

POLICY AND PROCEDURE	
Title: Claims Reimbursement	
Primary policy owner: Claims (CLMS)	Policy #: CLMS26
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 checked="" 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 checked="" 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) reimburse claims or any portion of the claim, for services rendered by contracted or non-contracted providers 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 determine timely submission, in the absence of good cause, as any claim from a non-contracted provider, enrollee, or enrollee's representative, received within 365 days from the date service for professional claims or the date of discharge for facility claims. Contracted providers must have the greater of the timely filing deadlines as outlined in their contract or 90 days from the date of service for professional claims or the date of discharge for facility claims.
1. Health Plan must determine good cause for any claim received more than the timely submission deadlines by reviewing accompanying documentation in support of a good cause timeliness determination.
 2. Health Plan must determine timeliness as a secondary payer using the above timeframes substituting the primary payer's remittance advice or denial notice date for the date of service.
 3. Claims received by the Plan in error are classified as misdirected and handled as described in CLMS20 Timely Payment of Claims.
- B. Health Plan must record the date of receipt as the date the claim is received by the organization, whether in hard copy or by an electronic means (837 file) or through the provider portal website. Claims received after 04:30 pm (1630) must be marked as received the following business day.
- C. Health Plan must return, to provider, any claim which does not include required fields to the extent such claim cannot be entered into the claims processing system.
- D. Health Plan must define a clean claim as a request for payment presented by any member or provider which includes all information necessary to make an organization determination. Claims which do

- not contain all information necessary to make an organization determination are identified as “other than clean” (unclean).
- E. Health Plan must develop other than clean claims by making at least one attempt to obtain the information necessary to make an organization determination.
 - F. Health Plan must process claims in accordance with Center for Medicare and Medicaid Services (CMS) requirements and contractual agreements within the following number of calendar days from the date of receipt.
 - 1. 95% of all non-contracted provider clean claims submitted for payment must be processed, for which no further written documentation or substantiation is required, within 30 calendar days of receipt by Health Plan.
 - 2. All non-contracted provider “other than clean” claims and member reimbursement claims must be processed within 60 calendar days of the date of receipt.
 - 3. All contracted provider claims must be processed in accordance with the provider contract or sixty (60) calendar days of the date of receipt.
 - 4. Payment timeliness must be determined by the number of days between the date Health Plan receives the claim and the date the remittance advice, explanation of payment, or denial notice enters the mail stream (dropped off with the United States Postal Service (USPS) or for electronic payments the date the funds are made available to the provider.
 - G. Health Plan must determine the payable amount for covered services provided by non-contracted providers and for member reimbursement requests as the lesser of; the billed charges for the service, the Medicare allowed amount, or the maximum benefit amount as defined in the Evidence of Coverage (EOC), less any applicable member responsibility amounts. For covered services provided by contracted providers the payable amount is the agreed upon contract rate, less any applicable member responsibility amounts.
 - H. Health Plan must deny non-emergency claims from sanctioned and excluded providers. Claims identified as emergency services from sanctioned or excluded providers are processed in accordance with all other applicable Medicare and Health Plan guidelines.
 - I. Health Plan must coordinate benefits for members having other primary health care coverage as identified by CMS’ Medicare

- Secondary Payor files, working-aged surveys, and other carrier Explanation of Benefits (EOB) attached to submitted claims.
- J. Health Plan must apply payment adjustments to the claim, including but not limited to, modifier-based reductions (multiple procedure, co-and assistant surgeons, etc.), mid-level provider reductions, National Correct Coding Initiative (NCCI) rules (bundling, global, mutually exclusive services), and other payment adjustments as specified in Health Plan policy or provider agreement, where applicable.
 - K. Health Plan must confirm the entity providing the technical component of advanced diagnostic imaging (ADI) services in a free-standing location (provider office, radiology center, etc.) has a valid accreditation as of the date of service for the modality and physical location at which the service is provided. Health Plan must deny the technical component of the service when the entity does not possess valid accreditation.
 - L. Health Plan must reimburse claims for Emergency Services, which includes all professional physical, mental, and substance use treatment services, including screening examination necessary to determine the presence or absence of an emergency medical condition and if any emergency medical condition exists for all services medically necessary to stabilize the member, as defined in California Health and Safety Code (CH&S) Section 1317.1, in the United States on, or after, September 1, 1999 and Section 53855 of Title 22 of the California Code of Regulations.
 - 1. Health Plan must not limit what constitutes an Emergency Medical Condition (EMC) based on lists of diagnoses or symptoms or refuse to reimburse emergency services based on the emergency room provider, hospital, or a fiscal agent not notifying the member's Primary Care Provider (PCP), Health Plan, or Department of Health Care Services (DHCS) of member's screening and treatment for Emergency Services.
 - 2. A member who has an EMC must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.
 - 3. Health Plan must not deny payment for treatment obtained when a member had an emergency medical condition (EMC) including cases in which the absence of immediate

medical attention would not have had the outcomes specified in 42 CFR section 438.114(a) of the definition of Emergency Medical Condition.

