HUMBOLDT INDEPENDENT PRACTICE ASSOCIATION
CLAIMS SETTLEMENT PRACTICES AND DISPUTE RESOLUTIONS 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 procedures as they relate to claim settlement practices and claim disputes for commercial HMO, POS and, PPO plans where the Humboldt Independent Practice Association (Humboldt IPA) is delegated to perform claims payment and provider dispute resolution processes.

As a contracted provider you have agreed to look only to IPA or Health Plan for compensation for medically necessary Covered Services and at no time shall seek compensation from Health Plan Members for such services except in the case of the co-payment or coinsurance permitted under Health Plan or in the case of billing for services not covered under the Health Plan. Providers shall be responsible for the collection of such co-payments or coinsurance.

It is the responsibility of the party providing services to obtain prior authorization when required. Please refer to IPA's website http://humboldtipa.com/auth.php for a list of services that require prior auth.

I. Claim Submission Instructions

A. Sending Claims to Humboldt IPA. Claims for services provided to members assigned to Humboldt IPA contracted health plans must be sent to the following:
Mail: Humboldt IPA, 2315 Dean St., Eureka, CA 95501
Office: Humboldt IPA, 2315 Dean St., Eureka, CA 95501
Fax: (707) 443-2527
Clearinghouse: Contact your clearinghouse partner for instructions and submit using the below payor identification for the member's health plan.

Health Plan	Office Ally 949-464-9129 x215
Anthem Blue Cross CaliforniaCare	hdnfc
Blue Lake Rancheria	hdnfc
Blue Shield CalPERS	hdnfc
UIHS Purchased Referred Care	hdnfc
Employee Assistance Program	hdnfc

B. Contacting Humboldt IPA Regarding Claims. For Claim filing requirements or status inquiries, you may contact Humboldt IPA's Customer Service Department at:
Telephone: (707) 443-4563 or, toll free at (866) 443-4563
Email: csr@humboldtipa.com
Fax: (707) 443-2527
Website: www.humboldtipa.com

C. Claims Submission Requirements. The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by the Humboldt IPA as required by Assembly Bill 1455.

D. Claims Filing Timeframe
Humboldt IPA will accept claims from contracting providers if they are submitted within 90 calendar days from the date of service except as described below. If Humboldt IPA is not the primary payer under coordination of benefits (COB) rules, the claim submission period begins on the date the primary payer has paid or denied the claim. Claims not received within the timely filing period will be denied. If

a claim is denied for timely filing but the provider can demonstrate "good cause for delay" through the provider dispute resolution process, Humboldt IPA will accept and adjudicate the claim as if it had been submitted within the provider's claim filing timeframe.

When a Provider submits a claim that they know in advance will be subject to denial for the 90 days timely filing, the Provider must attach evidence of timely filing to the claim and make a note somewhere on the claim(s) stating that timely filing evidence was provided.

Acceptable proof of timely filing would be:

- An explanation of benefits or claim denial letter from another carrier, which shows the original claim was sent within 90 days of the date of service. However, the claim must be submitted to the Humboldt IPA within 120 days of the date of the EOB/denial letter.
- A copy of a clearinghouse report indicating a successful transmission or batch number to the Humboldt IPA within 90 days of the date of service.
- Provider's computer-generated electronic claims transaction verification report showing the claim was sent within 90 days of the date of service.
- Provider's computer-generated report showing the claim was sent to the Humboldt IPA within 90 days.
- Evidence that the member provided incorrect insurance information at the time of the visit and the provider completed follow-up on the unpaid claim within 90 days of the date of service.

E. Complete Claims Definition

Humboldt IPA will adjudicate complete claims. A complete claim is a claim, or portion of a claim, including attachments and supplemental information or documentation, that provides reasonably relevant information or information necessary to determine payer liability and that may vary with the type of service or provider. Reasonably relevant information means the minimum amount of itemized, accurate, and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator to determine the nature, cost, if applicable, and extent of Humboldt IPA's liability, if any, and to comply with any governmental information requirements. Information necessary to determine Humboldt IPA liability means the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator to determine the nature, cost, if applicable, and extent of the plan's liability, if any, and to comply with any governmental information requirements. In addition, Humboldt IPA may require additional information from a provider where the Humboldt IPA has reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices.

F. <u>Claims Submission Information Instructions</u>

When submitting claims, providers must include, at a minimum, the following information:

Patient's Identification Number	Identification number on the patient's ID card.
Patient's last name and first name	Enter name exactly as it appears on the patient's ID card. Do not use nicknames or special symbols.
Patient date of birth	Do not include "/" or "-".
Employer group number	
Referring provider name	Not required for primary care provider claims.
Rendering provider name	Enter the provider's name. Do not cover it when signing the form.
Rendering Provider's Tax ID or Social Security number	No spaces or "-"are necessary.
ICD-10 Diagnosis	Decimal points are optional. Current year codes are required and

Codes	deleted codes will be rejected after a 90-day grace period.
Date(s) of Service	Enter both From and To dates.
Place of Service	Use the current 2-digit CMS codes (Professional claims only).
Type of Service	Use the current 2-digit CMS codes (Professional claims only).
CPT or HCPCS Code (professional claims) OR UB-92 Revenue code with description (hospital claims)	Current year codes required and deleted codes will be rejected after a 90-day grace period. Use only standard modifiers.
# of days or units per service line (professional claims only)	Enter actual quantity. "010" will be read as "10".
Billed Charge	
Authorization number, if required	Include medical records if necessary.
Locum Tenens Physicians	Indicate physician for whom they are providing coverage.
Primary payer remittance advice	Required only when submitting secondary claim for payment.
Injury information	Required only when submitting claim for injury-related services.
Invoice	Required only when billing DME, orthotics and supplies.
Medical Records	• When service billed requires authorization and it does not match the service authorized or is in addition to service authorized. • When an unlisted (XXX99) code is being billed.

