UC DAVIS HEALTH SYSTEM
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, POS, and, where applicable, PPO products where UC Davis Medical 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 UC Davis Medical Group. Claims for services provided to members assigned to UC Davis Medical Group must be sent to the following:

Via Mail: UC Davis Managed Care Operations
P.O. Box 179001
Sacramento, CA 95817
Attn: Claims

Via Physical Delivery: UC Davis Managed Care Operations
10545 Armstrong Avenue, Suite 1200
Mather, CA 95655
Attn: Claims

Via Clearing house: Office Ally (Payer ID: UCDMG)
Change (formally Emdeon, Payer ID:94603)

Via Fax: (916) 734-9972

B. Calling UC Davis Medical Group Regarding Claims. For claim filing requirements or status inquires, you may contact UC Davis Medical Group by calling: (916) 734-9900 (option #1) or 1-800-445-3936 (option #1). Providers may also e-mail UCDMG at hs-claims.inquiry@ucdavis.edu for status.

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

Participating providers must submit claims within 90 days from date of service. Non-participating providers must submit claims within 180 days from date of service.

Claims involving coordination of benefits much be submitted 90 days (par) or 180 days (non-par) from the date of payment or denial from the primary carrier.

Upon the submission of a claim all providers must include, at a minimum, all of the following information:

- Patient's ID#
- Patient Name and Date of Birth,
- Subscriber Name
- Name of Payor (HMO)
- Provider Tax ID#
- Provider State License Number
- Provider NPI Number
- ICD-9 or ICD-10 diagnosis codes and ICD-9 or ICD-10 procedure codes (hospital). ICD-10 codes required on claims with 10/1/15 date of service and later.
- Date of Service
- Billed Charges
- Current year CPT or HCPCS procedure codes (physician) or UB-04 revenue code with narrative description (hospital).
- Current year modifier when needed to further define a service
- Current year National Drug Code (NDC) when Average Wholesale Price (AWP) is required.
- Current year ASA code for anesthesia claims
- CMS place of service code (professional). UCDMG requires Urgent Care facilities to bill with POS "20"
- Number of Days or Units.
- Proof of authorization and/or authorization number, if applicable. Referring physician name and time authorized for Urgent care claims.
- Explanation of benefits from primary carrier when UCDMG is not primary carrier.
- Manufacture code or invoice with claims when required for contract rates.

If services are non-emergent and services were not pre-authorized, provider must submit supporting documentation such as:

- Trip sheets
- Radiology reports
- Chart notes
- Medical Records
- Referring Physician
- Time of Visit (urgent care claims only)

D. Claim Receipt Verification. For verification of claim receipt by UC Davis Medical Group, please do the following:

UC Davis Medical Group is required to provide an acknowledgement of claims receipt, whether or not claims are complete, within two business

days for electronically submitted claims. For all other claims submissions, UC Davis Medical Group will provide an acknowledgement of claims receipt within 15 business days of receipt. A provider may obtain an acknowledgement of claim receipt in the following manner:

Telephone: (916) 734-9900 or (800) 445-3936 option #1
E-mail confirmation: hs-claims.inquiry@ucdavis.edu

E. Late Submission of Claims: Late submission of claims will be accepted when demonstration of good cause for the delay in submission has been established.

II. Dispute Resolution Process for Contracted Providers

A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to UC Davis Medical 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 UC Davis Medical Group 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 UC Davis Medical Group. Contracted provider disputes submitted to UC Davis Medical Group must include the information listed in Section II.A., above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of UC Davis Claims Department Attn: Provider Disputes at the following:

Via Mail: UC Davis Managed Care Operations
P.O. Box 179001
Sacramento, CA 95817
Attn: Provider Disputes

Via Physical Delivery: UC Davis Managed Care Operations
10545 Armstrong Avenue, Suite 1200
Mather, CA 95655
Attn: Provider Disputes

Via Fax: (916) 734-9972

C. Time Period for Submission of Provider Disputes.

(i) Contracted provider disputes must be received by UC Davis Medical Group within 365 days from UC Davis Medical Group'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 UC Davis Group's inaction, contracted provider disputes must be received by UC Davis Medical Group 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) 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 UC Davis Medical Group within thirty (30) working days of your receipt of a returned contracted provider dispute.

