KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Claims Submission and Reimbursement	**Policy #**	6.01-P
Policy Owner	Claims	**Original Effective Date**	08/2000
Revision Effective Date	03/2025	**Approval Date**	7/8/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

Kern Health System (KHS) guidelines for claims submission shall be communicated to KHS contracted providers, and to non-contracted providers upon request, to provide for timely and accurate claims submission and reimbursement.

II. POLICY

KHS shall pay all claims within contractually mandated statutory timeframes and in accordance with the timely payment standards in the Contract for clean claims, which includes equivalent encounter submission, or bills or invoices submitted by Providers that adhere to billing and invoicing guidance such as for Enhanced Care Management (ECM), Community Social Services (CSS), and for Intermediate Care Facility for the Developmentally Disabled (ICF /DD) providers.

KHS shall reimburse 90% of clean claims from providers who are in individual or group practices or who practice in shared health facilities, within thirty (30) calendar days of the date of receipt and 99% of all clean claims within ninety (90) days. KHS shall reimburse each completed claim, or portion thereof, as soon as possible, but no later than forty-five (45) working days after the date of receipt of the complete claim, regardless of the providers contract status. This timeliness requirement applies to Contracted and non-contracted providers. It also applies to out of network providers when those dates of service were under continuity of care. If any portion of the claim is contested, all uncontested portions of the claim are paid within the above listed statutory timeframes.

KHS does not request irrelevant or unnecessary information from Providers during claims processing. If additional information is needed to complete the claim, a notice is sent to the provider via the Explanation of Benefits (EOB) and/or letter with the details of the information needed to properly and correctly adjudicate the claim. The request is sent within the statutory timeframes. In accordance with State regulations, KHS will pay interest on clean claims not paid within forty-five (45) working days of receipt[1].

See Procedures A (1.), A (1., a.) and A (1., b.). The date of receipt shall be the date KHS receives the claim, as indicted by its date stamp on the claim. The date of payment shall be the date of the check or the form of payment.

The KHS Claims Department (Claims) will make every effort to identify members that are covered under any other State or Federal Medical Care Program or under other contracted or legal entitlement including, but not limited to, a private group or indemnification program. Claims staff will make every effort to recover any monies paid for services provided to members prior to identifying such other coverage.

Claims will identify cases which involve Casualty Insurance, Tort Liability, or Workers' Compensation. KHS will notify the Department of Health Care Services (DHCS) or its designated contractor of all such cases involving Medi-Cal Product members.

A. Claims will be processed in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources: California Health and Safety Code §1371, 1371.35, 1371.36, 1371.37, and 1371.39.
B. California Code of Regulations (CCR) Title 28 §1300.71, 1300.71.38; and 1300.77.4.

III. DEFINITIONS

TERMS	DEFINITIONS
Information necessary to determine payer liability[2]	The minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claim's adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost if applicable, and extent of the plan's liability, if any, and to comply with governmental information requirements.
Reasonably relevant information[3]	The minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's liability, if any, and to comply with governmental information requirements.
Working Days[4]	Monday through Friday, excluding recognized federal holidays. Recognized federal holidays are as follows[5]: A. New Year's Day: closest weekday to January 1st B. ML King's Birthday: 3rd Monday in January C. Washington's Birthday: 3rd Monday in February (also known as (aka) Presidents' Day) D. Memorial Day: last Monday in May E. Juneteenth: closest weekday to 6/19 F. Independence Day: closest weekday to July 4th

	G. Labor Day: 1st Monday in September H. Columbus / Indigenous People Day: 2nd Monday in October I. Veteran's Day: Closest weekday to November 11th (aka Armistice Day) J. Thanksgiving Day: 4th Thursday in November K. Christmas Day: Closest weekday to December 25th

IV. PROCEDURES

A. CLAIMS SUBMISSION

The preferred method of claim submission is Electronic billing. Electronic billing may be used to bill KHS for any claims that do not require an attachment. All electronic transactions with KHS must be Health Insurance Portability and Accountability Act (HIPAA) compliant. Providers utilizing electronic billing should submit electronic claims through Change Healthcare (Emdeon, Relay Health), Cognizant, SSI, or Office Ally. Providers requiring assistance in submitting electronic claims through any of the clearinghouses listed above, should contact the KHS Provider Relations Department.

Should an attachment be required for claim submissions, such as PM330, Invoice pricing, requested records; Claims should be mailed to the following address:

Claims Department
Kern Health Systems
PO Box 85000
Bakersfield, CA 93380

KHS prohibits providers from using members Social Security Numbers (SSN) on claims submitted for reimbursement[6]. Providers shall use the member Client Identification Number (CIN) or the KHS Member Identification Number when submitting claims to reduce the fraudulent use of SSNs in the Medi-Cal program.

Hospitals, long term care facilities, licensed primary care clinics and emergency medical transportation are excluded from the SSN billing restriction. However, these excluded entities are required to make a good faith effort to obtain the member's CIN information for billing.

Providers shall restrict the use of the member's SSN whenever possible, especially as an identifier in the processing of claims.

For those providers that are unable to submit claims in an electronic file format, a mutually agreed upon format of claim delivery will be outlined during the provider onboarding process, which includes how to submit a clean claim. Provider Manuals issues to Network Providers and subcontractors and downstream subcontractors have up-to date policies and procedures on how to submit clean claims to KHS.

If for any reason a claim or invoice is rejected, KHS will provide sufficient detail to the provider

as to the additional information needed and/or appropriate billing changes that are required to make it a clean claim. All Policies and Procedures (P&Ps) and the Provider Manual is published by Provider Network Management Department on our website. During onboarding, all providers are afforded education and training on their billing, invoicing, and clean claims submission process. Our claims department personnel are available to hold additional trainings requested by the provider. The training includes education that providers cannot bill members for covered services, even if KHS pays late or denies payment of a claim. Our Provider Network Management department ensures trainings start within ten (10) working days and is completed within thirty (30) working days upon newly executed contracts with new network providers. Provider Network Management routinely evaluates the effectiveness of the training and makes adjustments as needed.

1. Deadlines
   Claims received after 3:00 PM are opened and scanned as received the following day. Claims submission deadlines for contracted and non-contracted providers differ as described below. Providers may submit a provider dispute regarding a claim that was denied as a late submission. If good cause for the delay is demonstrated, the 180-calendar day deadline will be waived, and the claim adjudicated as if it was submitted within 180 calendar days following the provision of covered services.[7]

   a. Contracted Providers
      In order to receive full compensation, contracted providers should submit to KHS a complete, written bill for all covered services rendered within one hundred and eighty (180) calendar days following the provision of the covered services.

