San Diego Metro ■ Chula Vista ■ Grossmont ■ Coronado ■ North County

Provider Notice

CLAIMS SETTLEMENT PRACTICES, DISPUTE RESOLUTION MECHANISM & FEE SCHEDULE NOTICE

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 for commercial HMO, Point of Service (POS) and, where applicable, PPO products where Sharp Community Medical Group ("SCMG") is delegated to perform claims payment and provider dispute resolution processes. Even though AB 1455 only applies to services provided to Commercial members, SCMG may, at its discretion, use the same processes for services provided to Senior HMO members. 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 SCMG. Claims for services provided to members assigned to SCMG must be mailed to the following address:

Sharp Community Medical Group
P.O. Box 939037
San Diego, CA 92193-9037

B. Claim Submission Requirements. The following is a summary list of claim timeliness requirements, claims supplemental information and claims documentation required by SCMG; the full list of requirements is available at the SCMG website, www.sharp.com/scmgproviders, "Billing and Claims Payment Procedures":

(i) All claims must be submitted within ninety (90) days of the date of service. Non-contracted providers have a maximum of one hundred and eighty (180) days to submit claims from the date of service.
(ii) Claims must be submitted with all reasonably relevant information to determine payer liability and to ensure timely processing and payment. "Reasonably relevant information" is any relevant and material information that enables a claims adjudicator to determine that the claims in question require a significantly different and separate adjudication process (i.e., operative reports when billing with modifier 50).
(iii) Claims documentation includes a complete and accurate CMS (Centers for Medicare and Medicaid Services) 1500 claim form or UB 92 form (or their successors) adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic form.
(iv) Non-contracted providers must submit a completed IRS Form W-9 with claims.
(v) Coordination of Benefits: if SCMG is the secondary payor, then providers must submit the primary payor Explanation of Benefits (EOB) documentation with applicable claims.

C. Claim Receipt Verification. For verification of claim receipt or claim status inquiries by SCMG, please do the following:

(i) Verify claim receipt and claim status via the Internet through SCMG's IDX Outreach application. If you are interested in signing up for IDX Outreach, please contact our Provider Relations Department at (858) 499-4553.
(ii) Providers can call SCMG's designated Customer Service line at (858)499-2550.
(iii) Providers and SCMG may mutually agree to an alternative accessible method of notification by which provider can readily confirm receipt of claim and recorded date of receipt.

D. SCMG Payment and Billing Policies. SCMG billing and payment policies are consistent with Current Procedural Terminology (CPT) guidelines, and standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies and major credentialing organizations. SCMG utilizes proprietary Claims Check® software that reviews billing codes for appropriateness and adjusts claim payments accordingly.

E. Claims Scanning. SCMG scans claims using Optical Character Recognition (OCR) software to capture claims information directly from claim forms. OCR output is largely dependent on the accuracy and legibility of the claim form submitted, therefore claim forms must:

- Be legible. Change typewriter ribbon/PC printer cartridge frequently, if necessary. Laser printers are recommended;
- Contain Black Ink;
- Contain Pica, Courier 10, or Courier 12 font type; and
- Contain CAPITAL letters.

Claim forms should not have:

- Broken characters;
- Script;
- Stylized print;
- Italic print;
- Mini-font;
- Proportional pitch (use only typefaces that have the same width for each character). Avoid Dot Matrix font;
- Liquid correction fluid changes;
- Data touching box edges or running outside of numbered boxes (instead, center claim information in each box). Exception: when using the 8-digit date format, information may be typed over the dotted lines shown in date fields, i.e., Item 24a.
- More than six service lines per claim (use a new form for additional services);
- Narrative descriptions of procedure, narrative description of modifier or narrative description of diagnosis (the CPT, Modifier or ICD-9 CM codes are sufficient);
- Stickers or rubber stamps (such as "tracer", "corrected billing," provider name and address, etc);
- Special characters (i.e., hyphens, periods, parentheses, dollar signs and ditto marks);
- Handwritten claims; or
- Attachments smaller than 8 ½" x 11".

The claim form must be:

- An original CMS-1500 (12/90) or UB 92 printed in red "drop out" ink with the printed information on back (photocopies are not acceptable);
- Size – 8 ½" x 11" with the printer pin-feed edges removed at the perforations;
- Free from crumples, tears, or excessive creases (to avoid this, submit claims in an envelope that is full letter size or larger);
- Thick enough (20-22lbs.) to keep information on the back from showing through; and
- Clean and free from stains, tear-off pad glue, notations, circles or scribbles, strikeovers, crossed out information or white out.

F. <u>Modifiers</u>. SCMG recognizes modifiers in accordance with CPT guidelines.

- <u>Modifier 25</u>: Significant, Separately Identifiable Evaluation and Management (E & M) service by the Same Physician on the Same Day of the Procedure or Other Service.

  A provider may need to indicate that on the day a procedure or service was performed the patient's condition required a significant, separately identifiable E & M service above and beyond the other service provided, or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E & M service may be prompted by the symptom or condition for which the procedure and/ or service was provided. As such, different diagnoses are not required for reporting of the E & M services on the same day. (This modifier is not used to report an E&M service that resulted in a decision to perform major surgery). The patient's records must contain information to support the use of modifier 25.

  Visits by the same physician on the same day as a surgical procedure with 000 or 010 days postoperative or endoscopy procedures that are related to the standard preoperative evaluation or recovery from the procedure are included in the global reimbursement for the procedure. However, if a significant separately identifiable service is performed and is clearly documented in the patient's records, payment can be made for the visit when billed with modifier 25. This modifier is not used to report an E&M service that resulted in a decision to perform surgery (see modifier 57 below).

