating the claim, then the plan shall do the following:

(A) For a provider claim involving emergency service and care, the plan shall forward the claim to the appropriate capitated provider within ten (10) working days of receipt of the claim that was incorrectly sent to the plan.

(B) For a provider claim that does not involve emergency service or care: (i) if the provider that filed the claim is contracted with the plan's capitated provider, the plan within ten (10) working days of the receipt of the claim shall either: (1) send the claimant a notice of denial, with instructions to bill the capitated provider or (2) forward the claim to the appropriate capitated provider; (ii) in all other cases, the plan within ten (10) working days of the receipt of the claim incorrectly sent to the plan shall forward the claim to the appropriate capitated provider.

28 CCR 1300.71(b)(3)

If a claim is sent to the plan's capitated provider and the plan is responsible for adjudicating the claim, the plan's capitated provider shall forward the claim to the plan within ten (10) working days of the receipt of the claim incorrectly sent to the plan's capitated provider.

28 CCR 1300.71(c)(1)

(1) In the case of an electronic claim, identification and acknowledgement shall be provided within two (2) working days of the date of receipt of the claim by the office designated to receive the claim, or

(2) In the case of a paper claim, identification and acknowledgement shall be provided within fifteen (15) working days of the date of receipt of the claim by the office designated to receive the claim.

Standards in Meeting Statutory & Regulatory Requirements:

1. Information systems must be able to either accept in an electronic format or process from a paper submission the following data elements:
 - The complete UB 92 data set
 - The complete CMS1500 (HCFA 1500) data set
 - Current Dental Technology Terminology codes and modifiers
 - Current Procedural Terminology codes and modifiers
 - International Classification of diseases, Ninth Edition, Clinical Modification (ICD-9 CM) codes
 - NCPDP codes
 - Any state designated data requirements included in statutes or regulations
2. Reimbursement calculations, edits or manual overrides based on reasonable and customary charges must take into consideration the following:
 - Is statistically credible
 - Is updated at least annually
 - Prevailing non-contracted provider rates in the geographic area where services were rendered
 - Provider characteristics (training, qualifications, time in practice)
 - Other economic aspects or unusual circumstances
3. The receipt of electronic claims must be acknowledged within (2) working days
4. Any system of cost or utilization reporting by practitioner, IPA or medical group must be made available to the relevant individual or group upon request.
5. Information systems necessary for all statutory and regulatory requirements must be in place.

Guidance:

1. The Plan has Information Systems (IS) in place to support the claims operating system and ensure accurate and timely claims payment including:
 - Acceptance of electronic claims including all relevant codes and data elements
 - Accurate and timely data entry of paper claims
 - Reference files for coding
 - Automated interface to member enrollment benefit tables
 - Automated interface to practitioner/provider fee schedules
 - Automated interface to authorization tables
 - Reference files for ranges of reasonable and customary payments by geographic area
2. The IS structure meets the statutory requirements of timely and accurate claims payments with:
 - Appropriate security systems to ensure data integrity
 - Appropriate back up systems for identified key data
 - System support of hardware and software

- A Process for system updates and maintenance that does not interfere with the plan's ability to pay claims accurately and in a timely fashion
 - Privacy protection, as mandated by Federal law
3. There is periodic assessment of use of edits, re-bundling and other adjudication software to ensure:
 - It does not interfere with timeliness of claims payment
 - It does not interfere with accuracy of claims payment
 - It does not result in an unfair payment pattern (as defined under 28 CCR28 CCR§1300.71(a) (Per official Fourth Period Text 5-5-03)
 4. All reference files are updated at least annually
 5. Claims personnel receive timely and thorough training and update training on IS systems and tools.
 6. All systems of cost or service utilization reporting by provider, IPA or group can report data to the appropriate individual or group, upon request.

Individual(s)/Position(s) that may be Interviewed:

- Claims Manager
- Claims Supervisor
- Provider Relations
- IS Manager

Document(s) that may be Reviewed:

- Sample of claims selected for review to compare submission to system capture (see CM 003 probe sample)
- Practitioner/provider model contract
- Paper claims submission forms
- Electronic submission protocol (including required format for transmission)
- Example of electronic claim receipts and provider acknowledgements
- Printouts of claims system screens showing required data elements
- Evidence of acknowledgment of claims
- Documentation of system updates
- Down time reports
- Training schedules and materials
- Privacy policies and procedures
- Data back up policies and procedures
- Disaster recovery plan and results of most recent test
- System integrity procedures
- Transaction system documentation including data dictionary; interface with membership, practitioner and authorization data; system edits; software adjudications in place
- Documentation of Plan payment rules and criteria and how they are applied
- Policies and procedures for manual overrides of system edits or adjudication

Level of Compliance:

Met: Statutory/regulatory requirements are met as defined in the Act or Rules

Not Met: Some (or all) statutory/regulatory requirements are not **met as defined in the Act or Rules**

Item	Requirement
CM 007	<p>Claims Payment Timeliness The health plan adjudicates claims within the required timeframes for contested and uncontested claims. The health plan reimburses interest and/ or fees at the mandated rate for payments made beyond the mandated time frames.</p>
	<p>Statutory & Regulatory Citation(s):</p> <p>CA Health and Safety Code 1371 A health care service plan, including a specialized health care service plan, shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.</p> <p>If an uncontested claim is not reimbursed by delivery to the claimants' address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically (automatically is defined as within five (5) working days of the payment of the claim without the need for any reminder or request by the provider or if under \$2.00, for an individual late claim, at the time the claim is paid a plan or plan's capitated provider that pays claims (hereinafter referred to as "the plan's capitated provider") may pay the interest on that claim along with interest on other such claims within ten (10) calendar days of the close of the calendar month) include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. Any plan failing to comply with this requirement shall pay the claimant a ten dollar (\$10) fee.</p> <p>For the purposes of this section, a claim, or portion thereof, is reasonably contested where the plan has not received the completed claim and minimum information necessary, as defined by CCR 28 1300.71(a)(10) and (11), to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the plan to determine the medical necessity for the health care services provided.</p> <p>If a claim or portion thereof is contested on the basis that the plan has not received the minimum amount of information necessary to adjudicate the claim to determine payer liability for the claim or portion thereof and notice has been provided pursuant to this section, then the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a plan has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim it has determined to be payable within 30 working days of the receipt of that information, or if the plan is a health maintenance organization, within 45 working days of receipt of that information, interest shall accrue and be payable at a rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working day period.</p>

CA Health & Safety Code 1371.35

(a) A healthcare service plan, including a specialized health care service plan, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after the receipt of the complete claim by the health service plan or if the health care service plan is an HMO, 45 working days after receipt of the complete claim by the health care service plan. However a plan may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial. A plan may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the plan pays those charges specified in subdivision (b).

(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the respective 30- or 45-working days after receipt, the plan shall pay the greater of fifteen dollars (\$15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working day period. A health care service plan shall (automatically is defined as within five (5) working days of the payment of the claim without the need for any reminder or request by the provider or if under \$2.00, for an individual late claim, at the time the claim is paid a plan or plan's capitated provider that pays claims (hereinafter referred to as "the plan's capitated provider") may pay the interest on that claim along with interest on other such claims within ten (10) calendar days of the close of the calendar month) include the fifteen dollars (\$15) per year or interest due in the payment made to the claimant, without requiring a request therefore.

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim pursuant to 28 CCR 1300.71(a)(2)(A). An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. However, if the plan requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the plan may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. The provider shall provide the plan reasonable relevant information within 10 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the plan requires further information, the plan shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. A plan shall specify, in a written notice sent to the provider within the respective 30- or 45-working days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the plan has not received the minimum amount of information reasonably necessary to adjudicate the claim to determine payer liability for the claim or portion thereof, then the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt of the additional information, the plan shall pay the greater of fifteen dollars (\$15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include the fifteen dollars (\$15) per year or interest due in the payment made to the claimant, without requiring a request therefore.

(f) The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services. This section shall not be construed to prevent a plan from assigning, by a written contract, the responsibility to pay interest and late charges pursuant to this section to medical groups, independent practice associations, or other entities.

(g) A plan shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the plan's actions to resolve the claim, to the provider that submitted the claim.

(h) A health care service plan shall not request or require that a provider waive its rights pursuant to this section.