      Claims received after 180 calendar days[8] following the provision of the covered services are denied with the following exceptions:

      i. Other Primary Insurance: Claims submitted within ninety (90) calendar days[9]of the date of the primary carrier's Explanation of Benefits (EOB). Any such claims received after the 90-calendar day deadline and are also beyond 180 calendar days are denied.
      ii. California Children's Services (CCS): Claims must be submitted within ninety (90) calendar days of the CCS denial letter. Any such claims received after the 90-calendar day deadline and are also beyond one hundred eighty (180) calendar days are denied.

   b. Non-Contracted Providers
      Claims received after six (6) month[10] following the provision of the covered services are denied with the following exceptions:

      i. Failure of the patient to identify himself or herself as a Medi-Cal beneficiary within four months after the month of service.
      ii. If a provider has submitted a bill to a liable third party, the provider has one year after the month of service to submit the bill for payment.

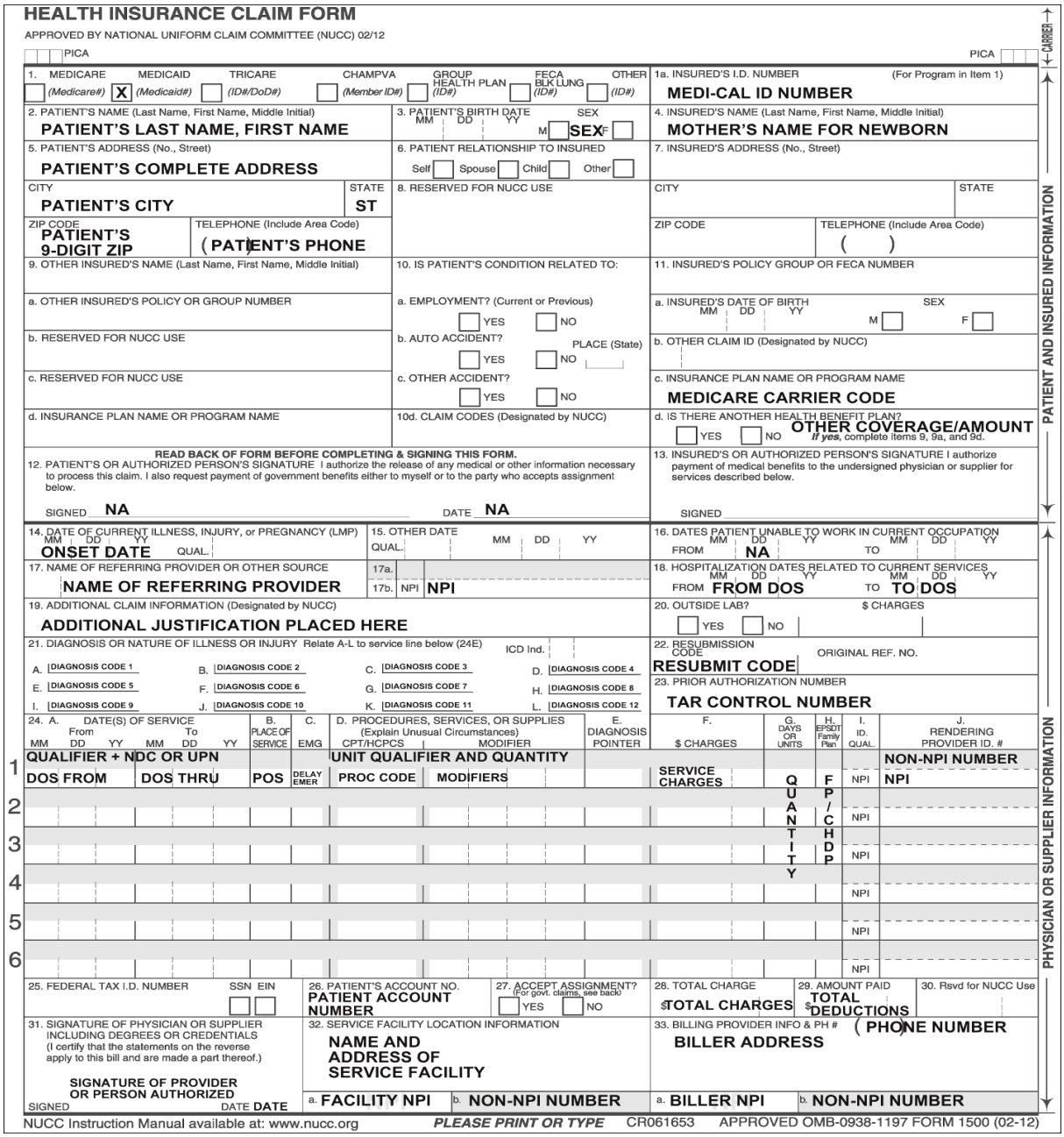
iii. If a legal proceeding has commenced in which the provider is attempting to obtain payment from a third party, the provider has one year to submit the bill after the month in which the services. have been rendered.
iv. The director finds that the delay in submission of the bill was caused by circumstances beyond the control of the provider.
v. Other Primary Insurance: Claims submitted within ninety (90) calendar days[11] of the date of the primary carrier's Explanation of Benefits (EOB). Any such claims received after the 90-calendar day deadline and are also beyond six (6) months are denied.
vi. California Children's Services: Claims submitted within ninety (90) calendar days of the CCS denial letter. Any such claims received after the 90-calendar day deadline and are also beyond six (6) months are denied.

All non-emergency services by non-contracted providers, except for Covid 19 Testing, Sexually Transmitted Disease (STD) and family planning services require prior authorization. See KHS Policies and Procedures #3.21-P, Family Planning Services and #3.17-P, Sexually Transmitted Disease Treatment.

2. Format for Paper Submissions
Appropriate claim forms or electronic data formats should be used. The red Health Insurance Claim Form (CMS 1500) with sensor block must be used to bill for professional/supplier services. It should be used by physicians, laboratories, and allied health professionals to submit claims for medical services. Durable medical equipment and blood products should also be billed using this form. Pharmacies may also use this form to bill for supplies not billable through the on-line pharmacy claims processing service.

The red UB-04 Claim Form should be used to submit claims for inpatient Hospital accommodations and ancillary charges and for hospital outpatient services.

3. Content
The billed amount should be based on the same fee schedule used to bill other third-party payers. Any copayment or coordination of benefits (COB) payments collected should be indicated in the appropriate data field of the claim. Providers should follow the Medi-Cal instructions for completing the CMS 1500 and UB-04 Forms, with the exception of Box 24J as indicated on page 8 of this policy. This includes the use of an alternative member identification number in lieu of the member's SSN[12]. KHS prohibits any use of the member's SSN when filing claims to KHS for KHS reimbursement. Paper claims will be denied, and Electronic Data Interchange (EDI) claims will be rejected.



