CHOC Health Alliance 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 CalOptima Kids Medi-Cal, members where CHOC Health Alliance 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 CHOC Health Alliance</u>. Claims for services provided to members assigned to CHOC Health Alliance must be sent to the following:

Via Mail:

Rady Children's Hospital San Diego Attn: CHOC/CPN Claims 3020 Children's Way, Mail Code 5144 San Diego, CA 92123

Via Clearinghouse: Contact the Provider Relations Department (800) 387-1103

- B. <u>Calling CHOC Health Alliance Regarding Claims</u>. For claim filing requirements or status inquiries, you may contact CHOC Health Alliance by calling: (800) 387-1103
- C. <u>Claim Submission Requirements</u>. The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by CHOC Health Alliance:

Contracted providers shall file claims within ninety (90) calendar days and noncontracted providers within 180 calendar days from the date of provision of Covered Service to Healthy Families enrollees. Failure to submit claims within the Prescribed time period may result in payment delay and/or denial. If a claim is denied for timely filing but the provider can demonstrate "good cause for delay" through the provider dispute resolution process, CHOC Health Alliance will accept and adjudicate the claim as if it had been submitted within the provider's claim filing timeframe. Providers shall use the most current diagnostic and procedure coding guidelines, including but not limited to International Classification of Diseases (ICD), American Medical Association Current Procedural Technology (AMA CPT), Health Care Financing Administration Common Procedural Coding System (HCPCS), Diagnostic Statistical Manual (DSM), Current Dental Terminology (CDT), Uniform Billing Data Elements (UB-92) Specification Manual, and State identified CPT/HCPCS codes as directed by CHOC Health Alliance.

D. <u>Claim Receipt Verification</u>. For verification of claim receipt by CHOC Health Alliance, please call (800) 387-1103.

CHOC Health Alliance will acknowledge receipt of paper claims within (15) business days after the date of receipt of the claim. Claims received electronically will be acknowledged within (2) business days after the date of receipt of the claim.

II. Dispute Resolution Process for Contracted Providers

A. <u>Definition of Contracted Provider Dispute</u>. A contracted provider dispute is a provider's written notice to CHOC Health Alliance 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 CHOC Health Alliance 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. <u>Sending a Contracted Provider Dispute to *CHOC Health Alliance*. Contracted provider disputes submitted to *CHOC Health Alliance* 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 Complaints at the following:</u>

Via Mail:	Rady Children's Hospital San Diego Attn: CHOC/CPN Provider Appeals 3020 Children's Way, Mail Code 5144 San Diego, CA 92123
Via Physical Delivery:	Rady Children's Hospital San Diego Attn: CHOC/CPN Provider Appeals 3020 Children's Way San Diego, CA 92123

- C. Time Period for Submission of Provider Disputes.
 - (*i*) Contracted provider disputes must be received by CHOC Health Alliance within 365 calendar days from CHOC Health Alliance'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 CHOC Health Alliance's inaction, contracted provider disputes must be received by CHOC Health Alliance within 365 calendar 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 returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to CHOC Health Alliance within thirty (30) working days of your receipt of a returned contracted provider dispute.
- D. <u>Acknowledgment of Contracted Provider Disputes</u>. CHOC Health Alliance will acknowledge receipt of all contracted provider disputes as follows:
 - *i.* Electronic contracted provider disputes will be acknowledged by CHOC Health Alliance within two (2) Working Days of the Date of Receipt by CHOC Health Alliance.
 - *ii.* Paper contracted provider disputes will be acknowledged by CHOC Health Alliance within fifth teen (15) Working Days of the Date of Receipt by CHOC Health Alliance.

- E. <u>Contact CHOC Health Alliance Regarding Contracted Provider Disputes</u>. All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to CHOC Health Alliance at: (800) 387-110.
- F. <u>Instructions for Filing Substantially Similar Contracted Provider Disputes</u>. 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 provider disputes by similar issue
 - *ii.* Provide cover sheet for each batch
 - *iii.* Number each cover sheet
 - *iv.* Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheets

G. <u>Time Period for Resolution and Written Determination of Contracted Provider Dispute</u>. CHOC Health Alliance 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. <u>Past Due Payments</u>. 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, CHOC Health Alliance 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. <u>Definition of Non-Contracted Provider Dispute</u>. A non-contracted provider dispute is a noncontracted provider's written notice to CHOC Health Alliance 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 CHOC Health Alliance 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. <u>Dispute Resolution Process</u>. 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., D.G., and II.H. above.

IV. Claim Overpayments

A. <u>Notice of Overpayment of a Claim.</u> If CHOC Health Alliance determines that it has overpaid a claim, CHOC Health Alliance 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 CHOC Health Alliance believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

B. <u>Contested Notice.</u> If the provider contests CHOC Health Alliance'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 CHOC Health Alliance stating the basis upon which the provider believes that the claim was not overpaid. CHOC Health Alliance will process the contested notice in accordance with CHOC Health Alliance's contracted provider dispute

resolution process described in Section II above.

- C. <u>No Contest.</u> If the provider does not contest CHOC Health Alliance's notice of overpayment of a claim, the provider must reimburse CHOC Health Alliance within thirty (30) Working Days of the provider's receipt of the notice of overpayment of a claim.
- B. <u>Offsets to payments.</u> CHOC Health Alliance may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse CHOC Health Alliance within the timeframe set forth in Section IV.C., above, and (ii) CHOC Health Alliance's contract with the provider specifically authorizes CHOC Health Alliance 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, CHOC Health Alliance 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.