

POLICY AND PROCEDURE	
Title: Claim Adjustments	
Primary policy owner: Claims (CLMS)	Policy #: CLMS25
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) <input type="checkbox"/> All Departments 2) <input type="checkbox"/> Behavioral Health & Social Services (BH/SS) 3) <input type="checkbox"/> Benefits Administration (BA) 4) <input type="checkbox"/> Case Management (CM) 5) <input checked="" type="checkbox"/> Claims (CLMS) 6) <input type="checkbox"/> Community Marketplace & Member Engagement (MAR) 7) <input type="checkbox"/> Compliance (CMP/HPA) 8) <input type="checkbox"/> Configuration (CFG) 9) <input type="checkbox"/> Provider Contracting (CONT) 10) <input type="checkbox"/> Cultural & Linguistics (CL) 11) <input type="checkbox"/> Customer Service (CS)	12) <input type="checkbox"/> Facilities (FAC) 13) <input type="checkbox"/> Finance (FIN) 14) <input type="checkbox"/> Human Resources (HR) 15) <input type="checkbox"/> Information Technology / Core Systems (IT) 16) <input type="checkbox"/> Pharmacy (PH) 17) <input type="checkbox"/> Provider Networks (PRO) 18) <input type="checkbox"/> QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) <input type="checkbox"/> Utilization Management (UM) 20) <input type="checkbox"/> Procurement (PRM) 21) <input type="checkbox"/> Administration (SAF/BC/EM) 22) <input type="checkbox"/> Medical Management (MM)
Product Type: <input type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> D-SNP	Supersedes Policy Number: N/A

I. PURPOSE

To ensure Health Plan of San Joaquin and Mountain Valley Health Plan (Health Plan) adjust claims or any portion of the claim, as defined by Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS) and California Department of Managed Health Care (DMHC).

II. POLICY

- A. Health Plan must accept written requests for reopens, provider disputes, and reconsiderations.
- B. Health Plan must classify adjustments as reopens, provider disputes, or reconsiderations.
 - 1. A reopen may be plan-initiated or requested by a provider when:
 - a. A clerical error, minor error, or omission has been made on the claim.
 - b. Additional Information Requested (AIR) is received after the initial claim has been denied and the AIR is received within 120 calendar days of the original AIR claim closing (Remittance Advice Date).
 - 2. A provider dispute is requested by a provider when:
 - a. The non-contracted provider asserts that the amount paid is less than the amount which would have been paid under original Medicare.
 - b. The contracted provider dispute organization determination for any reason.
 - 3. A reconsideration may be requested by an enrollee or their representative or a non-contracted provider when:
 - a. A claim is fully or partially denied.
 - b. The disputed amount is unrelated to the amount which would have been paid under original Medicare.
- C. Health Plan must determine timely submission, in the absence of good cause, such as:
 - 1. Requests for reopens received within 120 calendar days from the date of the remittance advice of the initial organization determination.
 - 2. Requests for reconsiderations received within 65 calendar days from the date of the remittance advice of the initial organization determination or coverage denial notice.

3. Requests for provider disputes received within 120 calendar days from the date of the remittance advice of the initial organization determination.
- D. Health Plan must determine good cause for any claim received more than the timely submission deadlines and with accompanying documentation to support a good cause timeliness determination.
 1. A good cause determination is solely the discretion of Health Plan.
- E. Health Plan must record the date of receipt of the request to reopen, reconsider, or dispute as the date the claim is received by the organization, whether in hard copy or through the provider portal website.
 1. Claims received after 4:30pm on a business day must be marked as received the following business day.
 2. Claims received outside of business hours (Monday-Friday 8am-4:30pm) must be marked as received the following business day.
- F. Health Plan must determine the received date for the purpose of interest calculation as the original received date when the root cause is a Health Plan error in the original organization determination and the information submitted with the reopen, dispute, or reconsideration was available at the time of the original organization determination.
 1. The received date in all other cases must be determined as the date the request to reopen, dispute, or reconsider was received by Health Plan.
 2. The received date of the request and the received date of the original organization determination must be maintained as separate fields in the claims processing system.
- G. Health Plan must effectuate determinations within 30 calendar days from the date of receipt of the request.
- H. Health Plan must pay interest when the determination is made more than 30 calendar days from the date of receipt. Health Plan must calculate interest only for the additional amount due.
- I. Health Plan must ensure required reporting data elements are recorded in the claims processing system in accordance with current Center for Medicare and Medicaid Services (CMS) Part C reporting technical specifications and Organization Determinations, Appeals and Grievances guidance.
- J. Health Plan must issue written requests for additional information related to disputes.

