Policy:	MA.3101
Title:	**Claims Processing**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 05/09/2024*
Effective Date:	08/01/2005
Revised Date:	05/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima Health or a Health Network in accordance with applicable statutory, and regulatory requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima Health or a Health Network shall reimburse a claim for Covered Services rendered to a Member in accordance with the standard allowances set by CalOptima Health Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a contracted Provider.

B. A Provider shall submit a claim for Covered Services rendered on, or after, January 1, 2010, as follows:

1. A Non-Contracted Provider shall submit a claim for Covered Services rendered to a Member within one (1) calendar year after the date of service.

2. A contracted Provider shall submit a claim for Covered Services rendered to a Member within the time frame specified in the contracted Provider agreement. If the contracted Provider agreement does not specify a time frame, the contracted Provider shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima Health or a Health Network shall make timely and reasonable payment for the following Covered Services provided to a Member by a Non-Contracted Provider:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the Member's health, as provided in CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. Emergency Services - Emergency medical services do not require Prior Authorization. If it is determined that the Member is to be admitted and CalOptima Health or a Health Network does not have a notification of an inpatient admission from the Emergency Room (ER) on file for the room and board charges, CalOptima Health or a Health Network must pay the

emergency triage fee and request Medical Records;

3. Urgently needed services;

4. Authorized post-stabilization care services;

5. Renal dialysis services when the Member is temporarily out-of-area and cannot reasonably access a contracted Provider for such Covered Services;

6. Denied Covered Services that are determined in the Appeal processes in CalOptima Health policies to be services the Member was entitled to have furnished, or paid for, by CalOptima Health or a Health Network; and

7. CalOptima Health or a Health Network shall provide Medically Necessary, Covered Services to a Member through an out-of-network Provider when CalOptima Health or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima Health Policy EE.1141: CalOptima Provider Contracts.

D. CalOptima Health or a Health Network shall pay, or deny, a claim as follows:

1. Contracted Providers

   a. CalOptima Health or a Health Network shall pay, or deny, a claim from a contracted Provider, or portion thereof, in accordance with the time frames, terms, and conditions of the Provider agreement.

2. Non-Contracted Providers

   a. CalOptima Health or a Health Network shall pay, or deny, ninety-five percent (95%) of all Clean Claims from Non-Contracted Providers within thirty (30) calendar days after the date of receipt.

   b. CalOptima Health or a Health Network shall pay, or deny, all other claims from Non-Contracted Providers within sixty (60) calendar days after the date of receipt.

   c. If CalOptima Health or a Health Network fails to pay a Clean Claim from a Non-Contracted Provider within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

   d. CalOptima Health or a Health Network shall reimburse a Non-Contracted Provider at the Medicare Fee Schedule for Medicare Part B professional services.

   e. For Dates of Service effective beginning January 1, 2019, CalOptima Health or a Health Network shall administer the Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) for Part B professional services provided by non-contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima Health or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by CMS in the MIPS adjustment data files.

i. CalOptima Health or a Health Network shall apply positive MIPS payment adjustments, within thirty (30) calendar days of receipt of a clean claim regardless of the dates of service.

E. CalOptima Health shall adhere to CMS guideline payment adjustments, or sequestration changes. The Protecting Medicare and American Farmers from Sequester Cuts Act impacts payments for all Medicare Fee-For-Service (FFS) claims.

1. No payment adjustment from May 1, 2020, through March 31, 2022.

2. One percent (1%) payment adjustment April 1, 2022, through June 30, 2022.

3. Two percent (2%) payment adjustment beginning July 1, 2022.

F. If CalOptima Health or a Health Network denies payment of a Clean Claim, CalOptima Health or a Health Network shall notify the Member with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima Health or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

a. The specific reasons for the payment denial;

b. Inform the Member of their right to request an Appeal;

c. Describe the Appeals process, time frames, and other elements; and

d. Inform the Member of their right to submit additional evidence in writing, or in person.

2. If a service is not covered under the Medicare program but is covered by and payable under a Member's Medi-Cal coverage, CalOptima Health or a Health Network shall not send the Member a Notice of Denial of Payment.

G. The CalOptima Health Claims Administration Department or a Health Network shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

H. CalOptima Health or a Health Network shall identify payers that are primary to Medicare, shall determine the amounts payable by them, and shall coordinate benefits, in accordance with CalOptima Health Policy MA.3103: Claims Coordination of Benefits.