Submitted claims must include a full itemization of charges and the following information:

Information	CMS 1500 Box	UB92 Box
Patient's KHS identification number or CIN (not SSN)	1a	60
Patient's name	2	8b
Patient's date of birth	3	10
Patient's home address	5	9a-e
Other insurance coverage, including Medicare (if applicable)	11a-d	50a, 58a, 59a, 60a, 61a, and/or 62a

Rendering/Ordering National Provider Identifier (NPI) number	17b	76
Diagnosis Code	21	66a-q **DIAGNOSIS CODE HEADER.** For claims with dates of service/dates of discharge on or after October 1, 2015, enter the International Classification of Diseases (ICD) indicator "0" in the white space below the Diagnosis Code field (Box 66). No ICD indicator is required if the claim is submitted without a diagnosis code.
ICD Indicator 9 or 0	21 ICD ind.	
Resubmission code (claim Frequency Code) 1 for an original encounter submission, 7 for a replacement submission (note replacement will replace the full previous claim)	22	
KHS Authorization Number (if applicable)	23	63a
Date of service, Place of service	24a, 24b	6, 12 and 45
Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Code (including appropriate modifier), Medi-Cal defined codes	24d	42, 44
Diagnosis Pointer	24E	NA
CHARGES. In full dollar amount, enter the usual and customary fee for service(s). Do not enter a decimal point (.) or dollar sign ($). Enter full dollar amount and cents even if the amount is even (for example, if billing for $100, enter 10000, not 100). If an item is a taxable medical supply, include the applicable state and county sales tax.	24F	47
Days or Units	24G	46
RENDERING PROVIDER ID NUMBER. Enter the NPI for a rendering provider (unshaded area), if the provider is billing under a group NPI.	24J	76

The rendering provider instructions apply to services rendered by the following providers: A. Acupuncturist B. Physicians C. Chiropractors D. Podiatrists E. Licensed audiologists F. Portable X-ray providers G. Occupational therapists H. Prosthetists I. Ophthalmologists J. Psychologists K. Orthopedists L. Radiology labs M. Physical therapists N. Speech pathologists O. Physician groups		
Vendor Federal tax identification number	25	5
Total Charge	28	47-line 23
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS. The claim must be signed and dated by the provider, or a representative assigned by the provider. Use black ballpoint pen only. An original signature is required on all paper claims. The signature must be written, not printed. Stamps, initials, or facsimiles are not acceptable.	31	NA
INFORMATION. Enter the provider's name. Enter the provider address, without a comma between the city and state, and a nine-digit Zone Improvement Plan (ZIP) code, without a hyphen. Enter the telephone number of the facility where services were rendered, if other than home or office. **NOTE:** Not required for clinical laboratories when billing for their own services	32	NA
Enter the NPI of the facility where the services were rendered.	32A	NA
Billing Provider Information and Phone Number	33	NA
Entering the billing provider's NPI	33A56	
	33a	1
	24J	56

For further clarification refer to the Medi-Cal Manual

4. Pre-payment and Post-Payment Claims Review

KHS reviews claims on a pre-payment and Post-Payment basis. All claims are submitted through an automated Medi-Cal National Correct Coding Initiative (NCCI) editing program prior to processing. Internal KHS programs also edit for appropriateness of Provider, member, and covered services validation. Any claims with identified issues are further reviewed on a manual basis by Claim Examiners.

a. Unbundling
KHS requires procedure codes to be bundled as outlined in the American Medical Association Current Procedural Terminology (CPT) Guidebook. Providers will not be reimbursed more for performing portions of a bundled group than they would be reimbursed for performing the complete group.

KHS uses a code auditing tool to assist claims processors in identifying claims that are potentially unbundled. Information regarding unbundling policies for specific CPT or HCPCS (Healthcare Common Procedure Coding System) procedure codes may be obtained by submitting a written request to the Claims Department or calling the Claims Department at 1-800-391-2000.

b. Supporting Documentation
Claims are processed according to the guidelines listed in the table below.

Procedure Code or Claim Type	Description / Explanation	Restriction/Requirement
Ambulance services	See KHS Policy and Procedure #3.50 – Ambulance Transportation Services for details.	For Non-participating providers, a trip sheet may be required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation.
By report procedures		Narrative Medical Summary is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation. Invoice for supplies.

Procedure Code or Claim Type	Description / Explanation	Restriction/Requirement
DME – Durable Medical Equipment	Items that do not have established Medi-Cal rates	Invoice is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation. Invoice for supplies.
Other insurance primary	Includes Medicare See KHS Policy #6.08 - Coordination of Benefits	EOB from primary insurance is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation. Note: Electronic claim submission requires appropriate fields completed. Actual EOB is not required for electronic claims.
Sterilization	See KHS Policy #2.19 – Sterilization Consent for details.	Sterilization consent form is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation.
Surgical procedures		By Report Surgical procedures, need to be submitted with necessary documentation or they will be denied. Claims may be resubmitted with required documentation.
99284	Non-Contracted Providers only. Emergency Department (ER) visit (detailed history, detailed examination, and medical decision making of moderate complexity)	Medical review of ER report may be required.
99285	Non-Contracted Providers only. Emergency Department visit (comprehensive history, comprehensive examination, and medical decision making of high complexity)	Medical review of ER report may be required.

5. Claims are audited on a pre and post payment basis.
   Random sample auditing by examiner is done on a pre-payment basis. High Dollar Claims may be sent to an external vendor for detailed claim review as well on a post payment basis. Special audits are also completed on a Pre or post payment basis, i.e., PM330 validation, Major Organ Transplant (MOT) claims, etc. Target audits are completed on a requested basis**.**

B. MISDIRECTED CLAIMS

Any claims for emergency service and care that are delegated to a capitated subcontractor, which are received by KHS will be forwarded to the appropriate capitated subcontractor within ten working days of receipt of the claim that was sent to KHS erroneously at no less than 95% of the time.

Claims not involving Emergency Services:
When KHS had delegated the adjudication of claims for services that do not involve emergency services and care to a capitated subcontractor, KHS will either forward the misdirected claim to the appropriate capitated provider or send a notice of denial to the provider with instructions to bill the appropriate capitated subcontractor within 10 working days of receipt of the claim at least 95% of the time.

C. ER SERVICES

KHS will reimburse all clean emergency claims according to the eligibility of the member at the time of service. KHS does not review emergency room claims for medical necessity nor determines emergency medical conditions based on a list of diagnoses or symptoms. KHS does not require notification to Primary Care Physician (PCP) or KHS as a condition for reimbursement. No authorization is required for emergency care. Emergent services by a non-contracted provider (Out-of-Network Providers) for the treatment of the Emergency Medical Condition, 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 instructions from KHS or the Member is stabilized sufficiently to permit discharge will be paid at the Medi-Cal Fee-for-service (FFS) rate. Contracted providers will be reimbursed pursuant to contracted rate. Emergency Medical Claims are subject to review for any suspected Fraud, Waste, or Abuse. At a minimum, reimbursement for a Medical Screening Examination (MSE) is made to all emergency room providers, (professional and facility component and hospital based urgent care facilities). Members are not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member. Note that if a KHS representative instructs the member to see Emergency Services, the services are payable as emergencies. See KHS Policy and Procedure #3.31 Emergency Services Section 5.0.