G. Date of Receipt

Date of receipt is the business day when a claim is first delivered, electronically or physically, to the Humboldt IPA's designated address.

H. Reimbursement of Claims

Humboldt IPA will reimburse each claim, or portion thereof, according to the agreed upon contract rate no later than 45 working days after receipt of the claim unless the claim is contested or denied. Humboldt IPA reserves the right to adjudicate claims using reasonable payment policies and non-standard coding methodologies that are consistent with standards accepted by nationally recognized medical organization, federal regulatory bodies and major credentialing organizations.

I. Virtual Examiner Edits

The Humboldt IPA processes claims following the requirements set forth by the Department of Managed Health Care and the Department of Corporations. *Industry Collaborative Effort* resources are used when available. The *Trilogy Claims Administration* is used as a resource where applicable. The *Virtual Examiner* (VE) program is used to apply the National Correct Coding Initiative Policy Manual for Medicare Services and Current Procedural Terminology correct coding policies. All VE denials are applied to claims submitted by IPA members, except when specifically exempted by the Executive Committee of the Humboldt IPA Board of Directors. The Executive Committee also approves guidelines for review of claims recommended for review by VE.

J. Interest on Late Payment of Claims

The late payment on a complete claim for emergency services that is neither contested nor denied will automatically include the greater of:

- $15 for each 12-month period or portion thereof on a non-prorated basis, or
- Interest at the rate of 15 percent per year for the period of time that the payment is late.

Late payments on all complete claims for non-emergency services will automatically include interest at the rate of 15 percent per annum for the period of time that the payment is late. If Humboldt IPA does not automatically (within five days of the late claim payment) include the interest fee with a late-paid complete claim or the interest was under paid, an additional $10 will be sent to the provider of service. Interest payments for less than $2.00 may be mailed by the 10th of the following calendar month.

If Humboldt IPA fails to notify the provider of service in writing of a denied or contested claim, or portion thereof, and ultimately pays the claims in whole or part, computation of the interest will begin on the first calendar day after the applicable time period for denying or contesting claims has expired.

K. Claim Receipt Verification and Acknowledgement of Claims

Humboldt IPA will provide claim receipt verification and acknowledgement of claims, whether or not the claims are complete, within two business days for electronically submitted claims. For all other claims submissions, Humboldt IPA will provide an acknowledgement of claims receipt within 15 business days of receipt. A provider may verify receipt of claims and obtain an acknowledgement of claim receipt in the following manner:

Telephone: (707) 443-4563 or toll free at 866-443-4563
Website: www.humboldtipa.com (Contact Customer Service for secure access information.)

L. Retroactively Approved, Non-urgent Services

- It is the responsibility of the party providing services to obtain prior authorization when required. Please refer to IPA's website https://humboldtipa.com/wrd-prs/for-providers/authorizations/ for a list of services that require prior auth.

- Claims for services that are authorized retroactively for medically necessary services that could have been authorized prior to the date of service will be allowed at 50% of the regular rate.

II. Dispute Resolution Process for Contracted Providers

A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to Humboldt IPA 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:

- If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Humboldt 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;
- 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
- 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 Humboldt IPA. Humboldt IPA does not accept verbal provider disputes (e.g. via phone). Providers must submit disputes in writing using either the PDR Request Form or some other format that includes all the required information in Section II. A., above. Authorization requests received after the service has been billed and denied will be handled as a PDR. Blank PDR Request Forms will be mailed, e-mailed or faxed to providers upon request, or can be downloaded from the Humboldt IPA's website at www.humboldtipa.com. All provider disputes must be sent to the attention of the Claims Manager, Humboldt IPA at the following:

Mail: Humboldt IPA, 2315 Dean St., Eureka, CA 95501
Office: Humboldt IPA, 2315 Dean St., Eureka, CA 95501
Fax: (707) 443-2527

C. Time Period for Submission of Provider Disputes.

- Contracted provider disputes must be received by Humboldt IPA within 365 days from Humboldt IPA's action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute.

- In the case of Humboldt IPA's inaction, contracted provider disputes must be received by Humboldt IPA within 365 days of the date of service.

- Contracted provider disputes that do not include all required information as set forth above in Section III.B. may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to Humboldt IPA within thirty (30) working days of your receipt of a returned contracted provider dispute.

D. Acknowledgment of Contracted Provider Disputes. Humboldt IPA will acknowledge receipt of all contracted provider disputes within two (2) working days of the date of receipt.

E. Contacting Humboldt 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 Humboldt IPA at: (707) 443-4563 or toll free at (866) 443-4563.

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 by using the Humboldt IPA's "Multiple Like Claims" PDR form or in some other format that includes all the required information in Section II. A., above.

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

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 Humboldt 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:

- If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Humboldt 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, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect;
- 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. Non-contracted Provider 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 II.B through H., above.

IV. Claim Overpayments

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

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

D. Offsets to payments. Humboldt 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 Humboldt IPA within the timeframe set forth in Section IV.C., above, and

(ii) Humboldt IPA's contract with the provider specifically authorizes Humboldt 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, Humboldt 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.