(i) This section shall not apply to capitated payments.

(j) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 in the United States on or after September 1, 1999.

(k) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 1371.

(l) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

Standards in Meeting Statutory & Regulatory Requirements:

1. The plan reimburses each claim or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after the receipt of the complete claim by the health service plan or if the health service plan is an HMO, 45 working days after the receipt of the complete claim by the health service plan.
2. When the Plan contests or denies a claim or portion thereof, it notifies the claimant in writing within 30 working days or 45 working days of the receipt of the claim

3. For contested claims or portion thereof, contested on the basis that the Plan has not received information reasonably necessary to determine payer liability for the claim or a portion thereof, the plan shall complete the reconsideration of the claim within 30-45 working days respectively.
4. If an uncontested claim is not reimbursed by delivery to the claimants' address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30-or 45-working day period. A health care service plan shall automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. Any plan failing to comply with this requirement shall pay the claimant a ten dollar (\$10) fee.
5. If an emergency claim or portion thereof is not reimbursed by delivery to the claimant's address of record within the respective 30-45 working days after receipt of the additional information, the plan shall pay the greater of fifteen dollars (\$15) per year or interest at the rate of 15% per annum beginning with the first calendar day after the 30-or 45 working day period. A health care service plan shall automatically (automatically is defined as within five (5) working days of the payment of the claim without the need for any reminder or request by the provider or if under \$2.00, for an individual late claim, at the time the claim is paid a plan or plan's capitated provider that pays claims (hereinafter referred to as "the plan's capitated provider") may pay the interest on that claim along with interest on other such claims within ten (10) calendar days of the close of the calendar month) include the fifteen (\$15) per year or interest due in the payment made to the claimant without requiring a request therefore.

Guidance:

1. The Plan demonstrates compliance with the above requirements for all claims upon review of a randomly selected sample of submitted claims (see CM 003 for a complete description of probe sampling and requirements for compliance rates.) Assessment includes (for claims paid outside the mandated timeframes) whether the plan reimburses the claimant the appropriate interest or fee without being requested to do so. See also CM 009 for review of sample of denied/contested claims
2. The Plan demonstrates compliance with requirements for emergency room claims upon review of a sample of submitted in area and out of area ER claims, chosen at random. See CM 012 for review of emergency claims

Individual(s)/Position(s) that may be Interviewed:

- Claims Manager
- Claims Supervisor
- Random Claims Processors

Document(s) that may be Reviewed:

- Sample of contested and uncontested claims (see CM 003 for probe sampling and CM 009 for review of denied/contested claims)
- Sample of in and out of area emergency claims. See CM 012 for review of emergency claims

Level of Compliance:

Met: Statutory/regulatory requirements are met as defined in the Act or Rules

Not Met: Some (or all) statutory/regulatory requirements are not met as defined in the Act or Rules

Item	Requirement
CM 008	<p>Dispute Resolution Mechanisms The Plan has adequate mechanisms in place to facilitate resolution of claims issues/disputes that include both enrollees and provider. The Plan reports on dispute resolution procedures and outcomes with providers annually. These reports are provided to the Director within 15 days of the close of the calendar year.</p>
<p>Statutory & Regulatory Citation(s):</p>	
<p>CA Health and Safety Code 1367(h) (1) All contracts with subscribers and enrollees, including group contracts, and all contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted. (2) Each health care service plan shall ensure that a dispute resolution mechanism is accessible to non-contracting providers for the purpose of resolving billing and claims disputes. (3) On and after January 1, 2002, each health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes. This Section has been updated by 28 CCR 1300.71.38(k) which states that, beginning with the 2004 calendar year, each plan must electronically file through the DMHC's web portal, no later than fifteen (15) days after the close of the calendar year, an "Annual Plan Claims Payment and Dispute Resolution Mechanism Report" that discloses compliance status of the plan and each of its claims processing organizations and capitated providers. The report for 2004 shall include claims data and dispute resolution data received from October 1, 2003 through September 30, 2004.</p>	
<p>CA Health and Safety Code 1371.38 (a) The Department shall, on or before July 1, 2001, adopt regulations that ensure that plans have adopted a dispute resolution mechanism pursuant to subdivision (h) of Section 1367. The regulations shall require that any dispute resolution mechanism of a plan is fair, fast, and cost-effective for contracting and non-contracting providers and define the term "complete and accurate claim, including attachments and supplemental information or documentation." (b) On or before December 31, 2001, the Department shall report to the Governor and the Legislature its recommendations for any additional statutory requirements relating to plan and provider dispute resolution mechanisms. This Section has been updated by 28 CCR 1300.71.38(e)(1) and (2) and 1300.71.38(f). 28 CCR 1300.71.38(e)(1) and (2) states that a plan or plan's capitated provider shall identify and acknowledge the receipt of each provider dispute. If filed electronically, this acknowledgement shall be provided within two (2) working days of the date of receipt of the dispute and, if filed by paper, within fifteen (15) working days of the date of receipt of the dispute. 28 CCR 1300.71.38(f) states that each plan or the plan's capitated provider shall resolve each dispute and issue a written determination within 45 working days after the date of the receipt of the provider dispute or the amended provider dispute.</p>	

28 CCR 1300.71(g)(3)

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.

28 CCR 1300.71.38

(a) All health care service plans and their capitated providers that pay claims (plan's capitated provider) shall establish a fast, fair and cost effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes, The plan and the plan's capitated provider may maintain separate dispute resolution mechanisms for contracted and non-contracted provider disputes and separate dispute resolution mechanisms for claims and other types of billing and contract disputes, provided that each mechanism complies with sections 1367(h), 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of title 28. Arbitration shall not be deemed a provider dispute or a provider dispute mechanism for the purposes of this section.

(b) Whenever the plan or the plan's capitated provider adjusts or denies a claim it shall inform the provider of the availability of the provider dispute mechanism and the procedures for obtaining forms and instructions, including the mailing address, for filing a provider dispute.

(c) Submission of Provider disputes. The plan and the plan's capitated provider shall establish written procedures for the submission, receipt, processing and resolution of contracted and non-contracted provider disputes that at a minimum, provide that:

(1) Provider disputes be submitted utilizing the same number assigned to the original claim; thereafter the plan or the plan's capitated provider shall process and track the provider dispute in a manner that allows the plan, the plan's capitated provider, the provider and the Department to link the provider dispute with the number assigned to the original claim

(2) Contracted Provider Disputes be submitted in a manner consistent with procedures disclosed in sections 1300.71(1-4)

(3) Non-contracted provider disputes be submitted in a manner consistent with the directions for obtaining forms and instructions for filing a provider dispute attached to the plan's or the plan's capitated provider's notice that the subject claim has been denied, adjusted or contested or pursuant to the directions for filing Non-contracted Provider Disputes contained on the plan's or the plan's capitated provider's website.

(4) The plan shall resolve any provider dispute submitted on behalf of an enrollee or a group of enrollees treated by the provider in the plan's consumer grievance process and not in the plan's or the plan's capitated provider's dispute resolution mechanism. The plan may verify the enrollee's authorization to proceed with the grievance prior to submitting the complaint to the plan's consumer grievance process. When a provider submits a dispute on behalf of an enrollee or a group of enrollees, the provider shall be deemed to be joining with or assisting the enrollee within the meaning of section 1368 of the Health and Safety Code.

(d) Time Period for Submission.

(1) Neither the plan nor the plan's capitated provider that pays claims, except as required by any state or federal law or regulation, shall impose a deadline for the receipt of a provider dispute for an individual claim, billing dispute or other contractual dispute that is less than 365 days of plan's or the plan's capitated provider's action or, in the case of inaction, that is less than 365 days after the Time for Contesting or Denying Claims has expired. If the dispute relates to a demonstrable and unfair payment pattern by the plan or the plan's capitated provider, neither the plan nor the plan's capitated provider shall impose a deadline for the receipt of a dispute that is less than 365 days from the plan's or the

plan's capitated provider's most recent action or in the case of inaction that is less than 365 days after the most recent Time for Contesting or Denying Claims has expired.