1. Disputes involving Emergency Services and/or Post Stabilization Care Services may be submitted for resolution under provisions of Welfare and Institutions (W&I) Code section 14454 and 22 CCR sections 53620 et seq. (except section 53698) to:

   Department of Health Care Services
   Office of Administrative Hearing and Appeals

3831 North Freeway Blvd., Suite 200
Sacramento, CA 95834

KHS will implement DHCS' determination and reimburse the Provider within thirty (30) calendar days of the effective date of a decision. Proof of payment will be provided to the DHCS as requested. Failure to do so within the 30-day timeframe will result in capitation offsets in accordance with W&I code sections 14454 (c) and 14115.5 and 22 CCR section 53702 and may subject KHS to sanctions pursuant to W&I Code section 14197.7.

As part of Emergency Department visits, CHWs (Community Health Workers) are to bill through their supervising physician. If CHW is an employee of the facility, CHW services are to be billed on the facility claim and paid per the facility contract rates. Under the ER component for ER services and under OP component for all other services, such as follow up to ER visits.

D. CLAIMS RESUBMISSION

Claims may be resubmitted for reprocessing within forty-five (45) business days of the date of payment/denial. Claims resubmitted after the 45-business day deadline are denied.

Simple resubmission of a claim does not initiate the provider dispute process. To initiate the dispute process, providers must follow the procedure outlined in KHS Policy and Procedure #6.04-P, Provider Disputes Regarding Claims Payment.

E. REIMBURSEMENT

KHS reimburses contracted providers based on the compensation agreement specified in their contract**.** KHS rates are based on the Medi-Cal fee schedule identified in the applicable provider contract. Providers may view an electronic fee schedule at www.medi-cal.ca.gov. Case rates and per diem rates are stipulated in the provider contract. Non-Contracted providers are reimbursed at Medi-Cal rates.

1. Emergency Services & Urgent Care
   If the group or site is Participating Provide (PAR) and the attending provider is Non-Participating Provide (Non-PAR), reimbursement is at the group/site contract rate.

   If the group or site is Non-PAR and the attending provider is Non-PAR, reimbursement is at Medi-Cal rates.

2. Physical Therapy, Occupational Therapy, and Speech-Language Therapy (PT/OT/ST), Lab, Pathology & Radiology Services
   If the group or site is PAR and the attending provider is Non-PAR, if Non-PAR provider is authorized reimbursement is at Medi-Cal rates otherwise claim is denied.

3. Hospitalist Providers
   If the group or site is PAR and the attending provider in Non-PAR, reimbursement is

at the Medi-Cal rate.

If the group or site is Non-PAR and the attending provider is Non-PAR, reimbursement is at the Medi-Cal rate.

If the group or site is PAR and the attending provider is PAR reimbursement is at the contract rate.

4. Skilled Nursing Facility (SNF) - Long Term Care (LTC) Facility Claims
Effective 01/01/2023, KHS will process SNF Long Term Care Facility Claims. In accordance with Women Infants and Children Program (WIC) Section 14184.201 (b)(2), and WIC Section 14184.102(d), SNF LTC claims that are authorized will be paid at the State Fee schedule rate determined at the time of service. The State fee schedule rate applies to both contracted and non-contracted facilities. These services are also subject to Coordination of Benefit rules, as KHS will always be the payer of last resort. For those members who are dually eligible for Medi-Cal and Medicare, KHS will pay the full deductible and coinsurance in accordance with All Plan Letter (APL) 13-003.

   KHS will use that the Medi-Cal FFS per diem rate remains effective for subsequent dates of service until an updated per diem rate is published for subsequent dates of service.

   KHS will update its system to the new published per diem rates for all claims with applicable dates of service, received on or after 30 Working Days of being notified by DHCS that the updated rates are published.

   KHS will make retroactive adjustments on any claims with applicable dates of service that were processed prior to the MCP implementing the updated per diem rates, without requiring the provider to resubmit the claim, within 45 Working Days after being notified by DHCS that the updated rates are published.

   a. Additional reimbursement guidelines are contained in the following KHS policies and procedures:

      i. 3.05-P: Preventive Medical Care
      ii. 3.12-P: Urgent Care Services
      iii. 3.23-P: Emergency Services
      iv. 3.24-P: Pregnancy and Maternity Care
      v. 3.46-P: Tuberculosis Treatment
      vi. 6.09-P: Assistant Surgeon
      vii. 6.18-P: Laboratory Billing Guidelines and Restrictions
      viii. 6.19-P: DME Billing Guidelines
      ix. 6.21-P: Infusion Billing Guidelines

   b. KHS uses Medi-Cal billing criteria unless otherwise specified in a KHS

policy. The Medi-Cal Provider Manual is available online at www.medi-cal.gov. The Medi-Cal Provider Manual includes but is not limited to the following:

i. Policies and procedures which provide detailed payment policies and rules, and non-standard coding methodologies used to adjudicate claims. These documents clearly and accurately describe all global payment provisions[13.]
ii. Information regarding reimbursement for the administration of injectable medications
iii. Policy regarding consolidation of multiple services or charges and payment adjustment due to coding changes
iv. Policy regarding reimbursement for multiple procedures
v. Policy regarding recognition of CPT modifiers

Complete claims or portions thereof are reimbursed or denied within forty-five (45) working days of receipt.[14] Only members for whom a premium is paid by the State to KHS are entitled to health services and benefits provided hereunder and only for services rendered or supplies received during the period for which the member is enrolled.[15]

As stated in the provider contract, except for applicable copayments, providers may not invoice or balance bill KHS members for the difference between billed charges and the reimbursement paid by KHS for any covered benefit.[16]

5. Subacute and ICF/DD Facilities
Effective 1/1/2024, subacute and ICF/DD facilities are paid according to W & I section 14184.201 (c)(2). Payments will be made for participating and non-participating providers at the exact applicable Medi-Cal FFS periderm rate.

6. Share of Cost (SOC)
KHS will check if a Provider has subtracted the correct SOC amount for claims submitted for Members with a SOC.

KHS has a process for handling claims where a Provider has not subtracted the correct SOC amount for claims submitted for Members with a SOC

KHS has a process for handling claims where the full SOC has not been deducted by the Provider due to Johnson v. Rank provisions.

7. Coordination of Benefits and Third-Party Liability
If the member has other medical coverage, the provider must file the claim with the other primary insurance carrier before filing with KHS. Upon receipt of partial payment or denial from the other carrier, the provider should submit the claim to KHS along with documentation of payment or denial from the primary carrier. The Claims Department requires a copy of the other Plan's payment determination prior to releasing payment for those members covered by another Plan.

KHS secondary payment for eligible services is limited to the maximum that KHS would compensate providers as specified in the provider's contract. The primary and secondary payments may not add up to more than 100% of eligible charges.

KHS does not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates either third party coverage, designated by the Other Health Coverage (OHC) code, or Medicare coverage without proof that the provider has first exhausted all other sources of payment. An exception to this guideline exists for services and OHC codes which request post-payment recovery. Proof of third-party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y or Z.

