Preferred IPA of California

Claims Settlement Practices

Provider Notification

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 notice is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes. 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.

This information is also available for contracted physicians in the Preferred IPA Provider Manual and for all other providers on the Preferred IPA website:

www.preferredipa.com

Preferred IPA
Provider Notice

Claim Submission Instructions

A. Sending Claims to Preferred IPA. Claims for services provided to members assigned to Preferred IPA must be sent to the following:

Via Electronic Submission:	Office Ally (866)575-4120 or (360)975-7000
Via Mail:	Preferred IPA Attn: Claims Department P.O. Box 4449 Chatsworth, CA 91313
Via Physical Delivery:	9131 Oakdale Avenue, Suite 150 Chatsworth, CA 91311
Via Fax:	(818) 407-1699

B. Calling Preferred IPA Regarding Claims. For claim filing requirements or status inquiries, you may contact Preferred IPA by calling: (800) 874-2091. The claims inquiry telephone line is open Monday through Friday from 9 a.m. – 4 p.m. The claims inquiry telephone line will be closed on Federal Holidays.

C. Claim Submission Requirements. The following is a list of claim submission requirements for Preferred IPA:

Timely submission of claims: Claims must be received at the claims address above within 180 days from the date of service. Claims received which exceed the timely filing limit must be accompanied by documentation supporting the reason for the late submission. Claims not received within the timely filing limit may be denied.

Complete Claim submission: Each submitted claim must be complete claim as that term is defined in, Title 28 California Code of Regulations (CCR) §1300.71(a)(2):

"Complete claim" means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides "reasonably relevant information" as defined in section (a)(10), "information necessary to determine payer liability" as defined in section (a)(11) and:

- For emergency services and care provider claims as defined by section 1371.35(j):
  - The information specified in section 1371.35(c) of the Health and Safety Code; and
  - Any state-designated data requirements included in statutes or regulations.
- For institutional providers:
  - The completed UB92 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC;
  - Entries stated as mandatory by NUBC and required by federal statute and regulations; and
  - Any state-designated data requirements included in statutes or regulations.
- For dentists and other professionals providing dental services:
  - The form and data set approved by the American Dental Association;
  - Current Dental Terminology (CDT) codes and modifiers; and
  - Any state-designated data requirements included in statutes or regulations.
- For physicians and other professional providers:
  - The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format;
  - Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD-9CM) codes;
  - Entries stated as mandatory by NUCC and required by federal statute and regulations; and
  - Any state-designated data requirements included in statutes or regulations.
- For pharmacists:
  - A universal claim for and data set approved by the National Council on Prescription Drug Programs; and
  - Any state-designated data requirements included in statues or regulations;
- For providers not otherwise specified in these regulations:
  - A properly completed paper or electronic billing instrument submitted in accordance with the plan's or the plan's capitated provider's reasonable specifications; and
  - Any state-designated data requirements included in statutes or regulations.

In addition, each claim shall include the following information:

Supplemental Claims Information and documentation: In addition to the information described above, supplemental claims information, including medical records and invoices for drugs or durable medical equipment, that is necessary to identify the patient and/or the nature and cost of the services rendered

may be required to process claims. In the event that any supplemental claims information necessary for claims processing is not included with the claims submission, a written request for the supplemental information will be mailed to the provider.

D. Claim Receipt Verification. For verification of claim receipt by Preferred IPA, please do the following (allow 15 working days after the claims submission for paper submissions and 2 working days after the claims submission for electronic submissions prior to requesting receipt verification):

Via Telephone: For claim receipt verification inquiries, you may contact Preferred IPA by calling: (800) 874-2091. The claims inquiry telephone line is open Monday through Friday from 9 a.m. – 4 p.m. The claims inquiry telephone line will be closed on Federal Holidays.

Via Mail: Should you wish to obtain claims receipt verification via mail, please submit a written request to:

Preferred IPA
Attn: Claims Department
P.O. Box 4449
Chatsworth, CA 91313

Preferred IPA of California
Provider Notice

Claims Payments

A. Fee Schedule. Claims are paid at the current contracted rate as outlined on the fee schedule exhibit of your current contract with Preferred IPA. If you need a copy of the current fee schedule exhibit to your contract, please contact Preferred IPA at (818) 265-0800.