(2) The plan or the plan's capitated provider may return any provider dispute lacking the information enumerated in either section (a)(1) or (a)(2), if the information is in the possession of the provider and is not readily accessible to the plan or the plan's capitated provider. Along with any returned provider dispute, the plan or the plan's capitated provider shall clearly identify in writing the missing information necessary to resolve the dispute consistent with sections 1300.71(a)(10) and (11) and 1300.71(d)(1), (2) and (3). Except in situation where the claim documentation has been returned to the provider, no plan or a plan's capitated provider shall request the provider to resubmit claim information or supporting documentation that the provider previously submitted to the plan or the plan's capitated provider as part of the claims adjudication process.

(3) A provider may submit an amended provider dispute within thirty (30) working days of the date of receipt of a returned provider dispute setting forth the missing information.

(e) Time Period for Acknowledgment. A plan or a plan's capitated provider shall enter into its dispute resolution mechanism system(s) each provider dispute submission (whether or not complete), and shall identify and acknowledge the receipt of each provider dispute:

(1) In the case of an electronic provider dispute, the acknowledgement shall be provided within two (2) working days of the date of receipt of the electronic provider dispute by the office designated to receive provider disputes, or

(2) In the case of a paper provider dispute, the acknowledgement shall be provided within fifteen (15) working days of the date of receipt of the paper provider dispute by the office designated to receive provider disputes.

(h) Designation of Plan Officer. The plan and the plan's capitated provider shall each designate a principal officer, as defined by section 1300.45(o) of title 28, to be primarily responsible for the maintenance of their respective provider dispute resolution mechanism(s), for the review of its operations and for noting any emerging patterns of provider disputes to improve administrative capacity, plan-provider relations, claim payment procedures and patient care. The designated principal officer shall be responsible for preparing, the reports and disclosures as specified in sections 1300.71(e)(3) and (q) and 1300.71.38(k) of title 28.

(k) Required Reports. Beginning with the 2004 calendar year and for each subsequent year, the plan shall submit to the Department no more than fifteen (15) days after the close of the calendar year, an "Annual Plan Claims Payment and Dispute Resolution Mechanism Report," described in part in Section 1300.71(q) of this regulation, on an electronic form to be supplied by the Department Managed Health Care pursuant to section 1300.41.8 of title 28 containing the following, which shall be reported based upon the date of receipt of the provider dispute or amended provider dispute:

(1) Information on the number and types of providers using the dispute resolution mechanism;

(2) A summary of the disposition of all provider disputes, which shall include an informative description of the types, terms and resolution. Disputes contained in a bundled submission shall be reported separately as individual disputes. Information may be submitted in an aggregate format so long as all data entries are appropriately footnoted to provide full and fair disclosure; and

(3) A detailed, informative statement disclosing any emerging or established patterns of provider disputes and how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results) and how the information has been used in the development of appropriate corrective action plans. The information provided pursuant to this paragraph shall be submitted with, but separately from the other portions of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report and may be accompanied by a cover letter requesting confidential treatment pursuant to

section 1007 of title 28.

(m) Review and Enforcement.

(1) The Department shall review the plan's and the plan's capitated provider's provider dispute resolution mechanism(s), including the records of provider disputes filed with the plan and remedial action taken pursuant to section 1300.71.38(m)(3), through medical surveys and financial examinations under sections 1380, 1381 or 1382 of the Health and Safety Code, and when appropriate, through the investigation of complaints of unfair provider dispute resolution mechanism(s).

Standards in Meeting Statutory & Regulatory Requirements:

1. There are fair, fast and cost effective dispute resolution mechanisms in place for both contracting and non-contracting providers
2. The providers are informed of the mechanisms, including procedures and instructions for filing a dispute, with every claims denial or adjustment.
3. The original claim number must link disputes to a claim.
4. Deadlines for filing disputes must not be earlier than 365 days after a plan's action, or 365 days after filing the claim, if no action is taken.
5. Disputes may be returned if they do not clearly identify the disputed item or an explanation of the basis for the provider's dispute. Returned disputes must clearly identify the missing information needed to resolve the dispute. Providers have 30 days from receipt of a returned dispute to submit an amended dispute.
6. The Plan may not make requests to resubmit previously submitted documentation, unless the materials have been returned to the provider.
7. A non-contracted provider's dispute over the calculation of the usual and customary value for health care services rendered is regarded as a provider dispute, and handled in accordance with this section
8. Plans must acknowledge receipt of disputes within 2 working days if submitted electronically, and within 15 working days if submitted in a paper format.
9. Plans must resolve and issue written determination of disputes within 45 working days after the date of receipt of disputes or amended disputes.
10. The Plan has a designated officer with responsibility and accountability for the dispute resolution mechanism.
11. As part of its Annual Plan Claims Payment and Dispute Resolution Report, Plan should report:
 - The number and types of providers submitting disputes
 - A summary of the disposition of all individual disputes with a description of the type, terms of resolution, pursuant to the format developed by the DMHC and submitted electronically through the web portal
 - A detailed and informative statement on any identified trends, and how opportunities for improvement have been identified, along with corrective actions taken.

Guidance:

1. Notice is provided to the providers about the availability of the provider dispute

resolution mechanism with every adjusted or denied claim. Notice includes:

- Procedures for obtaining forms
 - Instructions for filing a dispute
 - The mailing address
2. There are written procedures for submission, receipt, processing and resolution of contracted and non-contracted provider disputes which include:
- Tracking numbers
 - Timeframes and deadlines
 - Requests for additional information needed for reconsideration
 - Acknowledgment of receipt of dispute
 - Handling of amended disputes
 - Handling of disputed UCR calculations for non-contracted providers
3. There is a designated Plan officer with responsibility and accountability for the dispute resolution process.
4. The Plan tracks and trends the submission of provider disputes and their resolution
- Timeliness of resolution process
 - Opportunities for improvement are identified (e.g. type of disputes, resolution, etc.)
 - Corrective action plans are put in place
 - There is evidence that the information from the dispute mechanism is used to improve the organizations administrative systems:
 - Provider relations
 - Claims payments procedures
 - Quality assurance
 - Impact on patient care

Individual(s)/Position(s) that may be Interviewed:

- Plan Officer responsible for disputes
- Claims Manager
- Claims Supervisor
- Provider/network relations staff
- Quality Assurance Personnel

Document(s) that may be Reviewed:

- Policies and procedures on DRM
- Notice of DRM
- Denied Claim notices
- Trending reports on DRM
- Corrective actions, quality improvement activities implemented as a result of analysis
- Job Description of designated plan officer
- Sample of provider disputes (See CM 003 - Sample selection of provider disputes should be the same methodology used to select a random sample of claims)

Level of Compliance:

Met: Statutory/regulatory requirements are met as defined in the Act or Rules

Not Met: Some (or all) statutory/regulatory requirements are not met as defined in the Act or Rules

Item	Requirement
CM 009	<p>Claims Denial Requirements The Plan has mechanisms in place to ensure that denials are appropriate, timely and clearly communicated to enrollees and providers. Claims denials are performed by appropriately licensed Claims reviewers may not be compensated based a percentage of the amount by which the claim has been reduced or for the numbers or costs of denied claims. Only appropriate licensed health care professionals may deny claims for reasons of medical necessity. The Plan is compliant with denial of payment prohibitions.</p>
<p>Statutory & Regulatory Citation(s):</p>	
<p>CA Health and Safety Code 1367.01(b), (e) and (f) (b) A health care service plan that is subject to this section, supplemented by 28 CCR 1300.71(o), shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes.</p> <p>(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity.</p> <p>(f)The criteria or guidelines used by the health care service plan to determine whether to approve, modify or deny requests by providers prior to, retrospectively or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes</p> <p>CA Health and Safety Code 1371.36 (a) A health care service plan shall not deny payment of a claim on the basis that the plan, medical group, independent practice association, or other contracting entity did not provide authorization for health care services that were provided in a licensed acute care hospital and that were related to services that were previously authorized, if all of the following conditions are met: (1) It was medically necessary to provide the services at the time. (2) The services were provided after the plan's normal business hours. (3) The plan does not maintain a system that provides for the availability of a plan representative or an alternative means of contact through an electronic system, including voicemail or electronic mail, whereby the plan can respond to a request for authorization within 30 minutes of the time that a request was made.</p> <p>CA Health and Safety Code 1371.35(a) . . .however, a plan may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial. A plan may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the plan pays those charges specified in subdivision (b).</p>	

CA Health and Safety Code 1399.55

Health care service plans shall, upon rejecting a claim from a health care provider or a patient, and upon their demand, disclose the specific rationale used in determining why the claim was rejected. This section has been updated by 28 CCR 1300.71(d)(1) which states that a plan or a plan's capitated provider shall provide an accurate and clear written explanation of the specific reasons for the action taken.