The Claims Department does not attempt recovery in circumstances involving Casualty Insurance, Tort Liability, or Workers' Compensation awards to Medi-Cal members. Circumstances which may result in Casualty Insurance payments, Tort Liability payments, or Worker's Compensation awards are reported, in writing, to DHCS as appropriate within 10 (ten) calendar days after discovery by KHS.

F. MODIFERS

1. 25 Significant, Separately Identifiable Evaluation and Management (E&M) Service Description
   This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc.)

   CPT modifier -25 is used when, on the day a procedure or service was performed, the patient's condition required a significant, separately identifiable evaluation and management (E&M) service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

   a. Policy Statement
      KHS does not deny payment for CPT evaluation and management (E&M) codes with a CPT modifier -25 appended when submitted with surgical or other procedure codes for the same patient on the same date of service based solely on the existence of the modifier -25.

      The submission of modifier -25 appended to an E&M code indicates that documentation is available in the patient's records for review upon request that will support the significant and separately identifiable nature of the E&M service.

      All surgical procedures and some procedural services include a certain degree of physician involvement or supervision which is integral to that service. For those procedures and services, a separate E&M service is not normally reimbursed. However, a separate E&M service may be considered for reimbursement if the patient's condition required services above and

beyond the usual care associated with the procedure or service provided. To identify these circumstances, modifier -25 is attached to the E&M code.

i. Example of Proper Use of Modifier -25
An established patient is seen for a 2.0 cm finger laceration. The patient also asks the physician to evaluate swelling of his right knee that is causing pain.

Correct Codes – 12001 and 99213-25

ii. Example of Improper Use of Modifier -25
An established patient is seen for left knee pain. After evaluating the knee, the physician performs arthrocentesis.
Correct Code – 20610
It would not be appropriate to bill an E&M code because the focus of the visit was the knee pain which precipitated the arthrocentesis.

iii. Multiple E&M Services
Only one E&M service code per patient, per physician, per day is eligible for reimbursement unless:

a) the visits were for unrelated problems that could not be provided during the same encounter (i.e., scheduled office visit in the morning for ear pain and 4 hours later an unscheduled visit for a broken wrist).

In this case, modifier -25 should be attached to the E&M codes.

V. References

American Medical Association. "Appendix A: Modifiers." Current Procedural Terminology (CPT). Chicago: American Medical Association (AMA) Press. 2008.

National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, current version Chapter 1.

2. 53; Discontinued Procedure

a. Definitions
This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc. see modifier 73 & 74)

CPT Modifier -53 is appended to a code when a physician elects to terminate a surgical or diagnostic procedure due to extenuating circumstances.

b. Policy Statement

CPT Modifier -53 is valid only when a physician elects to terminate a surgical or diagnostic procedure due to extenuating circumstances that threaten the wellbeing of the patient.

Modifier -53 is eligible to attach to one code per operative session.

When modifier -53 is valid, the discontinued procedure may be reimbursed at a rate reduced from the usual allowable for the procedure.

Modifier -53 is not valid when used for elective cancellation of a procedure prior to anesthesia induction and/or surgical preparation in the operating suite.

Modifier -53 is not valid when a laparoscopic or endoscopic procedure is converted to an open procedure or when a procedure is changed or converted to a more extensive procedure.

c. References

i. American Medical Association. "Appendix A – Modifiers." Current Procedural Terminology (CPT). Chicago: AMA Press.

ii. American Medical Association (AMA). "Modifiers." CPT Assistant. Chicago: AMA Press, November 1996, p. 19.

Grider, Deborah J. Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage. Chicago: AMA Press, 2004, pp. 109 – 114.

3. 57; Decision for Surgery
This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc.)

a. Definitions
This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc.)

CPT modifier – 57 is used when the initial decision to perform a major surgical procedure is made during an E&M service provided the day before or the day of a major surgery.

Major surgery is defined as any code having a 90-day global period.

b. Policy Statement
KHS will not require a physician to submit clinical information of their patient encounters solely because the physician seeks payment for both surgical procedures and E&M services for the same patient on the same date

of service, provided that the correct E&M code, surgical code and modifier (e.g., CPT modifiers 25 or 57) are included on the initial claim submission.

An E&M service provided the day before or the day of a major surgery that resulted in the initial decision to perform surgery is eligible for reimbursement if modifier -57 is appended to the E&M code.

Modifier -57 should not be used when the E&M service is associated with a minor surgical procedure (defined as having a 0 or 10-day global period).

Modifier -57 should not be used when the E&M service was for the preoperative evaluation.

c. References
American Medical Association. "Appendix A – Modifiers." Current Procedural Terminology (CPT), Chicago: AMA Press.

4. 59; Distinct Procedural Service
This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc.)

a. Definitions
CPT modifier -59 represents a procedure or service that is distinct or independent from other services performed on that same day. Modifier -59 identifies procedures or services, other than E&M services, that are not normally reported together but are appropriate under the circumstances.

b. Policy Statement
CPT codes submitted with modifier 59 attached are considered appropriate coding to the extent they follow the AMA CPT book, and they designate a distinct or independent procedure performed on the same day by the same physician, but only to the extent that:

i. although such procedures or services are not normally reported together, they are appropriately reported together under the particular presenting circumstances; and

ii. it would not be more appropriate to append any other CPT recognized modifier to such CPT codes.

KHS does not deny payment for services with a CPT modifier -59 appended based solely on the existence of the modifier -59.

The submission of modifier -59 appended to a procedure code indicates that documentation is available in the patient's records for review upon request that will support the distinct or independent identifiable nature of the service submitted with modifier -59.

CPT codes submitted with modifier 59 attached will be eligible for payment to the extent they not only follow the AMA CPT book, but additionally are not considered a bundled component of a more comprehensive code or two codes that should not be reported together based on NCCI edits or NCCI coding guidelines.

iii. Valid use of modifier -59:

a) Differing anatomical site (e.g., skin lesions on separate body sites), different organ system (e.g., laparoscopy on separate organ systems), contralateral structures (e.g., bilateral knees although use of HCPCS modifiers –RT and –LT would be clearer.)
b) Separate surgical operative session on the same date of service.

iv. Invalid use of modifier -59:

a) Procedures in the same ipsilateral joint (including differing compartments) performed by open, scope, or combined open/scope technique, including added port or incisional sites.
b) Procedures in the same anatomical site (e.g., digit, breast, etc.), even with incision lengthening or contiguous incision.
c) CPT identified "separate" procedures performed in the same session, same anatomic site, or orifice.
d) Scope procedure converted to open procedure.
e) Incisional repairs are part of the global surgical package, including deliveries.
f) Contiguous structures in the same anatomic site, organ system, or joint.

c. References
National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, current version Chapter 1.

5. Payment of Interest on Late Claims[17]
Interest is automatically paid on late claims in accordance with KHS Policy and Procedure #60.05-I Payment of Interest on Late Claims. Interest is paid at the rate of 15 percent per annum beginning on the first calendar day after the forty-five (45) working day period and automatically include all accrued interest in any late payment.