4. At a minimum, Health Plan must reimburse claims from the non-contracting emergency department and, if applicable, its affiliated providers for physician services without requiring prior authorization. Payments to non-contracted providers must be for treatment of EMC, including Medically Necessary inpatient services rendered to a member until the member's condition has stabilized sufficiently to permit referral and transfer in accordance with instruction or the member is stabilized sufficiently to permit discharge.
 5. Health Plan must not require prior authorization or refuse to pay for any ambulance or ambulance transport services provided to a member because of a "911" emergency response system request for assistance if either of the following conditions apply:
 - a. The request was made for an emergency medical condition and ambulance transport services were required.
 - b. A member reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.
- M. Health Plan must not deny plan-directed care which occurs when a contracted provider refers to a non-contracted provider without obtaining prior authorization.
- N. Health Plan must not reimburse any provider claims nor reimburse a provider for Provider-Preventable Conditions (PPC), [Never-events] as defined by the National Quality Forum, in accordance with 42 CFR section 438.3(g) and APL Reporting Requirements Related to Provider Preventable Conditions.
- O. Health Plan must reimburse initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely and access requirements per APL Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services and federal regulation.
- P. Health Plan must pay the Merit-based Incentive Payment System (MIPS) to non-contracted provider claims at the claim level based on the

portion of the payment the provider would receive under Medicare Physician Fee Schedule (PFS) which is typically eighty (80) percent of the PFS allowed amount. The adjustment amount is applied at the time the claim is paid. No MIPS adjustment must apply to denied or zero-pay claims. The MIPS percentage for the calendar year corresponding to the date of service on the claim must be used in the calculation of the MIPS amount.

- Q. Health Plan must apply sequestration to non-contracted provider claims for all allowable services on the claim after member responsibility and the MIPS adjustment, where applicable, has been applied to the claim.
- R. Health Plan must apply interest to any non-contracted provider or member reimbursement clean claim paid after the timely payment window as defined in section F.4 above.

III. PROCEDURE

- A. A claims specialist will review claims with attachments pending for untimely filing to determine whether good cause evidence is present.
 - 1. If good cause is evident, claim will continue with processing.
 - 2. If good cause is not evident, the claims specialist will deny the claim for untimely filing.
- B. A claims quality assurance specialist will ensure all non-emergent claims provided by sanctioned providers are denied. Sanctioned providers are identified by the contract record assigned to the provider on the date of service.
- C. A claims specialist will review claims to determine if all information is present on a claim and its attachments to make an organization determination. If information is deemed missing or incomplete, the claims specialist shall indicate the claim is unclean in the claims

processing system and create a request for additional information letter to be sent to the provider.

1. The claim specialist will record the letter create date and reason the claim is identified as unclean. Unclean claim reasons include but are not limited to:
 - a. Primary carrier EOB needed.
 - b. Non-contracted provider claim having no prior authorization and referring provider is either not present on claim or is non-contracted.
 - c. Non-contracted lab claims missing referring provider.
 - d. Procedure Code Modifiers (59, 79, 80, etc.) on claim are conditionally payable and conditions cannot be determined by other claim data on file including other claims.
 - e. Durable medical equipment or part b drug claim missing the ordering provider.
 - f. Procedure codes on claim having no pricing on Medicare fee schedules including but not limited to:
 - i. Unlisted procedure codes.
 - ii. By report codes.
 - iii. Local coverage determinations.
 - a. Ambulance pick-up/drop-off address incomplete or missing.
 - b. Anesthesia starts/stops time missing.
2. The claims specialist will deny services if there is no response within 60 calendar days. The claims specialist will assign an explanation reason on the claim to appear on the remittance advice which clearly indicates the reason for the denial.
3. The claim specialist will evaluate the information received in response to additional information request.
 - a. Submit the information received to Utilization Management (UM) medical staff for a medical necessity or emergent need determination for non-

