

AB1455 DOWNSTREAM PHYSICIAN NOTICE

CLAIMS SETTLEMENT PRACTICES & DISPUTE RESOLUTION MECHANISM

As required by Assembly Bill 1455, the California Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care. This information notice is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes for commercial HMO, POS, and, where applicable, PPO products where IPA/Medical Group is delegated to perform claims payment and Physician dispute resolution processes. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

I. Claims Submission Instructions

- A. Sending Claims to IPA/Medical Group. Claims for services provided to beneficiaries assigned to IPA/Medical Group must be sent to the following:

Via Mail, or Physical Delivery:	IPA/Medical Group 4909 Lakewood Blvd., Suite 200 Lakewood, CA 90712
Via e-mail:	felicia.howard-spalding@coasthealthcare.net
Via Fax:	(562) 529-2807

- B. Calling IPA/Medical Group Regarding Claims. For claim filing requirements or status inquiries, you may contact IPA/Medical Group by calling: (562) 602-1563.
- C. Claim Submission Requirements. The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by IPA/Medical Group:
- (i) Claims must be submitted within ninety (90) days from date of services or payment may be denied. IPA/Medical Group shall pay or deny Physician's claims within sixty (60) calendar days or according to regulatory guidelines.
 - (ii) IPA/Medical Group has the right to request "reasonably relevant information" to determine the nature, cost and extent of the liability for the adjudication of claims.
- D. Claim Receipt Verification. For verification of claim receipt by IPA/Medical Group, please do the following:
Physician can request claims receipt verification via facsimile at (562) 529-2807 or telephone at (562) 602-1563.

II. Dispute Resolution Process for Contracted Physicians

- A. Definition of Contracted Physician Dispute. A contracted Physician dispute is a Physician's written notice to IPA/Medical Group and/or the beneficiary's applicable health plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually

numbered) or disputing a request for reimbursement of an overpayment of a claim. Each contracted Physician dispute must contain, at a minimum the following information: Physician's name; Physician's identification number, Physician's contact information, and:

- (i) If the contracted Physician dispute concerns a claim or a request for reimbursement of an underpayment of a claim from IPA/Medical Group to a contracted Physician the following must be provided: claim number, a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the Physician believes the payment is underpaid or incorrect;
- (ii) If the contracted Physician dispute is not about a claim, a clear explanation of the issue and the Physician's position on such issue; and
- (iii) If the contracted Physician dispute involves a beneficiary or group of beneficiaries, the name and identification number (s) of the beneficiary or beneficiaries, a clear explanation of the disputed item, including the date of service and Physician's position on the dispute, and the beneficiary's written authorization for Physician to represent said beneficiaries.

B. Sending a Contracted Physician Dispute to IPA/Medical Group. Contracted Physician disputes submitted to IPA/Medical Group must include the information listed in Section II.A. above, for each contracted Physician dispute. All contracted Physician disputes must be sent to the attention of the Director of Claims as follows:

Via Mail or Physical Delivery:	Director of Claims IPA/Medical Group 4909 Lakewood Blvd., Suite 200 Lakewood, CA 90712
Via e-mail:	felicia.howard-spalding@coasthealthcare.net
Via Fax:	(562) 529-2807

C. Time Period for Submission of Physician Disputes.

- (i) Contracted Physician disputes must be received by IPA/Medical Group within 365 days from Physician's action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute, or
- (ii) In the case of inaction, contracted Physician disputes must be received within 365 days after the Physician's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
- (iii) Contracted Physician disputes that do not include all required information as set forth above in Section II.A. may be returned to the submitter for completion. An amended contracted Physician dispute which includes the missing information may be submitted to IPA/Medical Group within thirty (30) working days of your receipt of a returned contracted Physician dispute.

D. Acknowledgment of Contracted Physician Disputes. IPA/Medical Group will acknowledge receipt of all contracted Physician disputes as follows:

- (i) Electronic contracted Physician disputes will be acknowledged by IPA/Medical Group within two (2) working days from date of receipt by IPA/Medical Group.
 - (ii) Paper contracted Physician disputes will be acknowledged by IPA/Medical Group within fifteen (15) working days from date of receipt by IPA/Medical Group.
- E. Contact IPA/Medical Group Regarding Contracted Physician Disputes. All inquiries regarding the status of a contracted Physician dispute or about filing a contracted Physician dispute must be directed to Director of Claims at: (562) 602-1563 ext. 249.
- F. Instructions for Filing Substantially Similar Contracted Physician Disputes. Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:
- 1. Sort Physician disputes by similar issue
 - 2. Provide cover sheet for each batch
 - 3. Number each cover sheet
 - 4. Provide a cover letter for the entire submission describing each Physician dispute with references to the numbered coversheets.
- G. Time Period for Resolution and Written Determination of Contracted Physician Dispute. IPA/Medical Group will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the date of receipt of the contracted Physician dispute or the amended contracted Physician dispute.
- H. Past Due Payments. If the contracted Physician dispute or amended contracted Physician dispute involves a claim and is determined in whole or in part in favor of the Physician, IPA/Medical Group will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination.

III. Dispute Resolution Process for Non-Contracted Physicians

- A. Definition of Non-Contracted Physician Dispute. A non-contracted Physician dispute is a non-contracted Physician's written notice to IPA/Medical Group challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted Physician dispute must contain, at a minimum, the following information: the Physician's name, the Physician's identification number, contact information, and:
- (i) If the non-contracted Physician dispute concerns a claim or a request for reimbursement of an underpayment of a claim from IPA/Medical Group to Physician the following must be provided: a claim number, a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the Physician believes the payment amount, request for additional information, contest, denial, request for reimbursement, or other actions;
 - (ii) Physician must attach a medical record to support the claim being contested and information related to his/her experience and credentials.

(iii) If the non-contracted Physician dispute involves a beneficiary or group of beneficiaries, the name and identification number(s) of the beneficiary or beneficiaries, a clear explanation of the disputed item, including the Date of Service, Physician's position on the dispute, and an beneficiary's written authorization for Physician to represent said beneficiaries.

B. Dispute Resolution Process. The dispute resolution process for non-contracted Physicians is the same as the process for contracted Physicians as set forth in sections II.B, II.C., II.D., II.E., II.F., II.G. and II.H. above. In addition, see page 5 for internal policies related to claim submission by non-contracted providers.

IV. Claim Overpayments

- A. Notice of Overpayment of a Claim. If IPA/Medical Group determines that it has overpaid a claim, IPA/Medical Group will notify the Physician in writing through a separate notice clearly identifying the claim, the name of the patient, the Date of Service(s) and a clear explanation of the basis upon which IPA/Medical Group believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.
- B. Contested Notice. If the Physician contests IPA/Medical Group notice of overpayment of a claim, the Physician, within 30 Working Days of the receipt of the notice of overpayment of a claim, must send written notice to IPA/Medical Group stating the basis upon which the Physician believes that the claim was not overpaid. IPA/Medical Group will process the contested notice in accordance with IPA's/Medical Group's contracted Physician dispute resolution process described in Section II above.
- C. No Contest. If the Physician does not contest IPA's/Medical Group's notice of overpayment of a claim, the Physician must reimburse IPA/Medical Group within thirty (30) Working Days of the Physician's receipt of the notice of overpayment of a claim.
- D. Offsets to Payments. IPA/Medical Group may only offset an uncontested notice of overpayment of a claim against Physician's current claim submission when:
- (i) the Physician fails to reimburse IPA/Medical Group within the timeframe set forth in Section IV.C., above, and
 - (ii) IPA's/Medical Group's contract with the Physician specifically authorizes IPA/Medical Group to offset an uncontested notice of overpayment of a claim from the Physician's current claims submissions. In the event that an overpayment of a claim or claims is offset against the Physician's current claim or claims pursuant to this section, IPA/Medical Group will provide the Physician with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

AB1455 DOWNSTREAM PHYSICIAN NOTICE
INTERNAL POLICY REGARDING PAYMENT TO NON-CONTRACTED PROVIDERS

Purpose:

To establish a payment methodology for paying claims to non-contracted providers as outlined in AB1455 and hold members harmless from balance billing by non-contracting providers.

Hospital Based Physicians

All non-contracted hospital based physicians will be paid according to the Group's established usual and customary rates for services provided in relation to emergency services. Usual and customary rates will be determined using the most current average contracted rate for professional services accepted by all hospital based physicians at hospitals in the Group's local service area. Usual and customary rates will be reviewed twice a year, in January and July.

A claim received for a high-level emergency or trauma service requires attachment of medical records and information related to the experience and credentials of the physician. The claim, along with the supporting documents, will be reviewed by the Medical Director and a determination will be made by the Medical Director related to the appropriateness of the coding and a payment above the usual and customary rate may be made based upon this review.

All Other Non-Contracted Physicians:

Other non-contracted providers will be paid a "good faith payment" if records and provider credentials **are not** included with the claim. If there are records and credentials attached, or a dispute is received, medical records and information related to the skill, training and experience of the provider are required in order to make a final payment determination. Once this information is received, the Medical Director will review all information related to the physician and services and make a determination based on the information received and his/her review. This determination will be sent to Contracting for negotiation and Claims for final resolution and notice to the Provider.

If the Group and Provider cannot agree on a payment resolution the Group will offer the Provider to access the DMHC's Independent Review Process.

Other:

The Explanation of Benefit (EOB) will include a statement that claims are paid under usual and customary rates and/or will alert the physician if additional information is required in order to make a determination (i.e., medical records, etc.).

Appeal Procedure:

1. Provider must submit a written Provider Dispute form in compliance with AB1455. The physician should supply medical records and information related to his/her experience and credentials. A dispute form with the requirements listed, can be downloaded from Coast's website at www.coasthealthcare.net
2. All Providers will receive notice of determination regarding their dispute within the timeframe required under AB1455.

Fee Schedules:

The Medicare fee schedule can be accessed at www.cms.hhs.gov/pfslookup/

Healthy Families and MediCal line of business utilizes the MediCal fee schedules and this can be accessed at www.medi-cal.ca.gov.

The Provider Dispute Form, along with related requirements, can be found at www.coasthealthcare.net.