G. PROVIDER PREVENTABLE CONDITIONS

Provider Preventable Conditions (PPCs) are either Health Care-Acquired Conditions (HCACs) or Other Provider-Preventable Conditions (OPPCs) as defined under 42 CFR 447.26 and must be reported to the Department of Health Care Services (DHCS) and KHS upon discovery in any health care setting. KHS' Quality Department will provide the information to KHCS via the on-line portal at Security Code (ca.gov).

1. Reimbursement
   KHS will not reimburse providers for PPC-related health care services.

2. Billing Guidelines
   The following guidelines apply to outpatient hospital providers, freestanding ambulatory surgery centers, and acute outpatient hospital provider billing for acute outpatient hospital-based physician services.

Outpatient Hospitals and Freestanding Ambulatory Surgery Centers	
UB-04 or 837I institutional claims	**CMS-1500 or 837P professional claims**
Acute outpatient hospitals and hospitals licensed health centers (HLHCs)	Acute outpatient hospital and HLHC claims for acute outpatient hospital-based physician services
Privately-owned chronic disease and rehabilitation outpatient hospitals	Freestanding ambulatory surgery centers (FASCs)
Psychiatric outpatient hospitals	
State-owned non-acute outpatient hospitals operated by the Department of Mental Health (DMH) state-owned non-acute outpatient hospitals operated by the Department of Public Health (DPH)	
Substance abuse treatment outpatient hospitals	

The following guidelines apply to inpatient hospital providers and acute inpatient hospital providers billing for acute inpatient hospital-based physician services.

UB-04 or 837I institutional claims:	CMS-1500 or 837P professional claims:
Acute inpatient hospitals	Acute inpatient hospital claims for acute inpatient hospital-based physician services
Privately-owned chronic disease and rehabilitation inpatient hospitals	
Psychiatric inpatient hospitals	
State-owned non-acute inpatient hospitals operated by the Department of Mental Health (DMH)	
State-owned non-acute inpatient hospitals operated by the Department of Public Health (DPH)	
Substance abuse treatment inpatient hospitals	

All inpatient hospital claims related to a PPC must include the appropriate Present on Admission (POA) indicator.

POA Indicator Reporting Description and PPC Payment Criteria for Inpatient Hospitals		
POA Value on UB-04 or 837I	Description	Payment adjustments
Y	Diagnosis was present at time of inpatient admission.	Payment is made for the condition.
N	Diagnosis was not present at time of inpatient admission.	Applicable PPC payment adjustments will be made

U	Documentation is insufficient to determine if the condition was present at the time of inpatient admission.	Applicable PPC payment adjustments will be made.
W	Clinically undetermined. The provider was unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment is made for condition.
Leave field blank	Effective January 1, 2011, the POA field will be left blank for codes exempt from POA reporting. Note: The number "1" is no longer valid on claims submitted under the 5010 format, effective January 1, 2011. Refer to Centers for Medicare and Medicaid Services (CMS) change request 7024. www.cms.gov/transmittals/downloads/R756OTN.pdf	Exempt from POA

H. RECOVERY OF OVERPAYMENTS[18]

KHS pursues recovery of overpayments that meet cost-benefit guidelines. When recovery is pursued, KHS sends a refund request letter to the provider. Within thirty (30) working days of receipt of the letter, the provider must submit to KHS either a complete refund of the overpayment or a provider dispute. Disputes must be submitted and will be processed in accordance with KHS Policy and Procedure # 6.04 – Practitioner/Provider Disputes Regarding Claims Payment.[19] As stipulated in the provider contract, if a dispute is not received within 30 working days or the full repayment amount, the overpayment will be offset against additional amounts due to the provider.

Overpayment process will be reviewed by the Claims Director or designee on a biannual basis for accuracy. All documentation of Overpayment/refund requests are kept for a minimum of 10 years in our MFILES online storage. Two (2) years are available for review, and Eight (8) years are archived.

Any recovery of an overpayment to a provider of $25 million or more, KHS and DHCS will share equally. Sixty (60) days after the date that the overpayment was identified, KHS will report the overpayment to the DHCS Contract Manager. KHS will submit the overpayment amount recovered, provider information, reason for the overpayment, services related to the overpayment, and steps taken to prevent future occurrences. This will not include any recoveries retained under the False claims Act or other investigations not covered under APL 17-003. Any recovery of an overpayment to a provider of less than $25 million will be retained by KHS with the exception of any OHC recovery over 13 months old.

KHS will report annually to DHCS on all recoveries of overpayments, including network providers excluded from participation in Medicaid program and those made to a network provider due to fraud, waste, or abuse. Documentation will include retention policies, processes, timeframes, and documentation required for reporting the recovery of all overpayments, will be provided upon request by DHCS. Report will be submitted through the DHCS Contract Manager.

KHS shall require network providers to report to KHS when it has received an overpayment, to return the overpayment to KHS within sixty (60) calendar days after the date on which the overpayment was identified, and to notify KHS in writing of the reason for the overpayment.

Any identification or recoveries of overpayments due to potential Fraud, Waste or Abuse, will be communicated to the DHCS Audits and Investigations Intake Unit within 10 days of identification via the Compliance Department.

I. INQUIRIES REGARDING UNPAID CLAIMS[20]

Providers may confirm the date of receipt of paper claims within fifteen (15) working days of receipt by calling 1-800-391-2000. Providers receive an electronic acknowledgement of the receipt of electronic claims within Two (2) working days of the date of receipt.

J. UNFAIR BILLING PATTERNS[21]

Providers who engage in an unfair billing pattern may be reported to the Department of Managed Health Care. Unfair billing patterns include, but are not limited to, demonstrable and unjust patterns of unbundling and up-coding. KHS will make efforts to work with providers to distinguish billing errors from unfair billing patterns and to help providers correct billing errors. Providers will only be reported to Department of Managed Health Care (DMHC) after efforts to resolve such billing issues have failed.

Additionally, Providers need to be aware that Kern Health Systems is contractually obligated to conduct, complete, and report to the Department of Health Care Services the results of a preliminary investigation of suspected fraud and/or abuse within ten (10) working days of the date that KHS first becomes aware of, or is on notice of, such activity.

K. MENTAL HEALTH AND SUBSTANCE USE DISORDERS (SUD)

Pursuant to APL 22-005 and 22-006, KHS will cover all initial mental health assessments by network providers without a referral/authorization. KHS will not deny reimbursement for Non-Serious Mental Health Services (NSMHS) provided during the assessment process if the assessment determined that the member does not meet the criteria for NSMHS or meets the criteria to Serious Mental Health Services (SMHS). KHS will not deny reimbursement for NSMHS provided to a member who meets NSMHS criteria on the basis of the member having a co-occurring SUD, when all other Medi-Cal and services requirements are met. KHS will not deny reimbursement for NSMHS provided to a member on the basis of the member also meeting SMHS criteria and/or also received SMHS services provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

L. COMMUNICATIONS REGARDING CLAIM PAYMENTS

Once a claim has been paid or denied, Providers will receive an Explanation of Provider Payment

(EPP) showing how the claim was adjudicated. The EPP uses standard Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) for denial explanations for any portions of the claim that may have been non-paid. KHS will also use more explanatory comments on the EPP when necessary. Providers can access the EPP from the Payment Portal. If additional communication is needed, Providers can call KHS at any time.

