<u>Dignity Health Medical Group Inland Empire</u>

Downstream Provider 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 **Dignity Health Medical Group Inland Empire ("DHMG IE")** is delegated to perform claims payment and provider 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. **Claim submission instructions.**

A. <u>Sending Claims to ***Dignity Health Medical Group Inland Empire "DHMG IE":***</u> . Claims for services provided to members assigned to *Dignity Health Medical Group Inland Empire* must be sent to the following:

Via Mail: ***Dignity Health Medical Group Inland Empire***
P.O. Box 10369
San Bernardino, CA 92423
Attn: ***<u>CLAIMS DEPT</u>***

<u>Via Clearinghouse, Office Ally</u>: To send claims via Group's Claims clearinghouse, claims may be sent electronically through Office Ally using Payer "DHFIE".

B. <u>Calling *Group* Regarding Claims</u>

1. <u>Calling IPA/Medical Group</u>: For claim filing requirements or status inquiries, you may contact ***DHMG IE*** by calling: ***1(800) 339-2964***
2. <u>Calling Clearinghouse:</u> If utilizing a clearinghouse you must contact them directly for filing requirements and /or status inquires.

C. <u>Claim Submission Requirements</u>. The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by ***DHMG IE***

Claims must be submitted within (90) calendar days of the date of service or payment may be denied. When billing for Services Provider shall submit to Group statements for such services rendered to Group Members, including all necessary Provider and Group Member identification, including: (a) the Group Member's name and I.D. number; (b) Provider's name; (c) date and place of service; (d) diagnosis code; (e) procedure for the appropriate line of business; (f) billed charges; (g) copies of any required referral or other authorization forms and (h) attachments and /or supplemental information or documentation which provides the relevant information necessary to determine payer liability. Supplement reports shall include – (1) A copy of the emergency room report for emergency room physicians billing, (2) Any information related to coordination of benefits and /or (3) Supplemental information necessary to support billing for services other that those authorized. Such billings shall be on the CMS 1500 or its successor format adopted by the National Uniform Claim Committee (NUCC) or UB04 form or its successor format adopted by the National Uniform Billing Committee, as appropriate.

D. Claim Receipt Verification.

1. For verification of claim receipt by *Dignity Health Medical Group Inland Empire* within 15 days working days (20 calendar days) of receipt, you may utilize the following option:

Telephone:
*You may call the provider service telephone number at :**1(800) 339-2964***

II. Dispute Resolution Process for Contracted Providers

A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to *Dignity Health Medical Group Inland Empire* and/or the member'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 provider dispute must contain, at a minimum the following information: provider's name; provider's identification number, provider's contact information, and:

i. If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from *Dignity Health Medical Group Inland Empire* to a contracted provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;

ii. If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and

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

B. Sending a Contracted Provider Dispute to Group. Contracted providers must use the Provider Dispute Resolution Form , a copy of which has been attached to this notice. Additional copies may be obtained by written request to the address listed below. Contracted provider disputes submitted to ***DHMG E*** must include the information listed in Section II.A., above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of ***Provider Dispute Resolution Unit*** for the Group at the following:

Via Mail: ***Dignity Health Medical Group Inland Empire***
Provider Dispute Resolution Unit
P.O. Box 10369
San Bernardino, CA 92423

C. Time Period for Submission of Provider Disputes.

(i) Contracted provider disputes must be received by ***DHMG IE*** within three hundred sixty-five (365) calendar days from the action of the group (such as the remittance explanation of payment date), or

(ii) In the case of inaction, contracted provider disputes must be received by Group Within three hundred sixty-five (365) calendar days after the Group time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

(iii) Contracted provider 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 provider

dispute which includes the missing information may be submitted to ***DHMG IE*** within thirty (30) working days of your receipt of a returned contracted provider dispute.

D. Acknowledgment of Contracted Provider Disputes. ***DHMG IE*** will acknowledge receipt of all contracted provider disputes as follows:

Contracted provider disputes submitted according to according Section II.B. above, will be acknowledged by *Dignity Health Medical Group Inland Empire* within fifteen (15) Working Days of the Date of Receipt by Group.

E. Contact ***DHMG IE*** Regarding Contracted Provider Disputes. All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to **Provider Dispute Resolution Unit (909) 748-6127/ (800) 339-2964.**

F. Instructions for Filing Substantially Similar Contracted Provider Disputes. Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute utilizing Provider Dispute Resolution Form along with, the Multiple ("LIKE') Claim Form (a copy of which has been provided attached to this notice), submitted in the following format:

[Enter instructions for filing substantially similar provider disputes. The following is provided for example only:

i. Sort provider disputes by similar issue
ii. Submit Provider Dispute Resolution form for each batch of similar issues
iii. You may choose to include your own log for multiple issues, but it must contain all field elements as found in the enclosed multiple form along with the Provider Dispute Resolution Form.

