Dignity Health Medical Foundation DBA

Dignity Health Medical Network-Ventura and Dignity Health Management Services Org

CLAIM SUBMISSION & PROVIDER DISPUTE RESOLUTION

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 ("commercial HMO plans"). In addition, the Center for Medicare and Medicaid Services (CMS) announced new rules in 2010 pertaining to non-contracted provider payment disputes under Medicare Advantage plans.

This informational notice is intended to inform Providers of your rights, responsibilities and related procedures concerning both claim submission to and claim disputes with DHMN-V for HMO plans This is also to inform you about DHMN-V's Provider Dispute Resolution processes. Unless otherwise defined 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.

Providers are not required to submit all disputes in writing and may, alternatively, telephone DHMN-V at (805) 604-3308 with inquiries or concerns; in which case DHMN-V will respond to the inquiry or concern by following DHMN-V's standard customer service procedures, in lieu of the Provider Dispute Resolution Process outlined below.

Time frames set forth in this procedure are intended to promote timely handling of provider disputes. Failure by DHMN-V to meet any of the specified time frames or to meet and confer with the provider shall not be construed to mean that the dispute has been resolved in the provider's favor; but rather shall be deemed an exhaustion of DHMN-V's internal appeals process, thus freeing the provider to proceed with other remedies available under their contract with DHMN-V.

1. Claim Submission Instructions:

A. **Sending Claims to DHMN-V: Claims for services provided to members assigned to DHMN-V should be sent to the following address within ninety (90) days following the date of service. DHMN-V will make all reasonable exceptions to this deadline due to circumstances beyond the provider's control (e.g., DHMN-V is the secondary payor and provider had to first bill the primary payor, or provider did not have proper insurance information on the patient:**

Via Mail: **DHMN-V– Claims Dept**
PO BOX 51840
Oxnard CA 93031

B. **Calling DHMN-V Regarding Claims: For claim filing requirements or status inquiries, you may contact DHMN-V by:**

Via Web Site: **www.dignityhealth.org/ventura**

Via Telephone: **(805) 604-3308**

C. **Claim Submission Requirements: The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by DHMN-V: Provider shall bill DHMN-V and/or plan for all Covered Services rendered to an Enrollee.**

Provider shall submit to DHMN-V and/or Plan a CMS 1500 or UB 04 claim form (or its successor form).

To expedite processing, claim should include complete billing information, including provider name, billing address, tax ID number, appropriate diagnosis (ICD-10) and procedure (CPT-4 / HCPCS) codes, date of service, along with patient information including name, date of birth, health plan name and ID number.

D. **Claim Receipt Verification: For verification of claim receipt by DHMN-V, please do the following:**

Via Web Site: **www.dignityhealth.org/ventura**

Via Telephone: **(805) 604-3308**

2. **Dispute Resolution Process for Non-Contracted Providers:**

Non-contracted providers may submit disputes only as regards payment issues. To do so, the provider would either follow the procedure below for contracted provider disputes concerning Commercial plans only, or may use DHMN-V's informal process by calling (805) 604-3325 or write to us about or fax your Medicare member payment dispute.

Non-Contracted Providers Disputing Our Payment Rate (commercial claims only). If the non-contracted provider disputes that DHMN-V has allowed Reasonable & Customary Value as its payment rate for services rendered, the provider must include information supporting his/her Reasonable & Customary Value demand (see below list). Disputes solely on the grounds that DHMN-V has not paid the provider at his/her billed charges, without supporting justification, will not be considered complete:

(i) **your training, qualifications and length of time in practice;**
(ii) **the nature of the services provided (medical record if applicable);**
(iii) **the fees usually charged by you and the fees usually paid to you for these services by all payers, including government payers;**
(iv) **the prevailing rates of other similarly qualified physicians in your specialty in your geographic area;**
(v) **other aspects of the economics of your practice that are relevant;**
(vi) **any unusual circumstances in the case; and**
(vii) **any other matter pertinent to a determination of reasonable and customary value.**

The above information requirement is consistent with state regulations set forth in California Code of Regulations, Title 28, Sec.1300.71, inclusive of subsection 1300.71 (a) (3) (B) also referred to as the "Gould Criteria" as well as recent California case law [*Children's Hospital Central California v. Blue Cross of California*, 226 Cal.App.4th 1260 (2014)], the findings of which were also endorsed by the DMHC, California law has been clarified in that a number of factors, including rates actually received and accepted by the provider for similar services by all payers, including government payers, are relevant in determining reasonable and customary value. In a March 11, 2015 letter, DMHC specifically states, "*The Children's Hospital case held that in determining quantum meruit cases the courts should consider a wide variety of evidence, including evidence of agreements to pay and accept a particular price.*" The DMHC (the "Department") further states, "*..the Department's current regulation contains a non-exhaustive list of factors that should be take[n] into consideration. This is not an exclusive list. If applicable, other factors, such as those considered under the common law theory of quantum meruit, may be appropriately applied when determining the reasonable and customary rate.*"

Special Notes for Medicare Payment Disputes from Non-Contracted Providers: For payment disputes involving Medicare Advantage member claims, non-contracted providers have the right to dispute claims only as follows:

A. **Zero ($0) Payments: If the claim was denied in total, you may dispute this directly with the member's health plan. This would technically be a Member Appeal which we are not delegated to handle. See our website notice titled "Medicare Advantage Non-Contracted Provider Payment Appeal Process."**

B. **Payment Rate Dispute: If we determine your claim is payable, Medicare law allows us to pay non-contracted providers at Medicare payment rates, pursuant to §§ 1852 (a) (2) (A) of the Social Security Act. If you believe we have not paid you in accordance with Medicare rates and guidelines, or if you believe we have down-coded your claim inappropriately, you may appeal this directly to us within 120 calendar days of our payment or last action on the claim (for good cause, exceptions to this deadline may be granted). Please note that we apply Medicare correct coding rules and reserve the right to audit your record prior to issuing or adjusting our payment (unlike Medicare carriers who often pay without question, but may perform retroactive audits). If you disagree with our appeal decision or if we fail to respond to your dispute within 30 days, you have a right to a second-level review, under certain conditions, by appealing directly to the member's health plan. You must file your appeal with the health plan within 180 days of our appeal decision or 180 days after expiration of the above 30 days, in the case of inaction on our part.**

3. Dispute Resolution Process for Contracted Providers (Commercial plans only):

A. **<u>Definition of Contracted Provider Dispute:</u> A contracted provider dispute is a provider's written notice to DHMN-V 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 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 DHMN-V, 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 that 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. **<u>Sending a Contracted Provider Dispute to DHMN-V:</u> Contracted provider disputes submitted to DHMN-V must include the information listed in Section 3.A, above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of: Provider Dispute Resolution / DHMN-V at the following:**

Via Mail:	**DHMN-V – Claims Dept** **PO BOX 51840** **Oxnard, CA 93031**
Via E-mail:	**pdr.identitymso@commonspirit.org**
Via Fax:	**(805) 918-4100**

C. **Time Period for Submission of Provider Disputes:**

(i) **Contracted provider disputes must be received by DHMN-V within 365 days from DHMN-V's action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute (Special Note for non-contracted provider payment disputes for Medicare Advantage: If your dispute is not filed with us by 120 days after receipt of our payment, you might not have the right to a second level appeal with the member's health plan.**

(ii) **Contracted provider disputes that do not include all required information as set forth above in Section 3.A. may be returned to the submitter for completion. An amended contracted provider dispute, which includes the missing information may be submitted to DHMN-V within thirty (30) working days of your receipt of a returned contracted provider dispute.**

D. **Acknowledgment of Contracted Provider Disputes (Commercial Plans Only): DHMN-V will acknowledge receipt of all contracted provider disputes as follows:**

(i) **DHMN-V will acknowledge electronic contracted provider disputes within two (2) working days of the date of receipt by DHMN-V.**

(ii) **DHMN-V will acknowledge paper contracted provider disputes within fifteen (15) working days of the date of receipt by DHMN-V.**

E. **Contact DHMN-V 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 DHMN-V at:**

Via Mail:	**PO BOX 51840** **Oxnard, CA 93031**
Via E-mail:	**pdr.identitymso@commonspirit.org**
Via Fax:	**(805) 918-4100**
Via Telephone:	**(805) 604-3308**

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, provided that such disputes are submitted in the following format:**

(i) **Sort by Health Plan (each plan should be submitted separately)**
(ii) **Sort disputes by similar issue / type**
(iii) **Provide cover sheet for each batch**
(iv) **Number each cover sheet**
(v) **Provide a cover letter for the entire submission describing each provider dispute with references to the numbered cover sheets.**

G. **Time Period for Resolution and Written Determination of Contracted Provider Dispute (Commercial plans only): DHMN-V will issue 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; except in the case of non-contracted provider disputes concerning Medicare Advantage Member claims, in which case we will issue our determination within thirty (30) calendar days of receipt of your dispute. Please see Section 2 above for additional information on non-contracted provider payment disputes and second level appeals.**

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, DHMN-V 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. If DHMN-V voluntarily issues a supplemental payment of a commercial claim to a non-contracted provider, which supplement DHMN-V deems in excess of Reasonable & Customary Value, interest may not be applied to the supplemental amount.**

4. Claims Overpayments

A. **Notice of Overpayment of a Claim: If DHMN-V determines that it has overpaid a claim, DHMN-V 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 DHMN-V 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 DHMN-V's notice of overpayment of a claim, the provider, within thirty (30) working days of the receipt of the notice of overpayment of a claim, must send written notice to DHMN-V stating the basis upon which the provider believes that the claim was not overpaid. DHMN-V will process the contested notice in accordance with DHMN-V's contracted provider dispute resolution process described in Section 3 above.**

C. **No Contest: If the provider does not contest DHMN-V's notice of overpayment of a claim, the provider must reimburse DHMN-V within thirty (30) working days of the provider's receipt of the notice of overpayment of a claim.**

D. **Offsets to payments: DHMN-V may offset an uncontested notice of overpayment of a claim against the provider's current claim submissions if the provider fails to reimburse DHMN-V within the time frame set forth above. 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, DHMN-V will provide a detailed written explanation identifying the specific overpayment(s) that have been offset against the specific current claim or claims.**