



<b>Policy and Procedure No: CL 4.2</b>	<b>Revision No: 2</b>
<b>Division: Care Management</b>	
<b>Department: Claims Operations</b>	
<b>Title: PHC-CA Claims Inventory and Pended Claims</b>	
<b>Effective Date: 1/2/2011</b>	
<b>Supersedes Policy No: CL 4.0, CL 4.1</b>	
<b>Reviewed/Revised by: Sandra Holzner</b>	<b>Review/Revision Date: 12/1/2025</b>
<b>Approving Committee: Member Provider Committee</b>	<b>Date: 12/15/2025</b>
<b>Executive Oversight Committee Date: 12/16/2025</b>	

**Purpose:**

To describe the policy of PHC California (the Health Plan) to manage and monitor claims and pended inventory.

**Policy:**

The Health Plan shall adhere to regulatory claims processing timeframes. The Health Plan shall finalize the underlying causes for pending clean claims within thirty (30) calendar days from date of receipt. The claims processing turnaround time (TAT) standards are outlined in the Health Plan’s Claim Policy and Procedure, CL 10 Claims Compliance Timeliness, Interest and Penalty Payments.

**Procedure:**

1. The Claims Manager or designee will review the claims inventory report to determine the current inventory and the oldest “date received” claim(s).
2. The report will be run by “date received”, thus allowing the report to include any unadjudicated claims.
3. Any claims that require immediate attention will be provided to the claim’s examiners for resolution.
4. The Claims Manager or their designee will run a report of all claims pending in HealthSUITE. A copy shall be provided to the Claims Examiners for review and adjudication of claims.
5. All claims pending to other Departments due to a request for additional information must be returned no later than two (2) working days. If the claim is not returned within the required timeframe, the Claim Examiner shall request the assistance of the Claims Manager or designee.

**Definitions:**

1. Clean Claim
  - a. As defined by DHCS, a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the State’s claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity; and
  - b. A claim that has no defect, impropriety, lack of any required substantiating documentation (consistent with § 422.310(d) or circumstance requiring special treatment that prevents prompt payment; and

- c. A claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.
2. Date of Receipt: the working day when a claim, by physical or electronic means, is first delivered to either the Health Plan's specified claims payment office, post-office box, or designated claims processor or to the plan's capitated provider for that claim. In the situation where a claim is sent to the incorrect party, the 'date of receipt' is the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.
3. Pended Claim Categories:
  - Eligibility verification
  - Utilization/medical necessity review
  - Benefits verification
  - Medical record request

**Monitoring:**

This policy is updated, as necessary, reviewed and approved annually by the Member Provider Committee.

**References:**

1. Policy and Procedure, CL 10 Claims Compliance Timeliness, Interest and Penalty Payments