G. Time Period for Resolution and Written Determination of Contracted Provider Dispute. *Dignity Health Medical Group Inland Empire* 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 provider dispute or the amended contracted provider dispute.

H. Past Due Payments. If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider**,** ***DHMG IE*** 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 Providers

A. Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a non-contracted provider's written notice to ***DHMG IE*** 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 provider dispute must be submitted on a completed **Provider Dispute Resolution Form** or contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information, and:

i. If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from ***DHMG IE*** to provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect;

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

B. Dispute Resolution Process. The dispute resolution process for non-contracted Providers is the same as the process for contracted Providers as set forth in sections II.B., II.C., II.D., II.E., II.F., II.G., and II.H. above.

IV. Claim Overpayments

A. Notice of Overpayment of a Claim. If ***DHMG IE*** determines that it has overpaid a claim, *Dignity Health Medical Group Inland Empire* will notify the provider 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 ***DHMG IE*** 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 provider contests ***DHMG IE*** notice of overpayment of a claim, the provider, within 30 Working Days of the receipt of the notice of overpayment of a claim, must send written notice to ***DHMG IE*** stating the basis upon which the provider believes that the claim was not overpaid. *Dignity Health Medical Group Inland Empire* will process the contested notice in accordance with ***DHMG IE*** contracted provider dispute resolution process described in Section II above.

C. No Contest. If the provider does not contest ***DHMG IE*** notice of overpayment of a claim, the provider must reimburse ***DHMG IE*** within thirty (30) Working Days of the provider's receipt of the notice of overpayment of a claim.

D. Offsets to payments. ***DHMG IE*** may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse *Dignity Health Medical Group Inland Empire* within the timeframe set forth in Section IV.C., above, and (ii) ***DHMG IE's*** contract with the provider specifically authorizes ***DHMG IE*** to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, ***DHMG IE*** will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims

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PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: **Dignity Health Medical Group Inland Empire**
  P.O. Box 10369
  San Bernardino. CA 92423

***PROVIDER NPI:**	**PROVIDER TAX ID:**
***PROVIDER NAME:**	
iPROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other ______________________________
(Please specify type of "other")

CLAIM INFORMATION ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet) *Number of claims*:___

*** Patient Name:**		**Date of Birth:**
*** Health Plan ID Number:**	**Patient Account Number:**	**Original Claim ID Number:** (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**

DISPUTE TYPE

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Disputing Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Contract Dispute
☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	**Title**	**Phone Number** ( )
Signature	**Date**	**Fax Number**

For Health Plan/RBO Use Only

TRACKING NUMBER ________________________ PROV ID# __________

CONTRACTED _____ NON-CONTRACTED _____

PROVIDER DISPUTE RESOLUTION REQUEST
For use with multiple “LIKE” claims (claims disputed for the same reason)

	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

Page ______ of ____

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**

ICE Approved 10/5/07, effective 1/1/08

PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

INSTRUCTIONS

- This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution.
- The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

TRACKING NUMBER:	**PROVIDER ID or NPI#:**
a. PROVIDER NAME:	**b. CONTRACTED PROVIDER: _____ YES _____ NO**
c. DATE DISPUTE RECEIVED (Date Stamped):	**d. DATE OF INITIAL PAYMENT OR ACTION:**
e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d) _____YES _____ NO (If NO, should be returned to provider without action)	
f.1. DISPUTE TYPE: ☐ CLAIM ☐ APPEAL OF MEDICAL NECESSITY/UM DECISION ☐ BILLING DETERMINATION ☐ OVERPAYMENT DISPUTE ☐ CONTRACT DISPUTE ☐ OTHER _______________ (Please specify type of "other")	
f.2. PROVIDER TYPE: ☐ PROFESSIONAL ☐ INSTITUTIONAL ☐ OTHER	
g. DATE DISPUTE ACKNOWLEDGED:	**h. TURNAROUND TIME (g – c):**

TYPE OF LETTER SENT: **(List the various ICE letters as applicable)**

IF NO ADDITIONAL INFORMATION REQUESTED:

j. DATE OF ACTION:	**k. ACTION TURNAROUND TIME (j – c):**	**l. TYPE OF ACTION** ☐ UPHELD ☐ OVERTURNED ☐ OTHER

IF ADDITIONAL INFORMATION REQUESTED:

m. DATE ADDITIONAL INFO REQUESTED:	**n. TURNAROUND TIME (m – c):**	
o. DATE ADDITIONAL INFO RECEIVED:	**p. RECEIPT TURNAROUND TIME (o – m):**	
q. DATE OF ACTION:	**r. ACTION TURNAROUND TIME (q – o):**	**s. TYPE OF ACTION** ☐ UPHELD ☐ OVERTURNED ☐ OTHER

COMPLETE DESCRIPTION OF DETERMINATION RATIONALE: