INDIVIDUAL PRACTICE ASSOCIATION MEDICAL GROUP OF SANTA CLARA COUNTY (SCCIPA)

AB 1455 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 Santa Clara County Individual Practice Association (SCCIPA) 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. Sending claims to SCCIPA. All paper claims and supporting information for services provided to members assigned to SCCIPA, must be submitted to:

Santa Clara County IPA
P.O. Box 5860
San Mateo, CA 94402

For inquiries regarding how to submit claims electronically if not already doing so, contact the **Pacific Partners Management Services, Inc. Information Technology Department at (650) 358-5832.**

B. Contacting SCCIPA Regarding Claims. For claim filing requirements or status inquiries, you may contact SCCIPA using one of the following methodologies
via e-mail by utilizing PPMSI Online claim inquiry
via phone by contacting **Provider Inquiry at 1-800-977-7332**

C. Claim Submission Requirements. The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by SCCIPA:

Complete Claim Definition

A "complete claim" is a claim or portion thereof, if separable, including attachments and supplemental information or documentation, that provides reasonably relevant information or information necessary to determine payer liability and that may vary with the type of service or provider. Reasonably relevant information means the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator to determine the nature, cost, if applicable, and extent of the payer's liability, if any, and to comply with any governmental information requirements. Information necessary to determine payer liability means the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator to determine the nature, cost, if applicable, and extent of the IPA's liability, if any, and to comply with any governmental information requirements.

Claim Information Requirement

When submitting claims, all providers must include, at a minimum, all of the following required information utilizing the CMS-1500 billing format for professional claims and the UB-92 billing format for facility claims:

- Patient's ID number (as they appear on their Plan ID card)
- Patient's name and date of birth (as they appear on their Plan ID card)
- Employer group number
- Submitting provider's tax ID number or Social Security number
- State license number of attending provider
- Submitting provider's name and address
- ICD-9 diagnosis code(s)
- Service date(s)
- Billed charge(s)
- Current year CPT or HCPCS procedure code (physician) or UB-92 revenue code with narrative description (hospital)
- CMS place of service code (professional claims only)
- Number of days or units for each service line

Additional Documentation Requirement

- **By report**: include the operative report or chart notes for report procedures.
- **Unlisted procedures**: include a complete description of the service rendered along with the operative report or chart notes.
- **Unusual services**: when billing modifier 22, (unusual services) include report or chart notes.
- **Coordination of benefits (COB)**: When SCCIPA is the secondary payor; the provider must submit the claim and a copy of the Explanation of Medical Benefits/Explanation of Benefits (EOMB/EOB) from the primary carrier to SCCIPA for payment consideration.
- **Medical Supplies**: itemize all supplies using HCPCS codes when possible. If expecting reimbursement at invoice cost, a copy of the invoice must accompany the claim.
- **Injectable medications**: list appropriate HCPCS code identifying medication name, NDC number, strength, dosage and method of administration.

Claim Filing Timeframe

If your contract does not contain a specific filing deadline, SCCIPA will follow a 90-calendar day timely filing requirement for contracted providers. If SCCIPA is not the primary payer under coordination of benefits (COB) rules, the claim submission period begins on the date the primary payer has paid or denied the claim.

II.Dispute Resolution Process for Contracted Providers

A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to SCCIPA 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 SCCIPA 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 SCCIPA. Contracted provider disputes submitted to SCCIPA must include the information listed in Section II.A., above, for each contracted provider dispute. Providers must use a Provider Dispute Resolution Request Form, which is attached to the back of this notice. All contracted provider disputes must be sent to the attention of the Provider Dispute Resolution Team at SCCIPA at the following address:

Santa Clara County IPA
Attn: Provider Dispute Resolution Team
P.O. Box 5860
San Mateo, CA 94402

C. Time Period for Submission of Provider Disputes.

i. Contracted provider disputes must be received by SCCIPA within 365 days from provider'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 provider disputes must be received by SCCIPA within 365 days after the provider's 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 retuned to the submitter for completion. An amended contracted provider dispute, which includes the missing information, may be submitted to SCCIPA within thirty (30) working days of your receipt of a returned contracted provider dispute.

D. Acknowledgement of Contracted Provider Disputes. SCCIPA will acknowledge receipt of all contracted provider disputes as follows:

i. Electronic contracted provider disputes will be acknowledged by SCCIPA within two (2) Working Days of the Date of Receipt by SCCIPA.
ii. Paper contracted provider disputes will be acknowledged by SCCIPA within fifteen (15) Working Days of the Date of Receipt by SCCIPA.

E. Contact SCCIPA 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 Inquiry at: 1-800-977-7332**

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 and batch disputes by issue
ii. Provide a Provider Dispute Resolution Form for each unique issue/batch
iii. Number each Resolution Form
iv. List individual claims involved in each batch using the back of the Resolution Form
v. Provide a cover letter for the entire submission describing each provider dispute with references to the numbered Provider Dispute Resolution Forms.

G. Time Period for Resolution and Written Determination of Contracted Provider Dispute. SCCIPA 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, SCCIPA 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 SCCIPA 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 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 SCCIPA 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. Unless otherwise specified in the Provider contract, if SCCIPA determines that it has overpaid a claim, SCCIPA 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 SCCIPA 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 SCCIPA's 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 SCCIPA stating the basis upon which the provider believes that the claim was not overpaid. SCCIPA will process the contested notice in accordance with SCCIPA's contracted provider dispute resolution process described in Section II above.

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

D. Offsets to payments. SCCIPA may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when;

   i. the provider fails to reimburse SCCIPA within the timeframe set forth in Section IV.C., above, and
   ii. SCCIPA's contract with the provider specifically authorizes SCCIPA 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, SCCIPA 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.

SANTA CLARA COUNTY INDIVIDUAL PRACTICE ASSOCIATION (SCCIPA)
CLAIMS PAYMENT PROTOCOLS

- **Coding Standards**
  SCCIPA utilizes industry standard coding methodologies for claims adjudication. Those methodologies include
  - Current Procedural Terminology (CPT)
  - Healthcare Common Procedure Coding System (HCPCS)
  - American Society of Anesthesiologists (ASA)
  - International Classification of Diseases, Ninth Revision (ICD-9)

  SCCIPA recognizes CPT guidelines for modifiers. Reimbursement is in accordance with these guidelines.

- **Code Review (unbundling and up-coding)**
  SCCIPA utilizes Auto-Audit, a claim screening system that assesses the appropriateness of medical claims payments in the context of the patients' medical claims history. The system uses extensively detailed, widely accepted clinical methodologies to flag claims that require further review based on the diagnosis, age/sex of the patient, claims history and code relationships.

- **Multiple Procedures**
  If two or more surgeries in the same operative session are billed, the major procedure is pay at 100 percent of its allowable rate, the secondary procedure is paid at 50 percent of its allowable rate, and the third and subsequent procedures are paid at 25 percent of their allowable rate.

- **Surgical Follow-up Care**
  SCCIPA utilizes the Global Period guidelines outlined in current year RBRVS. Any follow-up care or services performed within the global period of the procedure are considered included in the reimbursement for the procedure and will not receive additional reimbursement.

- **Co-Surgeons**
  If two surgeons with different skills are required to manage a specific surgical problem (e.g. a urologist and a general surgeon in the creation of an ilial conduit) value of the procedure will be 125 percent of the customary value listed. The adjusted value is apportioned in relation to the responsibility and work done.

- **Assistant Surgeons**
  Assistant surgeons' claims are paid at 20 percent of the surgeon's allowable rate. If multiple procedures are performed, the primary surgery is payable at 20 percent of the surgeon's allowable rate, the secondary procedure is paid at 10 percent of the surgeon's allowable rate, and the third and subsequent procedures are paid at 5% of the surgeon's allowable rate.

- **Anesthesia Services**
  Anesthesia claims are adjudicated utilizing the American Society of Anesthesiologists Relative Value Guide. Time units are allowed at one unit per 15 minutes for the first four hours, one unit per 10 minutes thereafter.

Physicians should refer to their current agreement for specific reimbursement variances.

- **Global Obstetrical Services**
  Global reimbursement for total OB care (uncomplicated) includes:
  - Office or other outpatient visits or consultations (includes routine OB visits for new and established patients)
  - Routine labwork such as urinalysis
  - Routine venipuncture (collection) and handling or conveyance of specimen for the purpose of transfer from the physician office to a laboratory
  - Delivery (vaginal or Caesarean), antepartum and postpartum care

Non-continuous coverage will be handled in the following manner:

Member switches from one SCCIPA OB-GYN to another.

- Services incurred prior to the switch in OB doctors will be paid at standard SCCIPA fee-for-service rate to the first OB-GYN for each visit. The provider must furnish an itemized bill indicating specific service dates, procedure codes and charges within 90 days of the date they were notified of member's change.
- The delivering OB-GYN will be reimbursed a percentage of the Global rate determined by the trimester in which the patient transferred into their care. The percentage breakdown is as follows:
  - For care from second trimester until delivery – 80% of global rate
  - For care from third trimester until delivery – 70% of global rate
  - Transfers for delivery only will be reimbursed at the SCCIPA rate for 59409 "vaginal delivery only" or 59514 "cesarean delivery only"
  - These prorated reimbursements will not be reduced by any amounts paid to the previous treating OB-GYN.

Member becomes covered with SCCIPA less than 6 months prior to delivery (within the second trimester).

- The delivering OB-GYN will be reimbursed a percentage of the Global rate determined by the trimester in which the patient transferred into their care. The percentage breakdown is as follows:
  - For care from second trimester until delivery – 80% of global rate
  - For care from third trimester until delivery – 70% of global rate
  - Transfers for delivery only will be reimbursed at the SCCIPA rate for 59409 "vaginal delivery only" or 59514 "cesarean delivery only"

Member terminates coverage with SCCIPA.

- Services rendered prior to the termination date will be paid at standard SCCIPA fee-for-service rate for the actual services rendered. However, these fee-for-service rates will not exceed the overall Global rate. The provider must furnish an itemized bill indicating specific service dates, procedure codes and charges within 90 days of the date they were notified of member's change.

When the provider who followed the patient throughout the pregnancy calls in another OB to perform the actual delivery via c-section, the following rules will apply:

- The delivering provider will be reimbursed the rate for delivery only (or delivery and postpartum care depending on the actual procedure code billed).
- The OB global rate will be reduced by the amount paid to the delivering provider. This amount is the maximum payable to the provider who performed antepartum care only. Proration percentages apply to this amount depending on when the member became effective with SCCIPA or transitioned to this particular provider for services.

Physicians should refer to their current agreement for specific reimbursement of OB services.

PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS

- ***Please complete the below form. Fields with an asterisk (*) are required.***
- ***Be specific when completing the DESCRIPTIONOF 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.***
- ***For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.***
- ***Mail the completed form to:***
  Santa Clara County IPA
  P.O. Box 5860
  San Mateo, CA 94402

***PROVIDER NAME:**	***PROVIDER TAX ID # / Medicare ID #:**
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health ☐ 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	☐ Seeking Resolution Of A Billing Determination
☐ Appeal of Medical Necessity / Utilization Management Decision	☐ Contract Dispute
☐ Request For Reimbursement of Overpayment	☐ Other:

*** DESCRIPTION OF DISPUTE:**

*** EXPECTED OUTCOME:**

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

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

For Health Plan Use Only
TRACKING NUMBER
PROVIDER ID #

PROVIDER DISPUTE RESOLUTION REQUEST

(For use with multiple "LIKE" claims)

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

Provider Name: _____ Provider Tax ID # / Medicare ID #: _____

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

For Health Plan Use Only
TRACKING NUMBER
PROVIDER ID #

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED