NON-CONTRACT PROVIDER DISPUTE AND APPEALS PROCESS

For Post-Service Claim Payment Issues

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Department of Managed Health Care
Provider Complaint Unit
980 9th Street, Suite 500
Sacramento, CA 95814

A signed WOL is not needed for Payment Disputes.

• Corrected or Rejected claims should not be submitted as a dispute or appeal. They are considered a new claim and should be sent to MEHP Claims Department for an initial Determination and will not be processed as a dispute or appeal. New claims should be mailed to:

MEHP.
Attn: CLAIMS
750 Medical Center Court, Suite 2
Chula Vista, CA 91911
Tel 619.421.1659 Tel/Fax. (619) 365-4346

Required Information

(See following page for required documentation)

Non-Contracted Provider Information:

• Non-Contracted Provider's Name
• Non-Contracted Provider's Tax ID #/Medicare ID #
• Non-Contract Provider's Address
• Non-Contract Provider Type (specify type – MD, Hospital, Ambulance, DME, etc.)
• Non-Contract Provider's Contact Name
• Non-Contract Provider's Contact Title
• Non-Contract Provider's Contact Phone #
• Non-Contract Provider's Contact Fax #

Member Information:

- Patient's Name (First, Middle, Last)
- Patient's Date of Birth
- Health Plan Name
- Patient's Account/ID #

Claim Information:

- Original Claim #
- Dates of Service (from/to)
- Original Claim Amount Billed
- Original Claim Amount Paid

DISPUTE/APPEAL TYPE	REQUIRED DOCUMENTATION
Rate/Fee Dispute – Dispute request for a claim that was paid or denied at an incorrect fee.	• Copy of fee schedule in effect during the dates of service • Copy of claim
Coding Edit Revise – Request for a claim that was denied or adjusted for CCI edit or bundling.	• Appropriate supporting documentation, e.g., OP report, path report • Letter stating rationale for complication • Copy of claim
Medical Necessity/Utilization Management Decision – Request for a claim that was denied on initial medical necessity review.	• Appropriate medical records, e.g., ER records, H&P, discharge summary (**Do not** send daily notes unless requested) • Rationale for service performed • Copy of claim

Addresses for Submitting a Non-Contract Provider Dispute or Appeal

Non-contract providers must mail a written request to MEHP at:

Provider Disputes:

MEHP
Provider Dispute Resolution
750 Medical Center Court, Suite 2
Chula Vista, CA 91911
Tel 619.421.1659 Tel/Fax. (619) 365-4346

Provider Appeals:

MEHP
Appeals Department
750 Medical Center Court, Suite 2
Chula Vista, CA 91911
Tel 619.421.1659 Tel/Fax. (619) 365-4346

Clearly indicate whether you are submitting a dispute (when full or partial payment was made on the initial Determination) or an appeal (when zero payment was initially made).

Deadlines for Submitting Non-Contract Provider Disputes and Appeals

Dispute/PDR – Non-contract providers have 120 calendar days from the initial Determination date (i.e., EOB/RA/determination letter) to file a written request for a dispute with MEHP.

Appeal/Reconsideration – Non-contract providers have 60 calendar days from the initial adverse determination date (i.e. EOB/RA/determination letter) to file a written request for an appeal with MEHP.

Resolution Time Frame for Non-Contract Provider Disputes and Appeals

MEHP will resolve each non-contract provider claim payment dispute (PDR) within 30 calendar days of receipt of the written request. Claim payment appeals will be resolved within 60 calendar days of receipt.

Non-Contract Provider Second-Level Independent Review Entity Process

Dispute/PDR – The non-contacted provider may submit a second-level written request for an independent Payment Dispute Decision (PDD) from MEHP via fax or mail within 120 calendar days of written notice from MEHP. Refer to the MEHP website at http://www.mediexcel.com/ for forms.

The PDD request may only be filed if:

• The non-contract provider received an initial Dispute decision from MEHP; or

• MEHP did not finalize or respond to the non-contract provider's Dispute within 30 calendar days.

Appeal/Reconsideration – If MEHP upholds the initial claim decision, The Department of Managed Health Care of California (DMHC) requires that MEHP send all cases in which we have not changed our decision to an IDRP External Reviewer.

After receiving the case file, the IDRP External Reviewer will contact the non-contract provider to advise where to send any additional information and about other rights that the non-contract provider may have.

WAIVER OF LIABILITY STATEMENT

_____ _____

Patient Name

_____ _____

Subscriber ID Number

_____ _____

Provider Name (Please Print)

_____ _____

Provider Tax ID Number

_____

Service “From/To” Date

MediExcel Health Plan

Beneficiary’s Health Plan

I hereby waive any right to collect payment from the above-mentioned patient for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

_____ _____

Signature / Date

_____ _____

Print Name / Telephone Number with Area Code

Provider Dispute Resolution Request Form

Instructions:

Please fully complete the form. Information with an asterisk (*) is required. Be specific when completing the Description of Dispute and Expected Outcome. Please provide supporting documentation to support your appeal.

Mail the completed form to:

Or fax the complete form to:

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

Address:

Provider Type: MD Mental Hospital Hospital ASC SNF

DME Home Health Rehab Ambulance

Other (Please specify)

Claim Information Single Multiple “LIKE” Claims (Please provide listing)

Number of claims

*Patient Name: *Date of Birth:

*Health Plan ID #: Patient Account Number: Original Claim ID Number (if multiple cases provide separate listing):

*Service From/To Date: Original Claim Amount Billed: Original Claim Amount Paid:

Dispute Type: Claim Seeking Resolution of Billing Determination

Appeal of Medical Necessity Other Requirement for Reimbursement of Overpayment

*Description of Dispute:

*Expected Outcome:

Contact Name (Please Print) Title Phone Number

Contact Name (Please Print) Title Phone Number Check if additional information is attached.

Information Regarding DMHC Independent Dispute Resolution Process (IDRP)

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Independent Dispute Resolution Process (IDRP) – General Information

The Department of Managed Health Care (DMHC) established an Independent Dispute Resolution Process (IDRP) to afford non-contracted providers who deliver EMTALA-required emergency services (“Providers”) a fast, fair and cost-effective way to resolve claim payment disputes with health care service plans or capitated providers ("Payers") concerning the “reasonable and customary” value of services rendered. IDRP is voluntary and non-binding as to both Providers and Payers.

To submit a claim dispute for review through the IDRP, the Provider must complete and submit an IDRP Request Form with supporting documentation. Upon receipt of the Provider’s request, the DMHC will review the provider’s submission and then contact the Payer to confirm the Payer’s willingness to participate in the IDRP with regard to the disputed claim. If the Payer declines to participate, the Provider will be notified. If the Payer elects to participate, the Payer will then provide its supporting documentation to the DMHC. Upon receipt of the Payer’s documentation, information concerning the claims dispute is forwarded to the IDRP External Reviewer, who may request further documentation or information, as needed.

A Provider may request review through the IDRP for an individual claim or for multiple claims (up to a total of 50 substantially similar claims.)

The IDRP utilizes a decision process that is similar to the "baseball style" model of arbitration. Accordingly, the IDRP External Reviewer is required to decide which figure (either the Provider’s billed amount, or the Payer’s paid amount) is most representative of the reasonable and customary value of the emergency services that were rendered. The IDRP External Reviewer cannot “split the difference” or choose a different amount (outside of those submitted by one of the parties). Note: Under the IDRP, a hospital provider may elect to lower its billed amount in connection with the hospital’s IDRP submission.

Ordinarily, an IDRP decision will be issued within sixty (60) days of receipt of required Provider and Payer documentation.

Except as required by law, documentation and information submitted to DMHC regarding disputed claims considered through IDRP will remain confidential.

Participation in IDRP is voluntary and, while the process is non-binding, DMHC feels that IDRP decisions may offer Providers and Payers a fast, fair and cost effective alternative to other slower

and more costly legal remedies. As such, the parties are encouraged to comply with the decision issued by the IDRP External Reviewer.

Eligible Claims

Eligible claim disputes are those disputes which are subject to DMHC jurisdiction and meet each of the following four criteria:

The disputed claim is limited to emergency services rendered by non-contracted physicians or hospitals.

The services were rendered within the last four years.

The dispute is limited to disagreement concerning the reasonable and customary value of the services rendered.

The Provider has completed the Payer's dispute resolution process.

Examples of ineligible claims:

Disputes concerning claims that have not been submitted to the Payer's dispute resolution process.

Disputes concerning claims that are currently in arbitration or litigation in state or federal court.

Late payment disputes.

Interest payment disputes.

Medi-Cal program claim disputes for which the State of California's "Fair Hearing Process" has commenced.

Claim disputes that are not subject to DMHC jurisdiction.

Claim disputes with health plans licensed or regulated by another state.

Disputes regarding claims that do not involve covered benefits.

