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 and POS products where Group 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 Group. Please submit all paper claims which are the financial responsibility of the affiliated IPA to the P.O. Box designated below. Claims that are the financial responsibility of the members affiliated Health Plan should be submitted directly to the health plan. For clarification of which claims are health plans risk, please contact the provider relations representative of the IPA.

B.

Via Mail:

GROUP NAME:	CLAIMS ADDRESS:
All Optum Care Networks (Formerly PrimeCare, Primary Care Associates, & Valley Physicians Network)	P.O. Box 6903 Rancho Cucamonga, CA 91729-6903 Attn: CLAIMS
Mercy Physicians Medical Group	P.O. Box 6907 Rancho Cucamonga, California 91729-6907 Attn: CLAIMS

Via Clearinghouse: You will need to follow the instructions of Group's contracted clearinghouse. Group currently accepts electronic submissions from ***Office Ally, Capario,*** and ***Emdeon***.

C. Calling Group Regarding Claims.

1) Calling IPA/Medical Group: For claim filing requirements or status inquiries, you may contact Group by calling: **(800) 956-8000**

2) Calling Clearinghouse: If utilizing a clearinghouse you must contact them directly for filing requirements and/or status inquiries.

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

Claims must be submitted within ninety (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 a full itemization of services rendered. Each statement shall include 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(s); (e) current year procedure code(s); (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 payor liability. Supplement reports shall include - 1) A copy of the emergency room report for emergency room physician billing, 2) Any information related to coordination of benefits and/or 3) Supplemental information necessary to support billing for services other than those authorized. Such billings shall be on the CMS 1500 or its successor format adopted by the National Uniform Claim Committee (NUCC) or UB 92 form or its successor format adopted by the National Uniform Billing Committee (NUBC), as appropriate.

E. Claim Receipt Verification.

i. For verification of receipt of paper claim by Group within fifteen (15) working days of receipt, you may utilize one of the following options:

Telephone – You may call the Customer service telephone number at (800) 956-8000.
Provider Portal Website – https://www.nammnet.com/. For information about access to this web site, please contact your group's Provider Services representative.

ii. You may verify the receipt of your electronic claims by contacting your clearinghouse directly.

II. Dispute Resolution Process for Contracted Providers

A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to Group 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 Group to a contracted provider the following must be provided: a clear identification of the disputed item such as the claims number, 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.** Copies may be obtained at http://www.nammcal.com/ClaimsContact.aspx. Contracted provider disputes submitted to Group must include the information listed above in Section II.A. for each contracted provider dispute. All contracted Provider Dispute Resolution Form(s) should be submitted electronically via Secure Provider Portal by using your User account at https://www.nammnet.com

C. If you do not have an account your Provider Disputes can be sent to the attention of the Provider Dispute Resolution Unit at the following address or fax number.

Via Mail: Provider Dispute Resolution Department
P.O. Box 6902
Rancho Cucamonga, CA 91729-6902
OR
Fax Submission #: (866) 929-7165

D. Time Period for Submission of Provider Disputes.
(i) Contracted provider disputes must be received by Group within three hundred sixty-five (365) calendar days from 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'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 Group within thirty (30) working days of your receipt of a returned contracted provider dispute.

E. Acknowledgment of Contracted Provider Disputes. Group will acknowledge receipt of all contracted provider disputes as follows:
i. Contracted provider disputes submitted according to Section II.B. above, will be acknowledged by Group within fifteen (15) Working Days of the Date of Receipt by Group.

F. Contact Group 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 the Provider Dispute Resolution Unit for Group at (800) 956-8000.

G. 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 the **Provider Dispute Resolution Form along with the Multiple ("LIKE") Claim Form**, submitted in the following format:

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 Request form.

H. Time Period for Resolution and Written Determination of Contracted Provider Dispute. 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 provider dispute or the amended contracted provider dispute.

I. 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, 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 Providers

A. Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a non-contracted provider's written notice to 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 provider dispute must be submitted on a completed **Provider Dispute Resolution Form** and can be faxed in to **(866) 929-7165 or mailed to address as listed in Section II.B.**

i. If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Group 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 above in sections II.B., II.C., II.D., II.E., II.F., II.G. and II.H.

IV. Claim Overpayments

A. Notice of Overpayment of a Claim. If Group determines that it has overpaid a claim, Group 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 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 provider contests Group'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 Group stating the basis upon which the provider believes that the claim was not overpaid. Group will process the contested notice in accordance with Group's contracted provider dispute resolution process described in Section II above.

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

D. Offsets to payments. Group may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse Group within the timeframe set forth above in Section IV.C. and (ii) Group's contract with the provider specifically authorizes Group 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, Group 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.

V. Fee Schedules and Other Required Information

A. Claim payment policies and rules are available at http://www.nammcal.com/ClaimsContact.aspx.