Current Medi-Cal rates are available in both viewable and downloadable formats at the following Internet address:

http://files.medi-cal.ca.gov/pubsdoco/rates/rateshome.asp

Current Medicare rates are available in both viewable and downloadable formats at the following Internet address:

https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

- To obtain the correct rate for a valid procedure code that has been billed apply the following formula:

  Contracted % of published fee schedule x **Current fee schedule rate** = **Contract rate**

B. Payment Methodologies. Preferred IPA utilizes the National Correct Coding Imitative edits published by the Centers for Medicare and Medicaid Services to make payments consistent with nationally accepted claims processing standards. These edits clearly identify services, which are components of a major service, mutually exclusive services, and other applicable edits.

C. Global Services. Global services related to surgery, services which are inclusive in a previously billed service or globally covered per the contract provisions will be processed consistent with the latest Current Procedural Terminology (CPT) and other applicable industry standard processing methodologies.

D. Multiple Surgeries: Claims for multiple surgery performed in the same operative session are cut down according to the following schedule:

- 1st Surgical procedure – 100% of contractually allowed amount
- 2nd and subsequent Surgical procedures – 50% of contractually allowed amount
- The following codes are exceptions to the reduced rate for multiple surgeries, in most instances these codes will not be paid at the reduced rate:

11001	20922	33518	44203	63035
11101	20924	33519	44500	63043
11201	20926	33521	44701	63044
11720	20930	33522	44955	63048
11721	20931	33523	47001	63057
11732	20936	33530	47550	63066
11922	20937	33572	48400	63076
11975	20938	33924	48554	63078
11977	20974	34808	49568	63082
13102	20975	34813	49905	63086
13122	20979	34826	51725	63088
13133	21088	35390	51726	63091
13153	21089	35400	51736	63308
15000	22103	35500	51741	64472
15001	22116	35572	51772	64476
15101	22216	35600	51784	64480
15121	22226	35681	51785	64484
15201	22328	35682	51792	64550
15221	22522	35683	51795	64623
15241	22585	35685	51797	64627
15261	22614	35686	54240	64727
15343	22632	35700	54250	64778
15351	22840	36218	56606	64783
15401	22841	36248	58300	64787
15787	22842	36488	58346	64832
16036	22843	36489	58611	64837
17003	22844	36490	59050	64859
17004	22845	36491	59051	64872
17304	22846	36550	59525	64874
17305	22847	36620	60512	64876
17306	22848	36625	61055	64901
17307	22851	36660	61107	64902
17310	26125	36823	61210	65767
19001	26861	37195	61316	66990
19126	26863	37206	61517	67225
19291	27358	37250	61609	67320
19295	27692	37251	61610	67331
19340	31500	38102	61611	67332
20660	32000	38746	61612	67334
20690	32002	38747	61795	67335
20692	32020	38792	62148	67340
20900	32501	43635	62160	69300
20902	33141	44015	62252	69990
20910	33225	44121	62284	
20912	33508	44128	62367	
20920	33517	44139	62368	

E. Assistant Surgeon: Payments made to assistant surgeons will be paid at 20% of the primary surgeon's payment. The 2nd and subsequent surgical procedures will be paid at the reduced fee of: 50% of the contractually allowed amount.

F. Coding Changes: Claims billed with codes that are mutually exclusive or included in a comprehensive procedure will be processed according to the National Correct Coding Imitative (NCCI) edits published by the Centers for Medicare and Medicaid Services to make payments consistent with nationally accepted claims processing standards. Current NCCI edits are available on the Centers for Medicare and Medicaid Services website at:

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinited/

G. Immunizations and injectable medications: Payments for immunizations and injectable medications will be made in accordance with the current health plan guidelines and at the current contracted rates.

H. Modifiers: Claims are processed consistent with the current industry standards for modifiers as described in the Current Procedural Terminology, by The Centers for Medicare and Medicaid Services, and the current Medi-Cal Provider Manual.

