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Claims Policy Statement

Subject:	New AB 1455 Regulations For Claims Settlement Practices and Provider Disputes
Effective Date:	January 1, 2004
Reviewed/Revised:	**July 2010, July 2011, January 2013 July 2014 (7/2014 rev. to include record retention 5 years) August 2018**

Policy: To comply with AB 1455 (Ch. 827, 2000) the Department of Managed Health Care revised the California Code of Regulations (CCR) adding sections 1300.71 and 1300.71.38 to Title 28 of the CCR. These sections describe requirements for claims settlement practices, provider dispute resolution, provider fee schedules and health plan and capitated medical group reporting that are applicable to claims with dates of service on or after January 1, 2004. The information contained in this policy describes Meritage Medical Network's claims settlement and provider dispute resolution policies and procedures.

Claim Filing Timeframe

Effective January 1, 2004, Meritage Medical Network will accept claims from contracting providers if they are submitted within 90 calendar days from the date of service except as described below. If Meritage Medical Network is not the primary payer under coordination of benefits (COB) rules, the claim submission period begins on the date the primary payer paid or denied the claim. Claims not received within the timely filing period will be denied.

If your contract provides for a claim- filing deadline that is greater than 90 days, the longer timeframe will continue to apply unless and until the contract is amended.

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

Submission of Claims

All paper claims and supporting documentation must be submitted to:

4 Hamilton Landing, Suite 100
Novato, CA 94949
Attention: Claims Department

Complete Claim Definition

Meritage Medical Network 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 position of the provider related to the billed services that enables a claims adjudicator to determine the nature, cost, If applicable, and extent of the plan's liability, if any, and to comply with governmental information requirements.

Information necessary to determine payer liability means the minimum amount of material information in the possession of third parties related to a provider's billed services required by a claims adjudicator to determine the nature, cost, if applicable, and the extent of the plan's liability, if any, and to comply with any governmental information requirements. In addition, the plan may require additional information from a provider where the plan had reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices.

Reimbursement of Claims

Meritage Medical Network will reimburse each complete HMO claim, or portion thereof, according to the agreed contract rate no later than 45 business days after receipt of the claim unless the claim is contested or denied. MMN reserves the right to adjudicate claims using reasonable payment polices and non-standard coding methodologies that are consistent with standards accepted by nationally recognized medical organizations, federal regulatory bodies and major credentialing organizations. Further information about these polices are available on our Web site, www.meritagemed.com

Denied or Contested Claims

Meritage Medical Network will notify the provider of service in writing of a denied or contested claim no later than 45 business days after receipt of the claim. A contested claim is one that Meritage cannot adjudicate or accurately determine payer liability because more information is needed from either the claimant or a third party. Date of contest or date of denial is the electronic mark or postmark date indicating the date when the contest or denial was transmitted electronically or mailed by U.S. postal service.

If the IPA needs additional information from the provider before a claim can be adjudicated, the necessary information must be submitted within 90 calendar days from the date of request. All denied/contested claims/requests for additional information, will be reflected on the Explanation of Benefits.

Date of Receipt

Date of receipt is the business day when a claim is first delivered, electronically or physically to Meritage Medical Network.

Acknowledgement of Claims

Meritage Medical Network is required to provide an acknowledgement of claims receipt, whether or not the claims are complete, within two business days for electronically submitted claims and fifteen business days for all other claims. For claim filing requirements or status inquires, you may call our Claims Customer Service Department at (415) 884-1840.

Overpayment of Claims

If Meritage Medical Network determines that an overpayment has occurred, the IPA will notify the provider of service in writing within 365 days of the initial claims payment through a separate notice that includes the following information:

- Member Name
- Claim Identification Number
- Date of Service
- Clear explanation of why Meritage Medical Network believes the claim was overpaid
- The amount of overpayment, including interest and penalties

If the provider does not believe that an overpayment has occurred, provider has 30 business days to **contest** our request. Contested overpayments will be will be treated as provider disputes and handled accordingly.