CA Health and Safety Code 1399.56

Compensation of a person retained by a health care service plan to review claims for health care services shall not be based on either of the following:

(a) A percentage of the amount by which a claim is reduced for payment.

(b) The number of claims or the cost of services for which the person has denied authorization or payment.

Standards in Meeting Statutory & Regulatory Requirements:

1. Upon the demand from a provider or a patient whose claim has been rejected, the Plan discloses the specific rationale used in rejection.
2. Compensation of a person retained by a health care service plan to review claims for health care services shall not be based on:
 - A percentage of the amount by which a claim is reduced for payment
 - The number of claims or the cost of services for which the person has denied authorization or payment
3. Only licensed physicians or appropriate health care professionals may deny or modify claims based on medical necessity
4. The criteria or guidelines used by the health care service plan to determine whether to approve, modify or deny claims shall be consistent with clinical principles and processes
5. The health care service plan does not deny payment of a claim for health care services that were provided in a licensed acute care hospital because of a lack of prior authorization if they were related to services previously authorized and if all of the following conditions are met:
 - It was medically necessary to provide the services at the time.
 - The services were provided after the plan's normal business hours.
 - The plan does not maintain a system that provides for the availability of a plan representative or an alternative means of contact through an electronic system, including voicemail or electronic mail, whereby the plan can respond to a request for authorization within 30 minutes of the time that a request was made.
6. Claims are denied or contested within 30 working days of receipt (45 working days for HMO).

Notice that a claim is being contested or denied include the portion of the claim being denied, and the specific reasons for denial

Guidance:

1. Policies and procedures are in place for:
 - Use of appropriately licensed review staff
 - Timeframes for decision making and notification taking into account the overall requirement of 30 working days (45 working days for an HMO) for payment and

- /or notification of a denied claim
- Development and application of criteria/payment guidelines as based on valid medical principles.
- To enforce denial of payment prohibitions for acute care hospital settings
- For contested claims, and specific needs to request additional information.

2. Claims denials are assessed for:
- Appropriateness of denial decision making
 - Timeliness of denial decision making
 - Claims denials are performed by appropriately licensed and trained clinical professionals who shall not be compensated based on a percentage of the amount by which the claim has been reduced or for the number or cost of claims denied
 - Completeness of the information used in the denial decision
 - Appropriate application of clinical principles/criteria
 - Consideration of requirements for provision of emergency stabilization and transport See CM 012 review of sample of Emergency services claims
 - Timely notification of enrollees and providers within 30 working days (45 working days for HMO) of the receipt of the claim including
 - Revenue code and specific portion of denied claim
 - Specific reason code for denial
 - Notification of the appropriate dispute/appeals process
 - Compliance with denial of payment prohibitions

Individual(s)/Position(s) that may be Interviewed:

- Claims Manager
- Claims Supervisor
- Medical Director
- Random Claims Processors

Document(s) that may be Reviewed:

- Sample of denied claims. Methods and results for audits of consistency of denial decisions
- Policies and procedures for handling denials
- Policies and procedures for handling appeals
- Denial notices
- Policies and procedures related to application of criteria
- Contracts with claims reviewers, including compensation terms

Level of Compliance:

Met: Statutory/regulatory requirements are met as defined in the Act or Rules

Not Met: Some (or all) statutory/regulatory requirements are not met as defined in the Act or Rules

Item	Requirement
CM 010	<p>Information for Contracting Providers Plan must disclose specific policies and procedures on claims submissions, dispute handling, fee schedules and other related information. Plans must provide 45 day written notice to contracted providers before changing these policies and procedures.</p>
	<p>Statutory & Regulatory Citation(s):</p>
	<p>28 CCR 1300.71 (l) Information for Contracting Providers. On or before January 1, 2004, (unless the plan and/or the plan's capitated provider confirms in writing that current information is in the contracted provider's possession), initially upon contracting and in addition, upon the contracted provider's written request, the plan and the plan's capitated provider shall disclose to its contracting providers the following information in a paper or electronic format, which may include a website containing this information, or another mutually agreeable accessible format: (1) Directions (including the mailing address, email address and facsimile number) for the electronic transmission (if available), physical delivery and mailing of claims, all claim submission requirements including a list of commonly required attachments, supplemental information and documentation consistent with section (a)(10), instructions for confirming the plan's or the plan's capitated provider's receipt of claims consistent with section (c), and a phone number for claims inquiries and filing information; (2) The identity of the office responsible for receiving and resolving provider disputes; (3) Directions (including the mailing address, email address and facsimile number) for the electronic transmission (if available), physical delivery, and mailing of provider disputes and all claim dispute requirements, the timeframe for the plan's and the plan's capitated provider's acknowledgement of the receipt of a provider dispute and a phone number for provider dispute inquiries and filing information; and (4) Directions for filing substantially similar multiple claims disputes and other billing or contractual disputes in batches as a single provider dispute that includes a numbering scheme identifying each dispute contained in the bundled notice.</p>
	<p>(m) Modifications to the Information for Contracting Providers and to the Fee Schedules and Other Required Information. A plan and a plan's capitated provider shall provide a minimum of 45 days prior written notice before instituting any changes, amendments or modifications in the disclosures made pursuant to paragraphs (l) and (o).</p>
	<p>(o) Fee Schedules and Other Required Information. On or before January 1, 2004, (unless the plan and/or the plan's capitated provider confirms in writing that current information is in the contracted provider's possession), initially upon contracting, annually thereafter on or before the contract anniversary date, and in addition upon the contracted provider's written request, the plan and the plan's capitated provider shall disclose to contracting providers the following information in an electronic format: (1) The complete fee schedule for the contracting provider consistent with the disclosures specified in section 1300.75.4.1(b); and (2) The detailed payment policies and rules and non-standard coding methodologies used to adjudicate claims, which shall, unless otherwise prohibited by state law: (A) when available, be consistent with Current Procedural Terminology (CPT), and standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies and major credentialing organizations; (B) clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments, and (C) at a minimum, clearly and accurately state the policies regarding the following:</p>

- (i) consolidation of multiple services or charges, and payment adjustments due to coding changes,
- (ii) reimbursement for multiple procedures,
- (iii) reimbursement for assistant surgeons,
- (iv) reimbursement for the administration of immunizations and injectable medications, and
- (v) recognition of CPT modifiers.

The information disclosures required by this section shall be in sufficient detail and in an understandable format that does not disclose proprietary trade secret information or violate copyright law or patented processes, so that a reasonable person with sufficient training, experience and competence in claims processing can determine the payment to be made according to the terms of the contract.

A plan or a plan's capitated provider may disclose the Fee Schedules and Other Required Information mandated by this section through the use of a website so long as the plan or the plan's capitated provider provides written notice to the contracted provider at least 45 days prior to implementing a website transmission format or posting any changes to the information on the website.

(p) Waiver Prohibited. The plan and the plan's capitated provider shall not require or allow a provider to waive any right conferred upon the provider or any obligation imposed upon the plan by sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28, relating to claims processing or payment. Any contractual provision or other agreement purporting to constitute, create or result in such a waiver is null and void.

Standards in Meeting Statutory & Regulatory Requirements:

1. The contracted provider, initially upon contracting, annually on or before the contract's anniversary date, and upon the contracted provider's written request, receives directions for claims processes in a written or electronic format (midyear changes would be made subsequent to a minimum 45 days' notice of the change received by the plan and/or its capitated providers):
 - Submission instructions for electronic and paper claims
 - Instructions for confirming receipt
 - Contact information and filing instructions for disputes
 - How to file batch disputes for identical or similar claims' issues
2. The contracted provider, initially, annually on or before the contract's anniversary date, and in addition upon the contracted provider's written request, receives fee schedules and other required information (midyear changes would be made subsequent to a minimum 45 days' notice of the change received by the plan and/or its capitated providers):
 - The complete fee schedule with disclosure of any risk agreements as provided in CA Code of Regulations Title 28 §1300.75.4.1(b)
 - Detailed payment policies, rules and non standard coding methodologies used for adjudication.
 - Policies on:
 - Payment adjustments (e.g. coding changes, bundling, down coding)
 - Reimbursement for multiple procedures
 - Reimbursement for assistant surgeons
 - Reimbursement for administration of immunizations and injectables
 - Recognition of CPT modifiers

3. The policies, rules and methodologies used to adjudicate claims should be consistent with CPT codes and standard used by:
 - Nationally recognized medical societies and organizations
 - Federal regulatory bodies
 - Major credentialing organizations
4. The policies, rules and methodologies used to adjudicate claims should cover what is covered by any global payment provisions for all professional and institutional services.
5. A plan and its contracted providers receive any changes to this information in writing a minimum of 45 days prior to any change, including changes to any information posted on a website.