Claims denied on the basis that the services were not medically necessary or were experimental/investigational in nature.

Complaint Fee Schedule

Currently, there is no IDRP complaint filing fee for individual physicians.

For hospital providers, the number of disputed claims listed on the IDRP Request Form determines the filing fee. Substantially similar claims can be aggregated up to fifty (50) in a single IDRP Request Form. "Substantially similar" claims are those that involve the same or similar services and the same Payer. Fees are subject to change without notice.

For hospital provider complaints:

1 individual claim - $100.00

2 to 10 claims - $200.00

11 to 25 claims - $400.00

26 to 50 claims - $600.00

How to Submit an Independent Dispute Resolution Process (IDRP) Request Form

1. Print and complete an IDRP Request Form.

2. Attach the supporting documentation listed on the IDRP Request Form.

3. Send the IDRP Request Form and the supporting documentation to:

Department of Managed Health Care
Provider Complaint Unit
980 9th Street, Suite 500
Sacramento, CA 95814

Prior to filing your complaint with the Department of Managed Health Care, please determine if your complaint is against a health plan (or a Medical Group or IPA that is contracted with a health plan) licensed under the Knox-Keene Health Care Service Plan Act of 1975. A list of all licensees is available. We are only able to review complaints against Knox-Keene licensees. Please verify your complaint concerns one of these health plans. Please be aware that with the exception of Blue Cross of California and Blue Shield of California, the Department does not have jurisdiction over most PPO plans. We do not have jurisdiction over self-funded plans although a self-funded plan may be administered by a Knox-Keene licensee.

We do not have jurisdiction over Blue Cross Life and Health products. Blue Cross Life and Health products are regulated by the California Department of Insurance. Please see the Department of Insurance regarding complaints about Blue Cross Life and Health.

The Department is unable to review complaints against Medicare Managed Health Plans. Complaints against Medicare Managed Health Plans should be submitted to the Centers for Medicare and Medicaid Services (CMS).

About the Provider Complaints Process

The Department of Managed Health Care recognizes that billing by providers and the handling of claims by health care service plans and their capitated providers are essential components of the health care delivery system. It has committed to make both more effective and efficient. This web page has been designed as part of a pilot project to accept and review provider complaints. The new electronic submission will allow the Department to look at complaint submissions to ensure that health plans and their capitated providers have implemented claims processing standards, contract disclosures and the dispute resolution mandates of the Knox Keene Health Care Service Plans Act (AB1455).

The Department's area of authority is limited to Health Maintenance Organizations (HMOs) and two PPO's - Blue Cross and Blue Shield of California. Before reporting a problem with a health plan, you should verify that the plan is regulated by the Department. To view a list of the plans regulated by the Department of Managed Health Care, go to HMO Reports.

Complaints within this area of jurisdiction will be closely reviewed in two steps:

Unfair Payment Pattern and Emerging Trend Analysis will be performed on ALL electronically filed provider complaints, including any which have not gone through the payor dispute resolution process. This review will be based on tracking and trending of the information provided within each complaint form filed. Data provided in these forms will be analyzed and reported to a Departmental Executive Review Committee, which will conduct monthly reviews to look for evidence of payor "unfair payment patterns." This group will be looking for prevalent types of payment, payor or contract issue problems. This analysis will help identify patterns of dissatisfaction with the existing Payor dispute resolution process. The data accumulated will provide the basis of targeted Departmental follow-up investigations, and follow-up actions to eliminate the root cause of these problems.

Case Review of provider complaints will be more limited based on staffing available to conduct these reviews. This process will require a verification of the facts presented in an electronically

filed complaint by comparing it with relevant documentation. When a Case Review has been initiated, the Department will open a case file and will request the provider to submit relevant documentation. Upon receipt of the documentation, the Department will determine whether there is non-compliance with the provisions of the Knox-Keene Act, and its recent amendments in AB1455(2001). In many instances, a case review will make a determination of whether claims should have been paid, or whether interest is due. In-depth analysis of the results of case reviews will also supplement the findings of Emerging Trend Analysis, to insure appropriate follow-up.

The Department recognizes that it is important for hospitals, doctors and other providers to be paid promptly and accurately, and our Provider Complaint process is offered as a primary means of ensuring prompt payment.

Reporting a Problem to the Department

If you would like to report a problem regarding claims payment, please complete an online Provider Complaint form.

For individual complaint disputes you wish to submit, please complete an Individual Provider Complaint Form. For multiple "like" complaint disputes you wish to submit, please complete a Multiple Provider Complaint Form. This will enable the Department to commence a substantive review, which may identify system patterns or problems with particular health plans or capitated providers.

Before reporting a problem with a health plan, you should verify that the Department regulates the plan. To view a list of the plans regulated by the Department of Managed Health Care, go to HMO Reports.

All Provider Complaint Form submissions will be tracked for trends and emerging patterns of demonstrable and unjust payment patterns. Before the Department can commence a review, the provider is required to submit the dispute to the payor's Dispute Resolution Mechanism for a minimum of 45 working days or until receipt of the payor's written determination, whichever period is shorter.

Please complete this form in as much detail as possible to report your concern with a health care service plan (health plan) or one of the health plan's capitated providers who pay claims.

Appropriate supporting documentation is a prerequisite for a review of any issue. Upon submission of your complaint, an acknowledgement of the Department's receipt of your complaint will be e-mailed to you along with a complaint number, a list of the required supporting documentation and instructions for submitting the documentation.

The Department may forward any information submitted with a provider complaint form to the payor for a response.

The Department is often compelled to make hard choices in light of the resources available to it. Therefore, the Department reserves the right to identify priorities and to process complaints consistent with those priorities.

A Word about Reasonable and Customary Payment Complaints

The Knox-Keene Act's Regulations, Title 28, Section 1300.71(a) (3) (B), require payors to reimburse non-contracted providers in an amount equal to the reasonable and customary value of the service. In the past several years the Department has seen a tremendous surge in complaints from non-contracted providers concerning reasonable and customary value payments by payors. The Department is not statutorily empowered to set rates for services.

The Department considers the fair reimbursement of providers a serious issue. Accordingly, in November 2009 the Department began an in depth data collection and study of the rates being paid in California. As of June 2010, the Provider Complaint Unit can no longer accept complaints which predominantly concern whether a payor's reimbursement constitutes the usual, customary, and reasonable amount. The PCU will instead accept these complaints only for IDRP resolution.

Submitting More Information During A Case Review

If you have already filed a complaint that was accepted for Case Review, and you would now like to submit more information for consideration, please mail it with a copy of the original case Confirmation Receipt, or with a letter that includes the assigned case number and other identifying information. These materials can be sent to:

Department of Managed Health Care
Provider Complaint Unit
980 9th Street, Suite 500
Sacramento, CA 95814
(877) 525-1295
(916) 255-2282 Fax
pcu@dmhc.ca.gov

Please note that if your case is in PENDED or CLOSED status, additional materials will not be reviewed. For further information you may call the number listed above.

MEDIEXCEL HEALTH PLAN

Claim List Continued

Please complete one line for **each claim.** Provider **may submit its own list, if similar.**

	Claim Number	Patient Last Name	Patient ID #	Date of Service	Amount Billed	Amount Paid	Alternate Amount
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
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49							
50							

MEDIEXCEL HEALTH PLAN

2nd Level Payment Dispute Decision (PDD) Request Form

Fill out all sections as required. Missing or incomplete information may result in your request being dismissed as invalid.

Provider/Supplier Contact Information

Provider name: _____

Provider correspondence street address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____

E-mail address: _____

Pricing Information

NPI number: _____ Zip code where services were rendered: _____

Physician specialty, if dispute is on a physician claim: _____

Plan name/number: _____

Reason for Payment Dispute – a description of the specific issue

(A separate attachment may be utilized if necessary)

_____)_)_____

_____

The following information ***MUST*** be submitted with this form:

1. Copy of the provider/supplier's submitted claim with disputed portion identified
2. Copy of the MEHP original payment determination
3. Copy of the MEHP's redetermination (dispute) payment decision
4. Copy of the relevant portion of any supporting documentation and correspondence that support your position that the plan's payment is not correct (this may include interim rate letters and/or documentation reflecting payment from identical services)
5. Appointment of Provider Representative Authorization Statement, if applicable

MEDIEXCEL HEALTH PLAN

Requester's Information

Name: _____

Title and company name: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Relationship to provider _____

Phone number: _____

E-mail address: _____

Requester's signature: _____

Date signed: _____

- **For electronic submissions only, in lieu of a signature:**

By checking this box, I certify that I have proper authorization to submit this payment dispute on behalf of this provider.

MEHP.
Attn: Second Level Dispute Processing
750 Medical Center Court, Suite 2
Chula Vista, CA 91911
Tel 619.421.1659 Tel/Fax. (619) 365-4346