Preferred IPA of California
Provider Notice

I. Dispute Resolution Process for Contracted Providers

A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to Preferred IPA 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 Preferred IPA 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 Preferred IPA. Contracted provider disputes submitted to Preferred IPA must include the information listed in Section II.A., above, for each contracted provider dispute. All contracted provider disputes must be sent to Preferred IPA to the attention of the Provider Dispute Resolution Department at the following:

Via Mail:	Preferred IPA Attn: Provider Dispute Resolution Department P.O. Box 4449 Chatsworth, CA 91313
Via Physical Delivery:	Preferred IPA Attn: Provider Dispute Resolution Department 9131 Oakdale Avenue, Suite 150 Chatsworth, CA 91311
Via Fax:	(818)407-1699

C. Time Period for Submission of Provider Disputes.

(i) Contracted provider disputes must be received by Preferred IPA within *365* days from IPA'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 Preferred IPA within *365* days after the IPA's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

(iii) Contracted provider disputes filed within the time period set forth in (i) and (ii) above that do not include all required information as set forth above in Section II.A. may be returned to the submitter with a description of missing information for completion. An amended contracted provider dispute which includes the missing information may be submitted to Preferred IPA within thirty (30) working days of your receipt of a returned contracted provider dispute.

D. Acknowledgment of Contracted Provider Disputes. Preferred IPA will acknowledge receipt of all contracted provider disputes as follows:

i. Electronic contracted provider disputes will be acknowledged by Preferred IPA within two (2) Working Days of the Date of Receipt by Preferred IPA.

ii. Paper contracted provider disputes will be acknowledged by Preferred IPA within fifteen (15) Working Days of the Date of Receipt by Preferred IPA.

E. Contact Preferred IPA 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 Department at Preferred IPA at: (800)874-2091.

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:

Submit substantially similar disputes with a cover letter which describes the provider dispute and references the attached batch of disputes. Include the following information:

i. Include a cover letter for each batch of like disputes which references how many disputes are attached which correspond to the cover sheet.

ii. Include a separate cover letter for each new dispute type with the corresponding batch attached.

iii. Number each page of the batch so that receipt of the entire batch can be confirmed.

iv. Follow instructions to submit the batches of provider disputes as described in the provider dispute resolution process above.

G. Time Period for Resolution and Written Determination of Contracted Provider Dispute. Preferred IPA 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, Preferred IPA 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.

I. Retention of Records. Copies of provider disputes and determinations, including all notes, documents and other information upon which the IPA relied to reach its decision, and all reports and related information shall be retained for at least the period specified in section 1300.85.1 of title 28.

II. **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 Preferred IPA 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 Preferred IPA 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, request for reimbursement for the overpayment of a claim, contest, denial, adjustment, 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 I.B., I.C., I.D., I.E., I.F., I.G., I.H., and I.I above.

PROVIDER DISPUTE RESOLUTION REQUEST
Preferred IPA of California

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF 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.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: Preferred IPA of California
  P.O. Box 4449
  Chatsworth, CA 91313

***PROVIDER NPI:**	**PROVIDER TAX ID:**
***PROVIDER NAME:**	
PROVIDER ADDRESS:	

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

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

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

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**

ICE Approved 10/5/07, effective 1/1/08

For Health Plan/RBO Use Only
TRACKING NUMBER _____ PROV ID# _____
CONTRACTED _____ NON-CONTRACTED _____

PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

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

ICE Approved 10/5/07, effective 1/1/08

Preferred IPA of California
Provider Notice

Claim Overpayments

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

C. No Contest. If the provider does not contest Preferred IPA's notice of overpayment of a claim, the provider shall reimburse Preferred IPA the amount of the overpayment described in the notice of overpayment of a claim within thirty (30) Working Days of the provider's receipt of such notice.

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

E. Overpayment Address. Remit overpayment refunds with a copy of the notice of overpayment or original remittance advice from Preferred IPA to:

Preferred IPA
Attn: Recovery Department
P.O. Box 4449
Chatsworth, CA 91313