- K. Health Plan must issue written notification of outcomes of reopens, disputes, and reconsiderations in compliance with the <Claims Notifications Policy>.

III. PROCEDURE

- A. An Adjustments & Disputes Specialist will process an adjustment request, no later than 30 working days after the receipt of the request.
- B. An Adjustments & Disputes Specialist will classify a request as a reopen, dispute or reconsideration according to the criteria outlined in Policy, section B above.
 - 1. Reopens are fully documented within the claims processing system.
 - 2. Reconsiderations and disputes are documented within the Appeals & Disputes processing system.
 - a. A data entry clerk will be pending reconsiderations received from providers which do not include the Waiver of Liability (WOL) and issue a letter requesting the WOL.
 - b. A data entry clerk will monitor the WOL pend cases.
 - i. A data entry clerk will dismiss reconsiderations and issue dismissal notice if the WOL is not received within 20 calendar days of receipt of the request.
 - ii. A data entry clerk will update the pend reconsideration requests to be worked by an Adjustment & Disputes Specialist when the signed WOL is received within 20 calendar days of the receipt of the request for reconsideration.
- C. An Adjustments & Disputes Specialist will determine the case as fully approved, partially, or fully denied according to the DSNP Claims Reimbursement Policy after reviewing all information submitted with the request.
- D. An Adjustments & Disputes Specialist will document the determination and rationale for the decision in both the claims processing and Appeals & Disputes systems.
- E. An Adjustments & Disputes Specialist will ensure claim adjustments are identified as a reopen, dispute, or reconsideration in the claim processing system in support of Part C Reporting requirements.

- F. An Adjustments & Disputes Specialist will provide written notification of the decision to submitters of reconsiderations.
- G. A data entry clerk will create images of all documents and working papers related to the case and save them to the assigned case in the Appeals & Disputes system.

IV. ATTACHMENT(S)

- A. Desk- Level Procedure (DLP) or Department Job Aide
- B. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
- C. [Glossary of Terms Link](#)
- D. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

V. REFERENCES

- A. Medicare Claims Processing Manual, Chapter 34 -Reopens and Revisions of claims determinations and decisions
- B. Part C and D Enrollee Grievances, Organization/Coverage Determinations, Appeals Guidance
- C. Part C Reporting Requirements
- D. State Medicaid Agency Contract (SMAC)
- E. Health Plan Contract with Centers for Medicare & Medicaid Services (CMS)

VI. REVISION HISTORY

*Version 001 as of 10/24/2025

Version*	Revision Summary	Date
001	New D-SNP Policy	
Initial Effective Date: 11/24/2025		
Published Date: 11/24/2025		

VII. Committee Review and Approval To Be Completed by Compliance

Committee Name	Version	Date
Compliance Committee (CC)	001	10/30/2025
<ul style="list-style-type: none"> Privacy & Security Oversight Committee (PSOC) 		
<ul style="list-style-type: none"> Program Integrity Committee (PIC) 		
<ul style="list-style-type: none"> Audits & Oversight Committee (AOC) 		
<ul style="list-style-type: none"> Policy Review Committee (PRC) 		
Quality Improvement Health Equity Committee (QIHEC)		
<ul style="list-style-type: none"> Quality Operations Committee (QOC) 		
<ul style="list-style-type: none"> Grievance Committee (GC) 		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare Services (DHCS)			
Department of Managed Care (DMHC)			



IX. Approval signature*

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy