Effective 2/1/2026

Lines Of Business: Mountain Health Trust

Itemized Bill Review (IBR)

DISCLAIMER

This policy does not govern whether a specific procedure is covered under any specific member plan or policy, nor is it intended to address every claim situation. The determination that any service, procedure, item, etc., is covered under a member's benefit plan shall not be construed as a determination that a provider will be reimbursed for services provided. Individual claims may be affected by other factors, including but not necessarily limited to state and federal laws and regulations, legislative mandates, provider contract terms, and THP's professional judgment. Reimbursement for any services shall be subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification, and utilization management guidelines. Unless otherwise noted within the policy, THP's policies apply to both participating and non-participating providers and facilities. THP reserves the right to review and revise these policies periodically as it deems necessary in its discretion, and it is subject to change or termination at any time by THP. THP has full and final discretionary authority for its interpretation and application. Accordingly, THP may use reasonable discretion in interpreting and applying this policy to health care services provided in any case. No part of this policy may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, whether electronic, mechanical, photocopying or otherwise, without express written permission from THP. When printed, this version becomes uncontrolled. For the most current information, refer to the following website: healthplan.org.

DEFINITIONS, ACRONYMS, TERMS

Institutional Claim	Claim submitted on a UB-04 (paper) or 837i (electronic)
Facility	Billing provider facility

BACKGROUND

The Health Plan (THP) partners with 6 Degrees Health (6DH) to conduct pre-payment integrity audits on its institutional claims.

POLICY

The Health Plan (THP) will submit to 6 Degrees Health (6DH), select pending institutional claims to conduct and administer a pre-payment audit.

THP will contact the facility via phone to request supporting documentation i.e., UB-04 form copy and itemized bill, as applicable.

Once the provider facility submits the required documentation within timely filing limits, THP will submit to 6DH.

6DH will review the claim and applicable supporting documentation to determine coding accuracy.

Within thirty (30) calendar days of receipt of a claim from THP and applicable supporting documentation from the provider facility, one of the following outcomes will occur:

1. If 6DH determines coding is incorrect, 6DH will USPS mail a determination letter to the facility's billing address on the claim and the facility must submit a replacement claim to THP within timely filing limits with the appropriate coding identified in the letter.
2. If 6DH determines coding is correct, THP will process the claim and no further action is needed by the provider facility unless requested by 6DH or THP.

Facility has the right to appeal 6DH findings within 180 days from the date of service by emailing, mailing, or faxing appeal and supporting documentation to the 6DH contact information on the determination letter.

Facility may appeal a single determination once. 6DH will respond to the appeal within seven (7) business days through the method in which the provider submitted the appeal.

If the facility appeals and the decision is overturned, 6DH will notify THP and the facility, and THP will process the claim.