Meritage Medical Network may recoup uncontested overpayments by offsetting from provider's current and or future claims but only if:

- The overpayment is not reimbursed within 30 business days of the notice of overpayment and

- The provider's contract with Meritage Medical Network authorizes it to offset overpayments from payment for current claims.

A written notification will be sent to the provider of service if an overpayment is recouped through offsets to claim payments. The notification will identify the specific overpayment and the claim identification number.

Definition of a Provider Dispute

A provider dispute is a written notice from the provider that:

- Challenges, appeals, or requests reconsideration of a claim (including a bundled group of similar claims) that has been denied, adjusted or contested
- Challenges a request for reimbursement of an overpayment of a claim
- Seeks resolution of a billing determination or other contractual dispute

Provider Dispute Timeframe:

Effective January 1, 2004, Meritage Medical Network will accept disputes from providers if they are submitted and received within 365 days of the original claim's last action date which is printed on the explanation of benefits.

Submission of Provider Disputes:

When submitting a provider dispute a provider must use the Provider Dispute Resolution Request Form. If the dispute is for multiple, substantially similar claims, the Provider Dispute Resolution Spreadsheet must be submitted with the Provider Dispute Resolution Form. This information is posted on our Web site, www.meritagemed.com --- The provider dispute must include the provider's name, ID number. Contact information, including telephone number, and the original claim number.

Additional information is required:

- If the dispute is regarding a claim or a request 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 provider believes the payment amount, request for additional information, request for reimbursement of an overpayment, is incorrect.
- If the dispute is not about a claim, a clear explanation of the issue and the basis of the provider's position thereon
- A provider dispute that is submitted on behalf of a member will be processed through the member appeal process provided the member has authorized the provider to appeal on behalf of the member.

Please note:

If the provider dispute involves a member, the dispute must include the member's name, identification number, and a clear explanation of the disputed item, including the date of service, and the provider's position thereon.

All provider disputes and supporting documentation must be submitted to:
Physical and Mail Delivery:

Meritage Medical Network Provider Dispute Intake Coordinator
4 Hamilton Landing, Suite 100
Novato, California 94949
Via Fax:
Meritage Medical Network Provider Dispute Intake Coordinator
(415) 884-3510

If the provider 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. The provider must resubmit the dispute along with the missing information within 30 business days from the receipt of the request for additional information.

Acknowledgement of Provider Disputes:
Meritage Medical Network will acknowledge receipt of each provider dispute regardless of whether or not the dispute is complete within 15 business days of receipt.

Provider Dispute Resolution Timeframe:
Meritage Medical Network will resolve each provider dispute within 45 business days following receipt of the dispute and will provide the provider with a written determination stating the reasons for determination.

Past Due Payments:
If a provider dispute involves a claim and is determined to be in favor of the provider, MMN will pay any outstanding money due, including any required interest and penalties, within five business days of the decision. Accrual of the interest and penalties will commence on the day following the date by which the claim should have been processed.

Interest on Late Payment of Claims:
Late payments on a complete claim for emergency services that is neither contested or denied will automatically include the greater of:

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

If Meritage Medical Network does not automatically (within five days of the late claim Payment) include the interest fee with a late paid complete claim, an Additional $10 will be sent to the provider of service.

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

Dispute Resolution Costs:
A provider dispute must be processed without charge to the provider; however, Meritage Medical Network has no obligation to reimburse the provider for any costs incurred during the provider dispute process.

Meritage Medical Network will not discriminate or retaliate against a provider due to a provider's use of the provider dispute process.

Claims Supplemental Information Requests:
A clean or uncontested claim is defined as one which can be paid as soon as it is received because it is complete in all aspects, including complete and accurate coding, itemization, dates of service and billed amounts.

Record Retention:
Copies of provider disputes and the determinations, including notes, documents and other information used to reach a decision will be retained for at least a five years.