  On a case-by-case basis medical records may be requested to validate documentation.

- <u>Modifier 26</u>: Split Global, Professional (26) & Technical Component (TC) – Only certain services include a technical and professional component. Many Fee Schedules include separate allowances for these services. Certain procedures are a combination of a physician component (professional) and a technical component. When the physician component is reported separately, the service may be identified by adding modifier "26" to the usual procedure number. SCMG recognizes only patient specific professional services billed with Modifier 26.

- <u>Modifier 50</u>: Bilateral Procedure - Procedures performed on both sides of the body or body area during the same operative session and on the same day are called bilateral procedures. Procedures which are usually performed as bilateral procedures or the code descriptor specifically states that the procedure is bilateral, should not be

reported with bilateral modifiers. Use of modifier 50 indicates that a procedure is bilateral, indicating that the procedure is performed twice during the same operative session. When billing for bilateral services the quantity in the units field should always be one. Bilateral procedures are reimbursed at 150% of the contracted allowable.

- Modifier 51: Multiple procedures- when the same provider performs multiple procedures, other than E/M services, at the same session, the primary procedure or service may be reported as listed. Appending the modifier 51 to the additional procedure or service code(s) may identify the additional procedure(s) or service(s). The payment for procedures billed with a modifier 51 will be reduced to 50% of the contracted allowable.

- Modifier 57: Decision to Perform Surgery – An evaluation and management service that resulted in the initial decision to perform the surgery.

- Modifier 59: Distinct Procedural Service - Under certain circumstances, the provider may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encounters or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Document in Box 19 of the CMS 1500 the explanation for the use of modifier 59 or Box 84 of the UB92. Include medical records such as operative reports if the documentation can support the use of modifier 59.

- Modifier 80: Assistant Surgeon - Surgical assistant services are identified by adding the modifier 80 to the procedure. Procedures with a modifier 80 appended will be paid at 16% of the contracted allowable amount.

G. Global Surgical Package. The CPT codes that represent readily identifiable surgical procedures include, on a procedure-by-procedure basis, a variety of services. The following services are always included in the global reimbursement rate, in addition to the surgical procedure:

- local infiltration, metacarpal/metatarsal/digital block or topical anesthesia;
- subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical);
- immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
- writing orders;
- evaluating the patient in the post-anesthesia recovery area; and
- typical postoperative care.

Follow-up care for therapeutic surgical procedures includes only that care which is usually a part of the surgical service.

II. Dispute Resolution Process for Providers

A. Definition of Provider Dispute. A provider dispute is a provider's written notice to SCMG 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 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 provider dispute concerns a claim or a request from SCMG for reimbursement of a claim overpayment the following must be provided on the Provider Dispute Resolution Request Form (available at www.sharp.com/scmgproviders): 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 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 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 Provider Dispute to SCMG. Provider disputes submitted to SCMG must include the information listed in Section II.A., above, for each provider dispute. SCMG's Provider Dispute Resolution Form can be found on SCMG's website: http://www.sharp.com/scmgproviders, or you can call your Provider Services Representative to obtain a copy. All provider disputes must be sent to the attention of **"SCMG Provider Dispute Department"** at the following address:

Sharp Community Medical Group
Attention: Provider Dispute Department
P.O. Box 939034
San Diego, CA 92193-9034

C. Time Period for Submission of Provider Disputes.

(i) Provider disputes must be received by SCMG within three hundred and sixty-five (365) days from SCMG's action that led to the dispute (or the most recent action if there are multiple actions), or

(ii) In the case of SCMG's inaction, provider disputes must be received by SCMG 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) 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 provider dispute that includes the missing information may be submitted to

SCMG within thirty (30) working days (approximately 45 calendar days) of your receipt of a returned contracted provider dispute.

D. Acknowledgment of Provider Disputes. SCMG will acknowledge receipt of all provider disputes within fifteen (15) working days of the date of receipt by SCMG.

E. Contact SCMG Regarding Provider Disputes. All inquiries regarding the status of a provider dispute or about filing a provider dispute must be directed to SCMG at: (858) 499-2550.

F. Instructions for Filing Substantially Similar 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 and on SCMG's "Multiple 'Like' Claims Spreadsheet", available at www.sharp.com/scmgproviders:

Please submit similar disputes as follows:

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. Time Period for Resolution and Written Determination of Provider Dispute. SCMG will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days (approximately sixty (60) calendar days) after the date of receipt of the provider dispute or the amended provider dispute.

H. Past Due Payments. If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, SCMG 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. Claim Overpayments

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

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

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

IV. Fee Schedules

A. If the basis of your reimbursement is Medicare, please review your contract and see the Medicare website below to determine your reimbursement:

www.medicarenhic.com/cal_prov/fee_sched.shtml

B. If the basis of your reimbursement is not Medicare, please see your individual agreement. If after reviewing your agreement and the claims payment polices and rules and you sill have questions, please contact your provider services representative.

V. Contractual Time Frames

If the time frames in your agreement with SCMG for the submission of claims is less than ninety (90) days from the date of service or has no reference to a claims submission time frame, the time frame to submit claims for dates of service January 1, 2004 and forward will now be ninety (90) days. Any other timeframes that do not meet the minimum requirements outlined in the AB 1455 Regulations will now be considered to be those timeframes required by law.

For further information regarding the AB1455 Regulation, please refer to the California Department of Managed Health Care's website address:

http://www.dmhc.ca.gov/library/regulations/existing.