I. CalOptima Health or a Health Network shall reopen a claim for clerical errors in accordance with this Policy.

J. Provider Appeal and Grievance

1. A Provider may Appeal a claim determination in accordance with CalOptima Health Policy MA.9005: Payment Appeal.

2. In case of a Payment Dispute Resolutions (PDR), the CalOptima Health Claim

Administration Department or Health Network shall inform the Non-Contracted Provider in the notice of PDR decision of his right to file a complaint with CalOptima Health, in accordance with CalOptima Health Policy MA.9006: Contracted Provider Complaint Process.

3. The CalOptima Health Claims Administration Department and Health Network staff shall accept, track, and report all NCP PDRs as determined by CalOptima Health's Audit & Oversight Department.

4. Non-Contracted Providers may file a PDR within one hundred and eighty (180) calendar days from the receipt of the Remittance Advice (RA) for level of payment disputes (The notice of initial determination is presumed to be received five (5) calendar days from the date of the RA unless there is evidence to the contrary.).

5. The Claims Administration Department or the Health Network shall issue a PDR notice to the NCP within thirty (30) calendar days of the receipt of the request.

6. The CalOptima Health Grievance and Appeals Resolution Service and Claims Administration Departments and Health Networks shall document all actions taken related to the PDR, or Appeal, request in its tracking system and/or hard copy including, but not limited to:

   a. Provider's name;

   b. Date received;

   c. Name of staff that received the complaint at CalOptima Health;

   d. Designated contact person;

   e. Description of the complaint;

   f. Date;

   g. Dispositions; and

   h. Appeal review.

III. PROCEDURE

A. If CalOptima Health or a Health Network receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) business days after the date of receipt, as applicable.

B. Invalid/Incomplete Claims

1. If CalOptima Health or a Health Network receives an Invalid or Incomplete Claim, it shall notify the Provider no later than ten (10) business days after the date of receipt, in writing, with a request for the missing or invalid information.

2. If CalOptima Health or a Health Network does not receive the requested information within forty-five (45) calendar days after the date of CalOptima Health's notice, CalOptima Health's

or a Health Network notice, CalOptima Health or a Health Network shall review the claim with the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima Health or a Health Network denies an Invalid/Incomplete Claim, the Provider shall have no rights to Appeal such denial.

C. Non-Clean Claims

1. If CalOptima Health or a Health Network receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima Health or a Health Network shall notify the Provider of a Non-Clean Claim no later than thirty (30) business days after the date of receipt, in writing, with a request for the missing information. If CalOptima Health or a Health Network requests reasonably relevant information from a Provider in addition to information that the Provider submits with a claim, CalOptima Health or a Health Network shall provide a written explanation of the necessity for such request. This can include information needed to successfully submit claims as complete and accurate Encounter Data to CMS in a timely manner.

3. Contracted/Non-Contracted Providers:

   a. If CalOptima Health or a Health Network does not receive the requested information within forty-five (45) calendar days after it receives the claim, CalOptima Health or a Health Network shall send a second (2nd) letter to the contracted/Non-Contracted Provider requesting such information.

   b. If CalOptima Health or a Health Network does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima Health or a Health Network shall review the claim with the information available and shall make a determination to pay or deny the claim.

4. CalOptima Health or a Health Network shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

5. If CalOptima Health or a Health Network denies a claim based on a Provider's failure to provide requested Medical Records or other information, it shall process any dispute arising from the denial of such claim as a Provider Grievance, in accordance with Section II.I. of this Policy.

6. If CalOptima Health or a Health Network denies a claim based on a Provider's failure to file the claim within the time frames set forth in Section II.B. of this Policy, upon the Provider's submission of a Grievance in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima Health or a Health Network shall have the right to accept and adjudicate the claim.

7. CalOptima Health or a Health Network may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims. CalOptima Health or a Health Network may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.

D. CalOptima Health or a Health Network Reopening of Claims

1. CalOptima Health or a Health Network shall reopen a claim for clerical errors including minor errors or omissions such as human or mechanical errors on the part of CalOptima Health or a Health Network, such as:

    a. Mathematical or computational mistakes;

    b. Transposed procedure or diagnostic codes;

    c. Inaccurate data entry;

    d. Misapplication of a fee schedule;

    e. Computer errors;

    f. Denial of claims as duplicates which the provider believes were incorrectly identified as a duplicate; or

    g. Incorrect data items, such as provider number, use of a modifier or date of service.

2. The following does not constitute grounds for Reopening of a claim:

    a. Failing to bill for certain items or services;

    b. Untimely filing; or

    c. Redetermination requests.