D. Acknowledgment of Contracted Provider Disputes. UC Davis Medical Group will acknowledge receipt of all contracted provider disputes as follows:

i. Electronic contracted provider disputes will be acknowledged by UC Davis Medical Group within two (2) Working Days of the Date of Receipt by UC Davis Medical Group.

ii. Paper contracted provider disputes will be acknowledged by UC Davis Medical Group within fifteen (15) Working Days of the Date of Receipt by UC Davis Medical Group.

E. Contact UC Davis Medical 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 UC Davis Medical Group at: (916) 734-9900 (option #1) or (800) 445-3936 (option #1) or e-mail to hs-claims.inquiry@ucdavis.edu

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:

Providers must use a Provider Dispute Resolution Request form which is attached. If the dispute is for multiple, substantially similar claims, the Provider Dispute Resolution Request Spreadsheet must be submitted with the Provider Dispute Resolution Request form. Only "Like" issues should be included on one spreadsheet. Each unique issue needs a separate cover sheet and spreadsheet clearly defining the type of issue.

The provider dispute must include the provider's name, Tax ID number, contact information including telephone number, and the number assigned to the original claim. If the provider dispute involves a member, the dispute must also include the member's name, ID number, and a clear explanation of the disputed item, including the date of service, and the provider's position thereon.

If the dispute is regarding a claim or a request for reimbursement of an overpayment of a claim, the dispute must include a clear identification of the disputed item, the date of service, and a clear explanation as to why the provider believes the payment amount, request for additional information, request for reimbursement of an overpayment or other action is incorrect.

If the provider dispute does not include the required submission elements as outlined above, the dispute will be returned to the provider along with a written statement requesting the missing information necessary to resolve the dispute. The provider must resubmit the dispute along with the missing information within 30 business days from the receipt of the request for additional information.

When submitting multiple disputes, provider should:
1. Sort disputes by similar issues.
2. Provide cover sheet and spreadsheet for each batch (separate issues).
3. Provide a cover letter for entire submission describing each provider dispute with reference to each batch.

F. Time Period for Resolution and Written Determination of Contracted Provider Dispute. UC Davis Medical 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. If the provider is not satisfied with the initial determination and the determination is related to medical necessity or Utilization Management, the provider has the right to appeal directly to the Health Plan within 60 working days of receipt of the written determination. Copies of the provider disputes and the determinations are retained for 7 years.

G. 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, UC Davis Medical 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. Accrual of the interest and penalties will commence on the day following the date by which the claim should have been processed

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 UC Davis Medical 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 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 UC Davis Medical 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 in sections II.B., II.C., II.D., II.E., II.F., II.G., and II.H. above.

IV. Claim Overpayments

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

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

D. Offsets to payments. UC Davis Medical 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 UC Davis Medical Group within the timeframe set forth in Section IV.C., above, and (ii) UC Davis Medical Group's contract with the provider specifically authorizes UC Davis Medical 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, UC Davis Medical 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. Right of Provider to Request a De Novo Review

Any provider that submits a claim dispute to the plan's capitated provider's dispute resolution mechanism(s) involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to the plan's dispute resolution process.

A provider has the right to submit an appeal for a de novo review and resolution to the Plan for a period of 60 working days from the capitated provider's Date of Determination.

Mail appeals to the respective health plan's addresses as listed below.

Anthem Blue Cross
Attention: Appeals/Grievance Unit
PO Box 4310
Woodland Hills, CA 91365-4310

Blue Shield of California
Blue Shield Initial Appeal Resolution Office
PO Box 272620
Chico, CA 95927-2620

CIGNA HealthCare Inc.
Attention: National Appeals Unit (NAO)
PO Box 188011
Chattanooga, TN 37422

Health Net
Attn: Appeals and Grievances Department
PO Box 10348
Van Nuys, CA 91410-0348

United HealthCare of California
Appeals & Grievances Department
PO Box 6106
Cypress, CA 90630
Mail Stop: CA 124-0157

Western Health Advantage
Attention: Appeals/Grievances Unit
2349 Gateway Oaks Dr., Suite 100
Sacramento, CA 95833