Reference Matrix for Member-Denials

Key Definitions

Denied Claim	For compliance purposes, this is a post-service financial claim where (a) one or more services will not be paid and (b) payment is the responsibility of the member. The member must have liability. Examples of claims that are not denials and should not be reported, submitted or presented to a health plan or regulator as "denied" claims include those: • for patients who remain enrolled with a health plan but have transferred to another delegated entity and you are just forwarding the claim to the health plan or the other entity for processing; • for patients who remain capitated to your organization but payment responsibility belongs to another contracting entity (health plan or hospital) and you are forwarding the claim; • that are duplicates to claims already paid or denied; • that are encounter-only, capitated claims and no patient liability is involved; • That are denied to a contracting provider who should write off the unpaid claim (unless the provider has written evidence that the member understood and accepted payment responsibility for him or herself); or • That involve reduced payment amounts due to contract terms or allowed Medicare fee schedules.
Denial Letter **or** **Denial Notice**	A document notifying a patient that an adverse coverage decision has been made as a result of adjudication of a provider claim for reimbursement. It identifies the billing provider, the services, the financial liability, the deciding organization, the reason for the decision, the appeal process and where to direct written or verbal appeals or to request additional information and the time limit to do so. This notice may comprise a letter or a properly formatted explanation of benefits form (EOB), remittance advice (RA) or payment advice (PA). Proper notices will meet 19 requirements for content, accuracy and timeliness (discussed in detail, below).

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	Medicare	Commercial	Medi-Cal
Denial Notice General Standards	Federal law, regulations and CMS guidelines govern initial coverage determinations that are adverse to a Medicare beneficiary (i.e., denials that result in financial liability for the beneficiary). These requirements apply to health plans and thereby to any entity to which authority to make coverage determinations has been delegated, such as medical groups, IPAs and capitated hospitals. Whenever we make such determinations, the currently approved denial notice/denial letter format must be sent to the member. CMS Region IX in their Regional Office HMO/CMP Letter 97-02, dated February 14, 1997 published a basic set of approved versions of letters and denial reasons. Some superseding materials have been issued from time to time, for example to incorporate "prudent layperson" language into denials of non-emergent care when appropriate or to require a re-formatting of the notice. ICE issued revised model notices and updated denial reasons in November, 2001 to meet the latest CMS requirements announced in Regional Office M+C Organization Letter 01-04 dated June 12, 2001 – effective 1/1/02. CMS requires that the health plan coordinate all member-initiated appeals. Health plans may not delegate administration of member appeals. Once a denial notice has been sent, no further adverse notices may be sent to the member except by the Center For Healthcare Dispute Resolution (CHDR).	The latest standards were presented at the ICE (Industry Collaboration Effort) Claims Standardization Seminar in January 2003. Whenever health plans and delegated claim shops make decisions to deny claims that result in liability for the enrollee, those decisions must be in accordance with State (DMHC) and U.S. Department of Labor (DoL) law and regulations, including required coverage for emergency care taking the "reasonable person" standard into account. The member should be given clear information including phone numbers and mailing addresses to assist them to in contacting the health plan or the physician group for more information or to appeal the denial decision. The required DMHC language and the agency's toll-free "800" phone numbers must be included, along with approved Independent Medical Review (IMR) language. When medical necessity denials are made, there must be evidence that a physician participated in the decision. Special information about the basis for the denial and how to contact the decision-maker must be given in the EOB or letter to the billing provider.	Requirements are a blend of federal and state law and regulations. The latest standards were presented at the ICE (Industry Collaboration Effort) Claims Standardization Seminar in November 2001. Whenever health plans and delegated claim shops make decisions to deny claims that result in liability for the enrollee, those decisions must be in accordance with California's DOI (Department of Insurance) requirements. Any notice of denial must include the "fair hearing" paragraph required by California's DHS (Department of Health Services).

Specific Denial Notice Standards: Requirements and Best Practices

The criteria are those from the 19-point, ICE-standardized audit tools as they were updated during 2001. ICE-participants from CMS, the DMHC and the DOI have reviewed these criteria and have not taken exception to them. The word "same" by itself in a column indicates that the text in the column to the left applies – it does not mean that the text from the row above applies.

Criteria	Medicare	Commercial	Medi-Cal
Format / Language			
1. Identifies Sender	Required: The IPA, group or capitated hospital is identified. In addition to the above entities, the management company or TPA may be identified if applicable.	Same	Same
2. Displays Date	The date of the notice is a critical item. It should fairly represent the date the notice is mailed, because the beneficiary has 60 calendar days from the date of the denial notice to file an appeal. Mailing delays and inaccurate dates may constitute a "denial of due process" under federal law.	Same except "denial of due process" does not apply.	Same as Medicare
3. Member ID'd	Required: Member name and ID number. Best Practice: the mailing address to which the notice was sent should be displayed. SSN should not be visible through a window envelope.	Same except ID number must not reveal SSN through a window envelope.	Same

Criteria	Medicare	Commercial	Medi-Cal
4. Dates of Service, Provider, Amounts Listed	Individual dates of service must be listed unless multiple dates are continuous, in which case a date range may be displayed. Provider must be identified by name. Total dollar amount of member liability should be displayed.	Same	Same
5. Font Adequate Size	Requirement: The minimum font size is 12 pitch. The notice title "NOTICE OF DENIAL OF PAYMENT" should be at least 14 pitch. Where bold text is indicated in the sample, the text should be bold or other means should be used to emphasize the words or phone numbers. The ICE format typically centers such text. *Exception may be granted to 14 pt and bolding if your system cannot support them.	Same except no 14 pitch.	Same except no 14 pitch.
6. Appeal Language Included and Correct	The entire letter, and in particular the appeal language must exactly match the text from the ICE-standardized, CMS-approved template letter (latest revision 12/01 [or 3/27/02 which includes history]).	The entire letter should include the information in the ICE-standardized, DMHC-reviewed template letter (latest revision 12/23/02), and must include the mandated DMHC and ERISA passages. When the reason for denial involves medical necessity, the medical criteria for the decision and the name and phone number of the deciding/responsible physician must be provided to the billing provider.	The entire letter, and in particular the appeal language must exactly match the text from the ICE-standardized, DOI-reviewed template letter (latest revision 11/01).
7. Health Plan Name, Address And Phone Numbers Correct	All data must be current.	Same	Same

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Denial Reason Detail			
8. Word "Denied" or "Denial" Appears	Must exactly match the text from the ICE-standardized, CMS-approved template letter (latest revision 12/01).	Must exactly match the text from the ICE-standardized, DMHC-reviewed template letter (latest revision 5/11/02).	Must exactly match the text from the ICE-standardized, DOI-reviewed template letter (issued 11/01).
9. Clear and Specific	Choose proper denial insert from the ICE-standardized, CMS-approved Denial Reason Guide. The most recent was issued 3/01.	Choose proper denial insert from the ICE-standardized, DMHC-reviewed Denial Reason Guide on 2-07-03.	Exact text not specified. Guidelines appear on page T58 of the Fall 2001 ICE Claims Standardization Training handout. Generally, if patient was HMO member (eligible) on date of service, can only deny if the services were not covered under the Medi-Cal program.
10. Proper Eligibility Test	To issue denial, there should be evidence that research included direct contact with the health plan for current information about effective dates with the plan. Assignment of the member to an IPA, group or capitated hospital is not relevant – if the member was still effective with the plan, the claim would be forwarded and no denial notice would be issued.	Same	Same
11. Proper Benefit Coverage Determination	Must follow health plan evidence of coverage and exclusion rules correctly.	Same	Limited to services not covered under Medi-Cal. Refer to list immediately below this table.

Criteria	Medicare	Commercial	Medi-Cal
12. Passes "No Authorization" Tests	This reason should be used only if other reasons do not apply (see further discussion in Choosing the Best Denial Reason section below.) Evidence of research to confirm lack of authorization should be kept, especially to rule out "implied" referral by a contracted provider (e.g., provider gives reference or system referral is vague but actually should include the service under question).	Same	Not applicable
13. Clear and Proper Maximum Benefit Determination	Inserts in denial reason must be made, evidence of research kept. Limit must be supported in health plan evidence of coverage.	Same	Not applicable
14. Emergent/Urgent Properly Cited	The proper denial reason should be chosen from the Guide. If care was rendered in an emergency room or otherwise was rendered in emergency circumstances, do not use the "not authorized" reason.	Same	Not applicable
15. Emergent/Urgent Justified	"Prudent layperson" standards of evaluation must be applied. If the presenting ICD-9 diagnosis code is listed on the ICE-standardized Emergency Diagnosis Guideline (most recently revised 3/01), rationale for any denials should be thoroughly justified, documented and are unlikely. However, the guideline is not an "auto-pay" list. And, if a code is not listed, medical review should take place before coverage is denied.	Same except "reasonable person" standard applies.	Not applicable

Criteria	Medicare	Commercial	Medi-Cal
16. Proper Development for Incomplete Information	Required: There must be evidence that the claim was pended while at least two letters were sent within 60 calendar days of claim receipt to the provider requesting the missing information.	Required: There must be evidence that a letter was sent within 45 working days of claim receipt to the provider, requesting the missing information. For ERISA-applicable members, the limit is 30 calendar days.	Same as commercial except ERISA does not apply.
17. Duplicate Claim Notice Not to Member	Letters must not be sent to members. Any such letters accidentally sent to members should still be reported and included on audit universe lists.	Same	Same
Decision			
18. Denial Action Valid	The decision to deny must be correct. If the denial is other than for administrative reasons (failed emergent/urgent or not medically necessary), evidence of physician participation is required.	Same	Same for actual denial. It is okay to send an advisory notice if the member was not eligible and s/he needs to submit the claim to the financially responsible plan.
Timeliness			
19. Meets Requirements	The notice must be dated and mailed within 60 calendar days of the earliest receipt of the claim within the health plan or any contracting/delegated entity.	The notice must be dated and mailed within 45 working days of the earliest receipt of the claim or requested missing information. Exceptions within 30 calendar days: • the member is ERISA-effective or • the denial is for medical necessity. If the claim was contested for more information, after receipt of the information the notice must be dated and mailed within: • 15 calendar days for ERISA-covered patients • 45 calendar days all others	Same as commercial except ERISA does not apply.

The following services are not covered under Medi-Cal:

- Experimental Procedures
- Cosmetic Surgery
- Personal comfort or convenience items
- Services to reverse surgically induced infertility
- Infertility treatment
- Non-medically-necessary, private, off-duty nurses
- Circumcisions that are not medically necessary
- Custodial care while confined in a facility or home
- Chronic kidney dialysis when a member is eligible for coverage or the services under Medicare program (ESRD)
- Emergency services and non-emergency services provided outside of the United States, Canada or Mexico