3. CalOptima Health or a Health Network, a Provider, or any other party to the determination decision may request CalOptima Health or a Health Network reopen a claim as follows:

    a. The request may be made verbally or in writing.

    b. CalOptima Health or a Health Network shall complete the claim determination within sixty (60) calendar days from the date of receipt of the party's written or verbal request to reopen.

    c. If the reopening action results in a revised claim determination or decision that results in payment to a Provider, CalOptima Health or a Health Network shall issue a revised electronic or paper remittance advice notice.

    d. If the reopening action results in an adverse revised claim determination or decision, CalOptima Health or a Health Network shall provide a written notice to the Provider that states the basis for the adverse determination and provide Appeal rights.

4. When reviewing a request to reopen a claim, CalOptima Health or a Health Network can consider new and material evidence if it meets the following:

    a. Was not readily available or known to the person or entity requesting/initiating the reopening at the time of the initial determination;

    b. Does not include evidence that was or reasonably could have been, available to the decision-maker at the time the decision was made; and

c. May result in a conclusion different from that reached in the initial claim determination or redetermination.

5. CalOptima Health or a Health Network may reopen a claim within one (1) to four (4) years from the date of the initial claim determination, as applicable.

6. The reopening of a claim is separate and distinct from the Appeals process as provided in CalOptima Health Policy MA.9005: Payment Appeal.

7. The decision of CalOptima Health or a Health Network to reopen a claim determination is not an initial claim determination and is therefore not subject to Appeal.

8. Revised claim determinations resulting from a reopening action will be subject to Appeal.

E. Denial to Reopen a Claim

1. CalOptima Health or a Health Network has the discretion to determine the criteria and corrections necessary to reopen a claim. CalOptima Health or a Health Network shall notify the requesting party in writing of the decision not to reopen.

F. Notifications Related to Determinations that are Reopened and Changed

1. CalOptima Health or a Health Network shall ensure the following for written notifications:

a. Are delivered to the last known address when the determination or decision is reopened and revised;

b. State the rational and basis for the reopening and revision;

c. State the specific reason for the revision or change in rationale, written in a manner that is understandable; and

d. Provide information on any appeal rights.

G. Record Maintenance

1. CalOptima Health or a Health Networks shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a Clean Claim, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima Health or a Health Networks took such action, in the same manner that the Provider submitted the claim.

2. CalOptima Health or a Health Networks shall maintain all Member Medical Records and claim information data for a period of at least ten (10) years from the latest CMS contracting period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare DSNP Coverage Decision Letter Integrated (CMS-10716); OMB Approval 0938-1386 (Expires: 11/30/2025)
B. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health PACE Program Agreement
C. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
D. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
E. CalOptima Health Policy MA.3103: Claims Coordination of Benefits
F. CalOptima Health Policy MA.9005: Payment Appeal
G. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
H. Centers for Medicare and Medicaid Services (CMS): Release of 2020 MIPS Payment Adjustment Data File
I. Centers for Medicare and Medicaid (CMS): Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments - Update
J. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections
K. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
L. Medicare Managed Care Claims Processing Manual Chapter 34: Reopening and Revision of Claim Determinations and Decisions
M. Protecting Medicare and American Farmers from Sequester Cuts Act
N. Patient Protection and Affordable Care Act, §6404
O. Title 31, United States Code (U.S.C.), §3902(a)
P. Title 42, Code of Federal Regulations (C.F.R.), §§405.927, 405.980(a)(3), 410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
05/05/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	01/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	12/03/2020	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2022	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	05/05/2022	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2023	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	12/07/2023	MA.3101	Claims Processing	OneCare PACE
Revised	12/31/2023	MA.3101	Claims Processing	OneCare PACE
Revised	05/01/2024	MA.3101	Claims Processing	OneCare PACE

IX. GLOSSARY

Term	Definition
Appeal	OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Clean Claim	A claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under Original Medicare.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors.
Emergency Care	Covered Services provided to a Participant immediately, because of an injury or sudden illness and the time required to reach a CalOptima Health PACE facility or a network provider would cause risk of permanent damage to the Participant's health. This includes inpatient and outpatient services. Participants are not required to receive prior authorization for emergency care.
Emergency Services	Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Encounter Data	The information that describes health care interactions between Members and Providers relating to the receipt of any item(s) or service(s) by a Member,

Term	Definition
Grievance	OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Invalid/Incomplete Claim	Claims lacking minimum data needed for adjudication through the core operating system. This includes any claim that: 1. Is incomplete or is missing required information; or 2. Contains complete and necessary information, however, the information provided is invalid.
Medical Record	OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.
Member	A beneficiary enrolled in a CalOptima Health program.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Non-Clean Claim	For purposes of this policy, a claim for covered services that lacks required documentation such as medical records or authorization numbers, or substantiating documentation needed to meet the requirements for Encounter Data.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.

Term	Definition
Prior Authorization	OneCare: A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a Participant to receive a specific service or procedure.
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.

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