Guidance:

1. Policies and procedures are in place for payment adjudication:
 - Bundling
 - Re-coding or down coding
 - Reimbursement for multiple procedures or charges
 - Reimbursement for assistant surgeons and co-surgeons
 - Reimbursement for injectables and immunizations
 - Recognition of CPT modifiers
 - Global payment provisions
 - Professional services
 - Institutional services
 - Per diems
2. The policies and procedures in place are based on CPT codes and industry standards from:
 - Nationally recognized medical societies and organizations
 - Federal regulatory bodies
 - Major credentialing organizations
3. Contracted providers receive the above information initially upon contracting, annually on or before the contract's anniversary date and upon written request of the provider; in addition they receive information about (midyear changes would be made subsequent to a minimum 45 days' notice of the change received by the plan and/or its capitated providers):
 - Claim submission requirements, both paper and electronic
 - Commonly required attachments and supplemental information
 - Confirming receipt of a claim
 - Identity of responsible party for dispute resolution, and resolution mechanism directions
 - Directions for batching identical or similar claims disputes with batched numbering system for reference
4. Any changes to the above information must be provided in writing to the contracted provider a minimum of 45 days prior to implementation
 - A website may be used to notify the contracted provider of changes as long as the provider receives written notice that material on the website is being changed.

Individual(s)/Position(s) that may be Interviewed:

- Claims Manager
- Claims Supervisor
- Contracts manager
- IT Manager
- Provider Relations Manager

Document(s) that may be Reviewed:

- Model Provider Contracts
- Contracted Provider Notice letters
- Policies and procedures on Claims adjudication
- Websites or other electronic formats

Level of Compliance:

Met: Statutory/regulatory requirements are met as defined in the Act or Rules

Not Met: Some (or all) statutory/regulatory requirements are not met **as defined in the Act or Rules**

Item	Requirement
CM 011	<p>Claims Appeals The Plan has mechanisms in place to ensure that all appeals are handled appropriately and timely consistent with statutory requirements.</p>
<p>Statutory & Regulatory Citation(s)</p>	
<p>CA Health and Safety Code 1368(a)(5) (a) Every plan shall do all of the following: Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.</p> <p>28 CCR 1300.68(d)(3), (4), and (5) (3) The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law. (4) For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814. (5) Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee. In addition to the notice set forth at Section 1368.02(b) of the Act, the response shall also include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.</p> <p>CA Health and Safety Code 1370.2 Upon an appeal to the plan of a contested claim, the plan shall refer the claim to the medical director or other appropriately licensed health care provider. This health care provider or the medical director shall review the appeal and if he or she determines that he or she is competent to evaluate the specific clinical issues presented in the claim, shall make a determination on the appealed claim. If the health care provider or the medical director determines that he or she is not competent to evaluate the specific clinical issues of the appealed claim, prior to making a determination, he or she shall consult with an appropriately licensed health care provider who is competent to evaluate the specific clinical issues</p>	

represented in the claim. For the purposes of this section," competent to evaluate the specific clinical issues" means that the reviewer has the education, training and relevant expertise that is pertinent for evaluating the specific clinical issues that serve as the basis of the contested claim. The requirements of this section shall apply to claims that are contested on the basis of a clinical issue, the necessity for treatment or the type of treatment proposed or utilized. The plan shall determine whether or not to use an appropriate specialist provider in the review of contested claims.

Standards in Meeting Statutory & Regulatory Requirements:

1. Claims contested based on clinical issues are reviewed by an appropriately licensed health care provider or Medical Director who:
 - Has determined that he/she is competent to evaluate the specific clinical issues which serve as a basis for the appeal
 - Determines the necessity of the treatment or
 - The type of treatment proposed or utilized
2. In cases where the reviewer determines that he or she is not competent to evaluate the specific clinical issue of the appealed claim prior to making a determination, he or she shall consult with an appropriately licensed health care provider who is "competent to evaluate the specific clinical issues represented in the claim.
3. The Plan provides subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the Plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract, EOC or member handbook that exclude that coverage. Identify the document and page number or provide a copy of the provision to the grievant.
4. The written responses to grievances also include all applicable documentation and references to the DMHC's independent medical review system.

Guidance:

1. Assess the Plan's appeals process for:
 - Accurate, thorough and timely representation of appeal rights to member in language of preference
 - Timeliness of appeals processing
 - Thoroughness of research during appeal handling
 - Compliance to all appropriate regulations regarding external review
 - Use of appropriately licensed individuals for review process for contested claims
 - Timely Communication to enrollees
 - Communication to enrollees with clear and concise explanations which include:
 - The criteria used and clinical reasons for the decision or
 - The provisions in the contract that exclude that coverage

Individual(s)/Position(s) that may be Interviewed:

- Claims Manager
- Medical Director
- Claims Supervisor
- Member Service
- Appeals Manager

Document(s) that may be Reviewed:

- Sample of 20 claims appeal files
- Policies and procedures on handling appeals
- Notification letters to enrollees

Level of Compliance:

Met: Statutory/regulatory requirements are met as defined in the Act or Rules

Not Met: Some (or all) statutory/regulatory requirements are not met as defined in the Act or Rules

Item	Requirement
<p>CM 012</p>	<p>Emergency Services Claims The health plan reimburses providers for emergency services for stabilization and transport of its enrollees, as long as the enrollee reasonably believed that his condition required an emergency response.</p>
	<p>Statutory & Regulatory Citation(s):</p> <p>CA Health and Safety Code 1371.4(b), (c), (d) (b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.</p> <p>(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.</p> <p>(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.</p> <p>CA Health and Safety Code 1371.5. (a) No health care service plan that provides basic health care services shall require prior authorization or refuse to pay for any ambulance or ambulance transport services, referred to in paragraph (6) of subdivision (b) of Section 1345, provided to an enrollee as a result of a "911" emergency response system request for assistance if either of the following conditions apply: (1) The request was made for an emergency medical condition and ambulance transport services were required. (2) An enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.</p> <p>(b) As used in this section, "emergency medical condition" has the same meaning as in Section 1317.1.</p> <p>(c) The determination as to whether an enrollee reasonably believed that the medical condition was an emergency medical condition that required an emergency response shall not be based solely upon a retrospective analysis of the level of care eventually provided to, or a final discharge of, the person who received emergency assistance.</p>

(d) A health care service plan shall not be required to pay for any ambulance or ambulance transport services if the health care service plan determines that the ambulance or ambulance transport services were never performed, an emergency condition did not exist, or upon findings of fraud, incorrect billings, the provision of services that were not covered under the member's current benefit plan, or membership that was invalid at the time services were delivered for the pending emergency claim.

28 CCR 1300.74.30

(c) Independent Medical Review

In cases involving a claim for out of plan emergency or urgent services that a provider determined were medically necessary, the IMR shall determine whether the services were emergency or urgent services necessary to screen and stabilize the enrollee's condition. For purposes of this section "emergency services" are services for emergency medical conditions as defined in section 1300.71.4 of Title 28 and "urgent services" are all services except emergency services, where the enrollee has obtained the services without prior authorization from the plan, or from a contracting provider.