- contracted provider claims which are not plan-directed.
 - b. Document response from UM in the claim record and apply decision to the claim.
 - c. Update claim record with missing information submitted.
 - d. Consult coders, UM staff, and claims management as needed to determine appropriate use of modifier and document decision in the claim record and proceed with processing.
- D. A claims specialist will not deny plan-directed care from non-contracted providers for a lack of prior authorization.
- 1. If a referring provider name and NPI are on the claim, identify contract status of the provider.
 - a. If contracted, notate claim in claims processing system as “plan-directed care”.
 - b. If non contracted, notate claim in claims processing system and request records from rendering provider.
- E. A claims specialist will calculate the Medicare secondary payer amount allowed using QNXT Method 7 to ensure the payment by Health Plan is not more than the Medicare allowed amount. The claim specialist will add claim explanation reason indicating claim paid up to the maximum amount allowed under Medicare.
- F. A claims specialist will validate free-standing facility sites providing the technical component of advanced diagnostic imaging (ADI) services (CT, MRI, Mammography, etc.) are accredited by one of the CMS approved accrediting bodies for the modality at the specific location by comparing the service facility location on the claim (CMS-1500 box 32), the procedure code for the radiology service(s), and the date of service to the accrediting body.
- 1. If accreditation can be confirmed, continue claims process.
 - 2. If no ADI certification is identified, claim will be denied.
- G. A claims quality assurance specialist will review a denied claims report prior to finalizing claim check run to ensure no emergency services are

included. Emergency services may be identified by several elements in the claim form including but not limited to:

Professional Claims

1. Place of service 23 on professional claims.
2. Procedure codes 99281-99285.
3. Professional component (modifier 26) radiology services.
4. Orthotics with place of service 12.

Facility Claims

5. Revenue code 0450 and Bill type 12x or 13x.

- H. A claims quality assurance specialist will ensure the merit-based incentive positive payment (MIPS) adjustment is applied to eligible
- I. non-contracted provider claims using the MIPS percentage rate in effect for the calendar year of the date of service on the claim.

Annual Process

1. Compliance will annually download the MIPS file from HPMS and provide Configuration.
2. Configuration will update the MIPS reference data with the provider information, positive percentage rates, with effective end dates.
3. Configuration will provide a report of MIPS eligible claims paid for the same calendar year prior to receipt of the current year's MIPS data.
4. Claims will verify the MIPS calculation is accurate by validating a sample of claims in the report that meet the following criteria:
 - a. Provider is non-contracted on the date of service
 - b. Services for which MIPS is calculated have a rate on the Medicare Physician Fee Schedule (MPFS).
 - c. Amount used to calculate the MIPS adjustment is the amount the provider would have been paid under original Medicare (i.e. 80% percent of MPFS).
 - d. Percentage is correct.
5. Claims will confirm with Configuration the MIPS calculation is being calculated correctly and attest to Claims Director and Chief Financial Officer (CFO).

6. Claims will create adjusted claims to pay the MIPS adjustment amount for the claims previously paid in the calendar year.

- J. Configuration will update the claims processing system to apply sequestration as a 2% reduction of the payment amounts to non-contracted providers after member responsibility and provider incentives, MIPS, have been reduced from the allowed amount.
 1. A claims quality assurance specialist will review a sample of claims to ensure the sequestration amount is accurately calculated after any system upgrade and at least annually.
 2. Claims Director, or their designee will provide a written attestation of sequestration accuracy to the CFO.

- K. Configuration will update the claims processing system with the interest rate to be used in the interest payment calculation for untimely paid claims.
 1. The interest rate is published by the Bureau of the Fiscal Service twice annually, January 1 and July 1
<http://fms.treas.gov/prompt/rates.html>.
 2. The applicable interest rate is selected on the paid date of the claim (not the date received or date of service).
 3. The interest rate calculation is *Payment amount x rate x days divided by 365 (366 in a leap year) = interest payment*.
 4. The amount of interest is paid at the claim level and rounded to the nearest penny.
 5. Interest is paid on untimely paid non-contracted provider and member reimbursement clean claims.
 6. Interest may be paid on contracted provider claims as outlined in their agreement.
 7. Member reimbursement claims paid untimely with interest will include the phrase "your payment includes interest".
 8. The interest period begins on the day after the payment is due and continues through the date the payment is released in the mail stream.

- L. A claims quality assurance specialist will confirm the interest rate amount is correct for a set of sample claims on the first payment cycle after a change in interest rates. Claims Director, or their designee will

provide a written attestation to the CFO for interest calculation accuracy.

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 Managed Care Manual Chapter 1
- B. Part C and D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.
- C. State Medicaid Agency Contract (SMAC)
- D. 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	
002		
003		
004		
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	001	10/30/2025

<ul style="list-style-type: none"> • Program Integrity Committee 		
<ul style="list-style-type: none"> • Audits & Oversight Committee 		
<ul style="list-style-type: none"> • Policy Review Committee 		
<ul style="list-style-type: none"> • Quality Improvement Health Equity Committee 		
<ul style="list-style-type: none"> • Quality Operations Committee 		
<ul style="list-style-type: none"> • Grievance Committee 		

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