Requests for additional information may occur when:

- A physician exceeds the level of prior authorized surgical services and fails to include an operative report
- The billing provider dispenses covered in office medical supplies and does not attach an invoice
- The billing provider submits a claim to the IPA as the secondary insurance carrier and fails to provide an explanation of benefits from the primary insurance carrier
- The billing provider fails to designate multiple procedures (Modifier-51) that are rendered at the same operative session or on the same day
- The billing provider fails to designate bilateral procedures (Modifier-50) which identifies an identical procedure performed bilaterally during a single operative session
- The procedure code(s) conflict with the diagnosis and or the place of service
- Failing to identify the appropriate HCPCS code, name of medication, strength, dosage and method of administration when billing for injectable medications.
- Failing to include chart and or hospital notes when billing two visits for the same patient on the same day

Global Payment Provisions-Surgical Package Definition

The services provided by a physician to any patient by their very nature are variable. In accordance with the Current Procedural Terminology Guidelines, the following services will always be "included" in a given surgical CPT code:

- 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 or other physicians;
- writing orders
- evaluating the patient in the post anesthesia recovery area;
- surgical endoscopy always includes diagnostic endoscopy

Surgical Modifier Payment Rules:

Modifier 50 Bilateral Procedures- If the procedural description does not identify the procedure as bilateral:

- If billed as one line item the allowance will be 150% of the global rate
- If billed as two line items the allowance will be 100% of the global rate for the first procedure, then 50% of the global rate for the second procedure

Modifier 50 Bilateral Procedure- When the procedural description identifies the procedure as bilateral:

- The allowable will be 100% of the global rate and must be billed as one line item.

Multiple Bilateral Procedures—Modifiers 50 and 51 (In addition to the above rules (total allowance not to exceed 150%)

- all other procedures will be reimbursed at 25% of the global rate

Modifier 51- Multiple/Secondary Procedures:

- the secondary procedure is allowed at 50% of its global rate
- each additional multiple procedure is allowed at 25% of its global rate
- five or more multiple procedures will automatically require medical review

Modifier 52- Reduced Services

- allowance is 100% of the global rate or the provider's billed charges whichever is less.

Modifier 62- Two Surgeons-

Each provider will receive an equal share according to the following payment methodology:

- global rate plus an additional 25%= Total allowable then divided in half.

Modifier 80- Assistant Surgeon

- 20% of the global allowance

Review Process For Facility Based Elective Surgery:

Meritage Medical Network Utilization Review Department utilizes the following procedures with regards to authorizing surgical services:

- Requested services are reviewed against health plan criteria and or MMN Best Practice Guidelines. Meritage Medical Network utilizes MCG Guidelines when necessary.

- Requests for multiple services that will be performed during the same operative session are checked for appropriateness based on Medicare CCI edits via a stand-alone surgical software program *Flashcode,* a product of DBL Enterprises

- Services that pass the initial editing process are then assigned a length of stay in accordance to MCG Guidelines

- A determination, based on MCG Guidelines, is made as to whether or not a surgical assistant is indicated

- Follow-up days are determined using Flashcode/CMS Guidelines

Review Process for Urgent/ Emergent Facility Based Surgery

Meritage Medical Network Utilization Review Department utilizes the following procedures
when authorizing surgical services:

- Urgent ambulatory procedures follow the same process as elective surgery; authorizations are issued the same day

- Hospitals must notify Meritage Medical Network of inpatient emergent surgical admissions within 24 hours or the next business day.

- The authorized hospital admission covered all services, including the surgical procedure

Claim Submission Format Requirements

The complete UB04 CMS-1450 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

Claim Submission Format Requirements 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

- International Classification of Diseases (ICD10CM) codes

Claim Submission Information Instructions

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

- Patient's ID number
- Patient's name and date of birth
- Billing provider's tax ID
- State license/NPI number of attending/rendering provider
- Submitting provider's name and address
- ICD-10 diagnosis code
- Service date
- Billed charge
- Current year CPT or HCPCS procedure code or UB04 revenue code with a narrative description
- CMS place of service (professional claims only)
- Number of days or units for each service line
- Prior authorization number (if applicable)
- Name of referring physician (if applicable)
- Name and address of facility where services were rendered (if applicable)