Standards in Meeting Statutory & Regulatory Requirements:

1. The Plan reimburses providers for emergency services provided to enrollees until care results in stabilization
 - The Plan may only deny care if it determines the services were not performed, or when the enrollee did not require emergency care, and reasonably should have known that an emergency did not exist
 - Prior Authorization may be required for payment for medically necessary care following stabilization of an emergency situation
2. Disagreements regarding the need for medically necessary care following stabilization of an emergency situation within the health plan service area shall:
 - Result in transfer of the patient to contracted medical personnel OR
 - Result in the transfer of the patient to a contracted acute care hospital OR
 - Result in treatment deemed authorized by the Plan that may not be denied
3. Plans pay for ambulance transport services as part of the 911 Emergency response system:
 - The Plan may only deny payment if it determines the services were not performed, or when the enrollee did not require emergency care, and reasonably should have known that an emergency did not exist.

Guidance:

1. The Plan has policies and procedures in place covering the payment of emergency services provided prior to stabilization of the enrollee
2. The Plan has policies and procedures in place covering the payment of medically necessary care following stabilization of an emergency situation
 - The plan has policies and procedures in place covering the transfer of patients to contracted providers or hospitals
3. The Plan has policies and procedures in place covering ambulance payment for emergency situations as part of the 911 emergency response system.

Individual(s)/Position(s) that may be Interviewed:

- Claims Manager
- Medical Director
- UM Manager

Document(s) that may be Reviewed:

- Policies and procedures
- Random Sample of Emergency care claims; including claims for 911 ambulance transport
- Review of Emergency care denials and ambulance denials for last 90 days

Level of Compliance:

Met: Statutory/regulatory requirements are met as defined in the Act or Rules

Not Met: Some (or all) statutory/regulatory requirements are not met as defined in the Act or Rules

Item	Requirement
CM 013	<p>Delegation of Claims Payment If the Plan contracts with claims processing organizations, capitated provider groups, IPAs or other entities to pay claims, the Plan retains its obligations to meet its statutory and regulatory requirements in the timely and accurate payment of claims.</p>
	<p>Statutory & Regulatory Citation(s):</p>
	<p>CA Health and Safety Code 1367 The obligation of the plan to comply with this section shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.</p> <p>CA Health and Safety Code 1371 The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services.</p> <p>CA Health and Safety Code 1371.35(f) The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services. This section shall not be construed to prevent a plan from assigning, by a written contract, the responsibility to pay interest and late charges pursuant to this section to medical groups, independent practice associations, or other entities.</p> <p>28 CCR1300.71 The following practices, policies and procedures may constitute a basis for a finding that the plan or the plan's capitated provider has engaged in a "demonstrable and unjust payment pattern:" as set forth in section (s)(4): (J) The failure to include the mandated contractual provisions enumerated in section (e) in three (3) or more of its contracts with either claims processing organizations and/or with plan's capitated providers over the course of any three-month period</p> <p>(e) Contracts for Claims Payment. A plan may contract with a claims processing organization for ministerial claims processing services or contract with capitated providers that pay claims, ("plan's capitated provider") subject to the following conditions: (1) The plan's contract with a claims processing organization or a capitated provider shall obligate the claims processing organization or the capitated provider to accept and adjudicate claims for health care services provided to plan enrollees in accordance with the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28. (2) The plan's contract with the capitated provider shall require that the capitated provider establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28, unless the plan assumes this function. (3) The plan's contract with a claims processing organization or a capitated provider shall require: (i) the claims processing organization and the capitated provider to submit a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to the plan within thirty (30) days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose the claims processing organization's or the capitated provider's compliance status with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37,</p>

1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28;

(ii) the capitated provider to include in its Quarterly Claims Report a tabulated record of each provider dispute it received, categorized by date of receipt, and including the identification of the provider, type of dispute, disposition, and working days to resolution, as to each provider dispute received. Each individual dispute contained in a provider's bundled notice of provider dispute shall be reported separately to the plan; and

(iii) that each Quarterly Claims Report be signed by and include the written verification of a principal officer, as defined by section 1300.45(o), of the claims processing organization or the capitated provider, stating that the report is true and correct to the best knowledge and belief of the principal officer.

(4) The plan's contract with a capitated provider shall require the capitated provider to make available to the plan and the Department all records, notes and documents regarding its provider dispute resolution mechanism(s) and the resolution of its provider disputes.

(5) The plan's contract with a capitated provider shall provide that any provider that submits a claim dispute to the plan's capitated provider's dispute resolution mechanism(s) involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to the plan's dispute resolution process for a de novo review and resolution for a period of 60 working days from the capitated provider's Date of Determination, pursuant to the provisions of section 1300.71.38(a)(4) of title 28.

(6) The plan's contract with a claims processing organization or the capitated provider shall include provisions authorizing the plan to assume responsibility for the processing and timely reimbursement of provider claims in the event that the claims processing organization or the capitated provider fails to timely and accurately reimburse its claims (including the payment of interest and penalties). The plan's obligation to assume responsibility for the processing and timely reimbursement of a capitated provider's provider claims may be altered to the extent that the capitated provider has established an approved corrective action plan consistent with section 1375.4(b)(4) of the Health and Safety Code.

(7) The plan's contract with the capitated provider shall include provisions authorizing a plan to assume responsibility for the administration of the capitated provider's dispute resolution mechanism(s) and for the timely resolution of provider disputes in the event that the capitated provider fails to timely resolve its provider disputes including the issuance of a written decision.

(8) The plan's contract with a claims processing organization or a capitated provider shall not relieve the plan of its obligations to comply with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28.

Standards in Meeting Statutory & Regulatory Requirements:

1. The Plan ensures the accurate and timely payment of claims by contracted claims processing organizations, capitated provider groups, IPAs and other entities.
2. Contracts with entities to pay claims must include:
 - Obligations to ensure the timely and accurate payment of claims
 - A requirement for fast, fair and cost effective dispute resolution mechanism
 - A requirement for a Quarterly Claims Report
 - 30 days after the close of the quarter
 - Discloses compliance with statutory and regulatory requirements
 - A tabulated record of provider disputes
 - Identification of provider
 - Type of dispute
 - Disposition
 - Working days to resolution

- **Is signed by and includes written verification of a principal officer of the claims processing organization or the capitated provider stating that the report is true and correct to the best knowledge and belief of the principal officer.**
 - **Any provider that submits a claim dispute to the plan's capitated provider's dispute resolution mechanism(s) involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to the plan's dispute resolution process for a de novo review and resolution for a period of 60 working days from the capitated provider's Date of Determination, pursuant to the provisions of section 1300.71.38(a)(4) of title 28.**
 - The right to appeal is within 60 days of the capitated provider's date of determination.
- The right for the Plan to assume responsibility for the reimbursement of claims in the event that contracting entity fails to timely and accurately reimburse its claims.
 - The right for the Plan to assume responsibility for the dispute resolution mechanism the event that contracting entity fails to timely resolve its provider disputes including the issuance of a written decision
3. Failure to include such terms in 3 or more contracts over a 3-month period may be the basis of finding that the plan engaged in an unjust payment pattern.

Guidance:

1. The Plan has policies and procedures in place to ensure that contracted entities meet the statutory and regulatory requirements for accurate and timely claims payments
2. Contracts with entities that pay claims contain provisions that include obligations for:
 - Accurate and timely claims payment
 - Compliance with statutory and regulatory requirements
 - A fair fast cost effective dispute mechanism
 - A right for second level appeal to the plan's dispute mechanism
 - A quarterly Claims Payment Performance report should include separate reports for claims processing and PDR data
 - Remedies including the assumption of claims payment by the plan, should the entity fail to meet its obligations
3. Claims submitted to contracted entities should demonstrate compliance to all statutory and regulatory requirements, including those for dispute resolution.
 - If a single contracted claims payor pays 30% or more of total claims submitted, or dollars paid for any category of claim, major delegation of the claims processing function is present
 - If 40% or more of total claims are handled by a contracted entity, major delegation of the claims processing function is present
 - If major delegation is present, interviews, site visits, policy and procedure reviews and auditing of claims and disputes should be conducted for key contracted entities, as well as for the plan
 - If minor delegation is present, interviews, site visits, policy and procedure reviews and auditing of claims and disputes regarding the delegation of claims services need to be conducted at the plan

Individual(s)/Position(s) that may be Interviewed:

- Contracts Department
- Provider Relations
- Claims Manager
- Medical Director
- UM Manager
- If Major Delegation:
Contracted entity:
 - Claims Manager
 - Principal Officer
 - Medical Director
 - IT Department
 - Individual responsible for Dispute Resolution Mechanism

Document(s) that may be Reviewed:

- Policies and procedures
- Contracts with claims paying organizations
- Appeal of Provider disputes
- Quarterly claims performance reports
- Pre-delegation audit methods and results
- Annual delegation oversight audit methods and results
- If Major Delegation:
Contracted entity:
 - Policies and procedures for ensuring statutory and regulatory complianceSample of claims: (see CM 003, CM 009, CM 011, CM 012)
 - Sample of disputes
 - Other materials as required by CM 001-CM 012

Level of Compliance:

Met: Statutory/regulatory requirements are met as defined in the Act or Rules

Not Met: Some (or all) statutory/regulatory requirements are not **met as defined in the Act or Rules**

APPENDICES

APPENDIX A: Supplemental Worksheet

Need to insert link to Excel Worksheets

Adjudication	Processing a claim through a series of edits in order to determine proper payment.
Allowable Charge	The maximum fee that a third party will reimburse a provider for a given service. An allowable charge may not be the same amount as either a reasonable or customary charge.
Allowable Costs	Charges for services rendered or supplies furnished by a health provider which qualify for an insurance reimbursement.
Appeal	A formal request by a provider or enrollee for reconsideration of a decision to deny, modify or delay health care services, with the goal of finding a mutually acceptable solution. This may include utilization review recommendations, benefit determinations, administrative policies quality-of-care or quality of service issues. (See Grievance)
Benefit	A service provided under an insurance policy or prepayment plan.
Bill Review	Third-party review of medical bills for excessive or inappropriate charges. Some workers compensation state statutes mandate payers to examine bills.
Billed Claims	The fees or costs for healthcare services provided to a covered person, submitted by a healthcare provider.
Capitation	In the strictest sense, a stipulated dollar amount established to cover the cost of healthcare delivered for a person. The term usually refers to a negotiated per capita rate to be paid periodically, usually monthly, to a healthcare provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider contract.
Claim	Information, submitted by a provider or a covered person to establish that medical services were provided to a covered person, from which processing for payment to the provider or covered person is made. The term generally refers to the liability for healthcare services received by covered persons. A claim can be clean or non clean. A clean claim is a complete claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides reasonably relevant information and information necessary to determine payer liability.
Claims Administration	A carrier function involving the review of health insurance claims submitted for payment, by individual claim or in the aggregate. Claims administration, as it relates to professional review programs, is an identification procedure, screening treatment or charge pattern, for subsequent peer review and adjudication.
Claims Review	The method by which an enrollee's healthcare service claims is reviewed before reimbursement is made. The purpose of this monitoring system is to validate the medical appropriateness of the provided services and to be sure the cost of the service is not excessive.
Clinical Guidelines	Systematically developed descriptive tools or standardized specifications for care to assist practitioners in treatment decisions about appropriate health care for specific clinical circumstances. Clinical guidelines are typically developed through a formal process and are based on authoritative sources, including clinical literature and expert consensus. Clinical guidelines may be called practice parameters, treatment protocols, clinical criteria, or practice guidelines.

APPENDIX B

Glossary of Terms

CMS 1500 (formerly known as HCFA 1500)	A universal form, developed by the government agency known as Center for Medicare and Medicaid Services (CMS), formerly known as Health Care Financing Administration (HCFA), for providers of services to bill professional fees to health carriers. HCFA 1500 forms may also be used. The only difference between the CMS 1500 form and the HCFA 1500 form is the name of the form; everything else remains the same.
Coding System	ICD-9 System- a diagnoses and procedure coding system for hospital care; CPT-4 System- used to identify physician services like injections and surgeries; NDC Coding System - a system used by insurers to pay outpatient pharmaceutical claims; HCPCS System- a Medicare system for identifying a wide variety of services including injectable drugs used in physicians' offices.
Coinsurance	The portion of covered healthcare costs for which the covered person has a financial responsibility, usually according to a fixed percentage. Often coinsurance applies after first meeting a deductible requirement.
Complaint	An oral or written expression of dissatisfaction by a member.
Concurrent Review	An assessment that determines medical necessity or appropriateness of services as they are being rendered, such as an assessment of the need for continued inpatient care for hospitalized patients.
Copay/Copayment	A cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as \$10 for an office visit. The covered person is usually responsible for payment at the time the healthcare is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital services. Some copayments are referred to as coinsurance, with the distinguishing characteristics that copayment are flat or variable dollar amounts and coinsurance is a defined percentage of the charges for services rendered.
Coverage	Entire range of protection provided under an insurance contract.
Coverage Decision	The approval or denial of health care services by a plan, or by one of its delegated entities based upon the benefits specified in the plan contract that applies to the enrollee.
Covered Expenses	Medical and related costs, experienced by those covered under the policy, that qualify for reimbursement under terms of the insurance contract.
Covered Services/Expenses	The specific services and supplies for which Medicaid will provide reimbursement. Covered services under Medicaid consist of a combination of mandatory and optional services within each state.
Criteria	Systematically developed objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcomes. Criteria are typically developed through a formal process and are based on authoritative sources, including clinical literature and expert consensus.
Customary, Prevailing, and Reasonable Charges	Method of reimbursement used under Medicare, which limits payment to the lowest of the following: physician's actual charge, physician's median charge in a recent prior period (customary), or the 75 th percentile of charges in the same time period (prevailing). See definitions of UCR & Reasonable and Customary on pg. B-7.

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Date of Service	The date on which healthcare services were provided to the covered person.
Deductible	The amount of eligible expense a covered person must pay each year from his/her own pocket before the plan will make payment for eligible benefits.
Delegation	A formal process by which the plan gives another entity the authority to perform certain functions on its behalf such as claims processing, credentialing, and utilization management. The plan maintains the responsibility for ensuring that the function is performed correctly.
Denial	Non approval of a requested of care or service. This includes any partial approvals and denials, modifications, or delays to the original request.
Disallowance	A denial by the payer for portions of the claimed amount. Examples of possible disallows include coordination of benefits, not-covered benefits, or amounts over the maximum fee.
Duplicate Coverage Inquiry (DCI)	A request to an insurance company or group medical plan by another insurance company or medical plan to find out whether coverage exists for the purpose of coordination of benefits.
Eligible Expenses	The lower of the reasonable and customary charges or the agreed upon health services fee for health and supplies covered under a health plan.
Encounter	Any measurable utilization of service by an enrollee.
Evidence of Coverage (EOC)	A description of the benefits included in a carrier's plan. The evidence of coverage is required by state laws and represents the coverage provided under the contract issued to the employer. The EOC is provided to the employee in the form of a certificate, agreement, contract, brochure, or letter of entitlement.
Explanation of Benefits	The statement sent to covered persons by their health plan listing services provided, amount billed, and payment made.
Exclusions	Specific conditions or circumstances listed in the contract or employee benefit plan for which the policy or plan will not provide benefit payments.
Expected Claims	The projected claim level of a covered person or group for a defined contract period. This level also becomes known as a desired loss ratio or break-even point in relationship to projected premium.
Experimental Therapy	Any treatment, device, or procedure that is not currently approved as an accepted standard of practice, but is subject to rigorous ethical and scientific investigative methods in a controlled setting. (See Investigational Therapy)
FFS	Fee-For-Service
Fee Schedule	A schedule of services with pre-established payment amounts that could be expressed as a percentage of billed charges, a percentage of Medicare RBRVS, flat rates, maximum allowable amounts, or other equivalent payment arrangement.