M. PROHIBITED CLAIMS

Kern Health Systems adheres to 22 CCR sections 53866, 53220 and 53222; and does not submit a claim, demand or any other type of collection request to a member or persons acting on behalf of a member for any services provided under this program except to collect: Third-party payments in accordance with Section 53222(a), or Payment for services provided pursuant to Section 53210(d). KHS does not attempt recovery in circumstances involving casualty insurance, tort liability, or worker's compensation, but rather reports that to DHCS within 10 days of discovery by KHS.

1. KHS holds harmless and indemnifies members for any debt to providers for services rendered and billed to Members.

N. NON-CONTRACTED CERTIFIED NURSE MIDWIVES AND CERTIFIED NURSE PRACTIONERS AND FREE-STANDING BIRTHING CENTERS

If the KHS network does not include a Free-Standing Birthing Center (FBC) in its network at any time, KHS will reimburse out of network FBCs for services provided to its members at the Medi-Cal FFS rate for the services. Also, if the KHS network at any domes does not include a Certified Nurse Midwife or Licensed Midwife, KHS will reimburse out of network providers at the Medi-Cal FFS rate.

O. LONG TERM CARE: SNF and NF (Nursing Facility)

In accordance with W&I Code section 14184.201(b), effective 01/01/2023, KHS will reimburse covered Long Term Care services at Skilled Nursing and Nursing facilities that are authorized, at the Medi-Cal FFS rates established at the time of service. This includes contracted and non-contracted providers. Services of Long-Term Care at Subacute facilities or Intermediate Care facilities are still the responsibility of the Medi-Cal FFS plan and will become the responsibility of KHS on 01/01/2024 in accordance with W&I Code section 14132.25. Those services that are authorized for contracted or non-contracted providers will be paid at the Medi-Cal FFS rates established at the time of service. Those services that are part of Continuity of Care will also be paid at the established rates. While Long Term Care claims are fast tracked, all services are paid no later than the timeliness standards outlined in this policy. Note that all Medi-Cal covered services rendered in a Long-Term Care facility are also reimbursed per contract. Long Term Care claims also apply to our Coordination of Benefits Policy, 6.08-P. Please reference Utilization Management policy and procedure, 3.91-P, Long-Term Care Services Program.

P. SUBCONTRACTORS AND DOWNSTREAM SUBCONTRACTORS

KHS ensures all subcontractors and Downstream subcontractors operate in full compliance with our Contract, applicable state and federal statutes and regulations, APLs, and all other applicable policy guidance relative to timely payments of providers. (Reference Delegation Oversight Policy for Claims, 6.33-I)

Q. STATE DIRECTED PAYMENTS (SDP)

KHS adheres to timely payment requirements regardless of whether a Provider's claim, bill, or invoice, or equivalent encounter is tied to a State Directed Payment. KHS is not subject to timely payment of SDPs until so directed and the 30-calendar day standard does not apply in instances where the SDP amount is not published prior to the service date.

R. As of July 1, 2025, KHS will allow claims from community paramedicine programs, triage to alternate destination programs, or mobile integrated health programs, whether in-network or out of network to be paid at the same percentage of cost share for the member. Since we are in a zero cost share county, services will be paid at 100% of the Medi-Cal rate, which is our usual and customary charges for services rendered.

VI. ATTACHMENTS

N/A

VII. REFERENCES

Reference Type	Specific Reference
Regulatory	[1] Health and Safety Code Sections 1371, 1371.35
Regulatory	[2] CCR Title 28 §1300.71(a)(11)
Regulatory	[3] CCR Title 28 §1300.71(a)(10)
Regulatory	[4] CCR Title 28 §1300.71(a)(13)
Regulatory	[5] Title 5 USC 6103 specifies the federal holiday schedule. See www.canb.uscourts.gov/canb/genifo.nsf (click on "general information"; click on "search"; enter "federal holidays" in the search box) for a yearly schedule.
Regulatory	[6] MMCD All Plan Letter 07-020 Medi-Cal Billing Restriction on the Use of Social Security Numbers 12/26/07
Regulatory	[7] CCR Title 28 §1300.71(b)(4)
Regulatory	[8] KHS may not impose a deadline less than 90 days after the date of service (CCR Title 28 §1300.71(b)(1).
Regulatory	[9] KHS may not impose a deadline less than 90 days after the date of payment or date of contest, denial or notice from the primary payer (CCR Title 28 §1300.71(b)(1).
All Plan Letter(s) (APL)	[10] MMCD All Plan Letter 08-002
Regulatory	[11] KHS may not impose a deadline less than 90 days after the date of payment or date of contest, denial or notice from the primary payer (CCR Title 28 §1300.71(b)(1).
All Plan Letter(s) (APL)	[12] MMCD All Plan Letter 07-020

Regulatory	[13] CCR Title 28 §1300.71(o)(1)(B). Also, must be electronic.
Regulatory	[14] CCR Title 28 §1300.71(g) and (h); HSC §1371
Regulatory	[15] HFAM Contract 05MHF016 Exhibit B, II B (1). Inclusion requested by B. Davenport.
DHCS Contract	[16] DHS Contract 03-76165 Exhibit A-08 (6). Non contracting emergency providers are not allowed to balance bill. (DMHC Letters May 12, 2003, and July 2, 2003. See AB1455 information).
Regulatory	[17] HSC §1371
Regulatory	[18] CCR Title 28 §1300.71(d)(3) through (6)
Regulatory	[19] CCR Title 28 §1300.71(d)(4)
Regulatory	[20] CCR Title 28 §1300.71(c)
Regulatory	[21] HSC §1371.39(b)

VIII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	3-20-2025	The policy was revised to comply with DMHC APL 24-023.	R.D.M Senior Director of Claims
Revised	02-10-2025	Revised Per DHCS APL 24-009 AIR 2, approved on 2/14/2025.	R.D.M Senior Director of Claims
Revised	01-23-2025	Revised to align with DHCS APL 24-006.	R.D.M Senior Director of Claims
Revised	2025-01	Revised to align with the DHCS APL 24-009 AIR 1	R.D.M Senior Director of Claims
Revised	2024-11	Revised for DHCS APL 24-009, Submitted on 12/13/2024 for DHCS APL 24-009, 24-010, and 24-011. Approved for DHCS APL 24-010 and 24-011 on 2/14/2025.	R.D.M Senior Director of Claims
Revised	2024-10	The policy was reconciled with the 2024 Operational Readiness Project, the final edits were approved by the Senior Director of Claims. Policy was submitted to the DMHC on 10/28/2024, closure letter received on 11/27/2025.	A.H Compliance
	2024-06	Policy revised by Senior Director of Claims to comply with technical changes made to	R.D.M Senior Director