Fiscal Intermediary	The agent that has contracted with providers of service to process claims for reimbursement under healthcare coverage. In addition to handling financial matters, it may perform other functions such as providing consultative services or serving as a center for communication with providers and making adult of providers' records.
Grievance	Any request by an enrollee for a plan to address a perceived problem. NCQA classifies all such requests as stages in the appeals process. The State of California classifies all complaints and appeals as grievances.
Healthcare Common Procedural Coding System (HCPCS)	A listing of services, procedures and supplies offered by physicians and other providers. HCPCS includes Current Procedural Terminology (CPT) codes, national alphanumeric codes and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid Services (CMS) in order to supplement CPT codes. They include physician services not included in CPT as well as non-physician services such as ambulance, physical therapy and durable medical equipment. The local codes are developed by local Medicare carriers in order to supplement the national codes. HCPCS codes are 5-digit codes, the first digit a letter followed by four numbers. HCPCS codes beginning with A through V are national, those beginning with W through Z are local.
In-Area Services	Healthcare received within the authorized service area from a participating provider of the health plan.
Incurred But Not Reported (IBNR)	Refers to a financial accounting of all services that have been performed but, as a result of a short period of time, have not been invoiced or recorded. Estimates of costs for medical services provided for which a claim has not yet been filed. Refers to claims which reflect services already delivered, but, for whatever reason, have not yet been received by the health plan or provider paying the claims. These are bills "in the pipeline." This is a crucial concept for proactive providers who are beginning to explore arrangements that put them in the role of adjudicating claims--as the result, perhaps, of operating in a sub-capitated system. Failure to account for these potential claims could lead to some very bad decisions. Good administrative operations have fairly sophisticated mathematical models to estimate this amount at any given time.
Incurred Claims	All claims with dates of service within a specified period.
Incurred Claims Loss Ratio	Incurred claims divided by premiums.
Independent Medical Review (IMR)	The review of a disputed health care service by an unbiased clinically and financially separate expert or panel of experts.
Independent Practice Association (IPA) model	A plan that contracts directly with physicians in independent association (IPA) model practices; and/or contracts with one or more multi-specialty group practices the plan may be predominantly organized around solo/single specialty practices.
International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)	This is the universal coding method used to document the incidence of disease, injury, mortality and illness. A diagnosis and procedure classification system designed to facilitate collection of uniform and comparable health information. The ICD-9-CM was issued in 1979. This system is used to group patients into DRGs, prepare hospital and physician billings and prepare cost reports. Classification of disease by diagnosis codified into six-digit numbers.

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Investigational Therapy	Any treatment, device, or procedure that is not currently approved as an accepted standard practice, but is subject to rigorous ethical and scientific investigative methods in a controlled setting. (See Experimental Therapy)
Life Threatening	Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted or disease or conditions with potential fatal outcomes, where the end point of clinical interventions is survival.
Maximum Allowable Cost (MAC) List	Specified multi-source prescription medications that will be covered at a generic product cost level established by the plan. This list, distributed to participating pharmacies, is subject to periodic review and modification by the plan. The MAC list may require covered persons to pay a cost differential for a brand name product.
Maximum Allowable Fee Schedule	A healthcare payment system which reimburses up to a specified dollar amount for services rendered.
Medical Necessity	The determination that an intervention recommended by a treating practitioner is (1) the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and (2) known to be effective in improving health outcomes. For interventions not yet in widespread use, a plan determines effectiveness, based on the best available scientific evidence. For established interventions, a plan determines effectiveness based on scientific evidence, professional standards and expert opinion.
Met	The plan meets all identified standards.
Monitor	A periodic or ongoing performance measurement to determine opportunities for improvement or the effectiveness of interventions.
National Drug Code (NDC)	Classification system for drug identification, similar to UPC code.
Net Loss Ratio	The result of total claims liability and all expenses divided by premiums. This is the carrier's loss ratio after accounting for all expenses.
Non-formulary Prescription Drugs	A drug listed on the formulary.
Not Met	The plan does not meet any identified standards. Not Met implies that standards are not met, and that a corrective action must be formulated and implemented in order to achieve compliance.
Paid Claims	The amounts paid to providers to satisfy the contractual liability of the carrier or plan sponsor. These amounts do not include any covered person liability for ineligible charges or for deductibles or copayments. If the carrier has preferred payment contracts with providers (e.g., fee schedules or capitation arrangements), lower paid claims liability will usually result.
Paid Claims Loss Ratio	Paid claims divided by premiums.
Partially Met	The plan meets some, but not all standards. Partially Met implies that a standard is not met, and that a corrective action must be formulated and implemented in order to achieve compliance in the future.
Payer	A public or private organization that pays for or underwrites coverage for healthcare expenses.

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Peer Review	Evaluation or review of the performance of colleagues by professionals with similar types and degrees of expertise (e.g., the evaluation of one physician's practice by another physician).
Physician's Current Procedural Terminology (CPT)	List of services and procedures performed by providers, with each service/procedure having a unique 5-digit identifying code. CPT is the health care industry's standard for reporting of physician services and procedures. Used in billing and records.
Practitioner	A licensed professional who provides health care services.
Primary Care Physician	A physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialty care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.
Primary Care Provider	Any provider who defines their scope of services to be that of a primary care physician. (See "primary care physician")
Prior Review/Authorization	A formal process requiring a provider obtain approval to provide particular services or procedures before they are done. This is usually required for nonemergency services that are expensive or likely to be abused or overused. A managed care organization will identify those services and procedures that require prior authorization, without which the provider may not be compensated.
Protocols	A written plan specifying the procedures to be followed in giving a particular examination, in conducting research or in providing care for a particular condition. (See Clinical Guidelines)
Provider	Usually refers to a hospital or doctor who "provides" care. A health plan, managed care company or insurance carrier is not a healthcare provider. Those entities are called payers. The lines are blurred sometimes, however, when providers create or manage health plans. At that point, a provider is also a payer. A payer can be provider if the payer owns or manages providers, as with some staff model HMOs.
Provider Group	A medical group, independent practice association, or any other similar group of providers.
Prudent Layperson Rule	A standard where the judgment of a medically untrained individual is used as the basis for the urgency or emergent nature of any condition.
Quality Improvement	Also called performance improvement (PI). This is the more commonly used term in healthcare, replacing QA. QI implies that concurrent systems are used to continuously improve quality, rather than reacting when certain baseline statistical thresholds are crossed. Quality improvement programs usually use tools such as cross functional teams, task forces, statistical studies, flow charts, process charts, pareto charts, etc.
Quality Management (QM)	A formal set of activities designed to review and to safe guard the quality of care and services provided to enrollees. The effort to assess and improve the level of performance of key processes and outcomes within an organization. Opportunities to improve care and service are found primarily by examining the systems and processes by which care and services are provided. QM includes quality assessment and implementation of corrective actions to address any deficiencies identified in the quality of care

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	and services provided to individuals or populations, as well as re-assessment to determine the impact, if any, of corrective actions on the identified deficiencies.
Reasonable and Customary	Commonly charged fees for health services in a certain area. The use of fee screens to determine the lowest value of provider reimbursement based on: (1) the provider's usual charge for a given procedure, (2) the amount customarily charged for the service by other providers in the area (often defined as a specific percentile of all charges in the community), and (3) the reasonable cost of services for a given patient after medical review of the case. Most health plans provide reimbursement for usual and customary charges, although no universal formula has been established for these rates. See Customary, Prevailing and Reasonable Charges definition on pg. B-2.
Retrospective Review	Assessment of the appropriateness of medical services on a case-by-case or aggregate basis after the services have been provided.
Standards	Authoritative statements of (1) minimum levels of acceptable performance or results, (2) excellent levels of performance or results or (3) the range of acceptable performance or results.
Stop-loss Insurance	Insurance purchased by an insurance company or health plan from another insurance company to protect itself against losses. Reinsurance purchased to protect against the single overly large claim or the excessively high aggregated claim during a set period. Also see Reinsurance and Specific Stop Loss.
Turnaround Time (TAT)	The measure of a process cycle from the date a transaction is received to the date completed. (For claims processing, the number of calendar days from the date a claim is received to the date payment is in the mail.)
Unbundling	The practice of providers billing for a package of health care procedures on an individual basis when a single procedure could be used to describe the combined service.
Uniform Billing Code of 1992 (UB-92)	Bill form used to submit hospital insurance claims for payment by third parties. Similar to CMS 1500, but reserved for the inpatient component of health services.
Usual, customary and reasonable (UCR)	Commonly charged fees for health services in a certain area. Most health plans provide reimbursement for usual and customary charges, although no universal formula has been established for these rates. See Customary, Prevailing and Reasonable Charges definition on pg. B-2. See also Reasonable and Customary definition stated above.
Utilization Management (UM)	The system of evaluating the necessity, appropriateness and efficiency of health care services. Includes determining the coverage for medical care services as well as providing any needed assistance to clinician or patient in cooperation with other parties, to ensure appropriate use of resources. In some plans, discharge planning and case management are part of the UM system.
Utilization review	A formal review of the utilization and coverage of health care services, which can be performed on a prospective (prior authorization), concurrent, and retrospective basis.

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