Revised		DHCS APL23-011**.** Approved for APL 23-011 on 6/19/2024. Submitted to DHCS for APL 24-003 on 6/25/2024 – DHCS approved policy for APL 24-003 on 7/16/2024.	of Claims
Revised	2024-04	Revised by Senior Director of Claims	R.D.M Senior Director of Claims
Revised	2023-11	Revised per DHCS APL 23-020**,** DHCS approved 12/6/2023. DMHC approval received on 12/21/2023, Filing No. 20234921.	Claims
Revised	2023-11	Policy revised by Director of Claims to comply with DHCS APLs 23-023 and 23-027. DHCS approval issued on 7/23/2024.	Claims
Revised	2023-08	Policy revised by Director of Claims to comply with DHCS APL 23-011, DHCS approval on 9/6/2023.	Claims
Revised	2023-05	Policy revised by the Director of Claims comply with DHCS 2024 Operations Readiness (R.0095) – approved by DHCS on 5/22/2023.	Claims
Revised	2023-04	Policy revised by Director of Claims to comply with DHCS 2024 Operational Readiness (R.0088, R.0089) – approved by DHCS on 5/1/2023. Submitted also for 2024 OR (R.0091 and R.0092) – approved by DHCS on 5/2/2023.	Claims
Revised	2022-11	Revised by Claims Director to comply with DHCS APL 22-018. DMHC approval on 12/28/2022 and DHCS approval on 2/22/2023. [1]	Claims
Revised	2022-08	[1]DHCS Contract Template R.0079	Claims
Revised	2022-06	Revised by Claims Director to comply with DHCS APL 22-006 and 22-005, revisions approved by the DHCS on 7/26/2022 and by DMHC on 11/10/2022, Filing No 202223746.	Claims
Revised	2021-09	Added Juneteenth as declared a new federal holiday in 2021.	Claims

Revised	2021-08	Director of Claims added additional required language of 99% of all clean claims are processed in 90 days for ILOS review of P&P.	Claims
Revised	2017-05	Added additional required language and processes to comply with APL-17-003 effective 7/1/17.	Claims
Revised	2016-05	Revisions to ICD codes. Updated Health Insurance Claim Form provided by Claims Director.	Claims
Revised	2016-03	Policy revised to comply with All Plan letter (APL) 15-006 regarding provider preventable conditions. Additional language added by Director of Claims on reimbursement**.**	Claims
Revised	2014-03	Revised to comply with DHCS Medical Audit review 2013. Section 3.5 new language to include stipulation that misdirected claims are sent to appropriate payer within ten (10) days. References to Healthy Families removed.	Claims
Revised	2013-10	New language added for various modifiers. Contractual requirements for KHS added regarding reporting to the DHCS.	Claims
Revised	2011-11	Revised to comply with new DHCS Contract requirements and made changes to comply with MMCD. Policy Letter 08-002. Added clarifying language that Providers may use the KHS Member Identification Number.	Claims
Revised	2010-05	Policy revised to comply with DHCS Deliverable 7.B. Policy updates provided by Director of Claims.	Claims
Revised	2009-01	Policy revised to comply with MMCD 08-002.	Claims
Revised	2008-11	Revised mailing address for Claims submission, process returned to Bakersfield, CA. Policy Revision date not changed, and signatures not required per CCO.	Claims
Revised	2008-06	Routine revision initiated by Claims Manager. Policy reviewed against MMCD All Plan Letter 07-020 Medi-Cal Billing Restriction on the Use of Social Security Numbers 12/26/07	Claims
Revised	2005-08	Routine review initiated by Director of Claims. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004).	Claims

Revised	2004-04	Revised to include 30 business day deadline for claims resubmission. Should have been included in Revision 2003-12. Also updated with new addresses and phone numbers.	Claims
Revised	2003-12	Revised to comply with AB1455 Claims Settlement Regulations; effective 01/01/2004. Revised per request of Claims Manager. Policy #6.03 – Unbundled Claims (2001-03) is deleted and incorporated into this policy. Policy #60.06 – Third Party Liability (2001-08) is deleted and incorporated into this policy and the associated internal policy.	Claims
Revised	2002-05	Revised per DHS request. Clarify that 90-submission deadline applies only to contracted providers. Also added Processing Guidelines section. Revised per Amendment to 2002 Service Agreements (11/8/01).	Claims
Revised	2001-03	Changes made per Provider Relations request. Changed submission deadline from 60 to 90 days to match contract; added HFAM PO Box. Issue date changed to correct previous error.	Claims

IX. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Department of Health Care Services (DHCS)	6/27/2025, Jan 2026 CS MOC	
Department of Managed Health Care (DMHC)	3/22/2025, APL 24-023	
Department of Health Care Services (DHCS)	3/12/2025, (Updated OR P&P R.0088)	4/3/2025
Department of Health Care Services (DHCS)	3/12/2025, (Updated OR P&P R.0095)	4/2/2025
Department of Health Care Services (DHCS)	3/12/2025, (Updated OR P&P R.0091)	4/2/2025
Department of Health Care Services (DHCS)	3/12/2025, (Updated OR P&P R.0089)	4/2/2025
Department of Health Care Services (DHCS)	2/19/2025, APL 24-006	3/14/2025

Department of Health Care Services (DHCS)	12/12/2024, APL 24-011	2/14/2025
Department of Health Care Services (DHCS)	12/13/2024, APL 24-010	2/14/2025
Department of Health Care Services (DHCS)	2/10/2025, APL 24-009	2/14/2025
Department of Managed Health Care (DMHC)	10/28/2025, eFile #2024464-1	11/27/2024
Department of Health Care Services (DHCS)	6/25/2024, APL 24-003	7/16/2024
Department of Health Care Services (DHCS)	6/13/2024, DHCS APL 23-011	6/19/2024
Department of Managed Health Care (DMHC)	12/8/2023, DMHC APL 23-020	12/21/2023
Department of Health Care Services (DHCS)	11/27/2023, DHCS APL 23-023	
Department of Health Care Services (DHCS)	11/27/2023, DHCS APL 23-027	
Department of Health Care Services (DHCS)	11/7/2023, DHCS APL 23-020	12/6/2024
Department of Health Care Services (DHCS)	8/7/2023, DHCS APL 23-011	9/6/2024
Department of Health Care Services (DHCS)	5/2023, DHCS Operational Readiness R.0095	5/22/2024
Department of Health Care Services (DHCS)	4/2023, Operational Readiness R.0091 and R0092	5/1/2023
Department of Health Care Services (DHCS)	04/2023, Operational Readiness R.0088, R.0089	5/1/2023
Department of Managed Health Care (DMHC)	DHCS APL 22-018	12/28/2022
Department of Health Care Services (DHCS)	DHCS APL 22-018	2/22/2023
Department of Managed Health Care (DMHC)	DHCS APL 22-006	11/10/2022
Department of Health Care Services (DHCS)	DHCS APL 22-005	7/26/2022

Date posted to public drive: _____

Date posted to website ("P" policies only): _____