

**PROSPECT MEDICAL GROUP
DOWNSTREAM PROVIDER NOTICE
CLAIMS SETTLEMENT PRACTICES
AND 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, and POS, products where Prospect 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 Prospect Medical Group. Claims for services provided to members assigned to Prospect Medical Group must be sent to the following:

Via Mail: **Prospect Medical Group
P.O. Box 11466
Santa Ana, CA 92711-1466
Attn: Claims Department**

Via Physical Delivery: **Prospect Medical Group
1920 E. 17th Street, Ste. #200
Santa Ana, CA 92705
Attn: Claims Department**

Via Fax: **(714) 667-8154**

Via Clearinghouse: **www.officeally.com
Contact Provider Relations at
1-800-708-3230**

- B. Calling Prospect Medical Group Regarding Claims. For claim filing requirements or status inquiries, you may contact Prospect Medical Group by calling: 1-800-708-3230.

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

Contracted Providers:

Contracted providers are required to submit claims within 90 days from the date services were rendered, or according to the time specified in the contract, whichever date is longer.

Non-Contracted Providers:

Non-contracted providers are required to submit claims within 180 days from the date services were rendered, except as required by state or federal law or regulation.

Hospital-Based Physicians:

Hospital-based physicians are required to submit claims within 365 days from the date services were rendered.

Professional Providers:

All claims and encounter data must be submitted on a properly completed HCFA 1500 claim form. The information must include the following:

- Patient's name
- Patient's address
- Patient's date of birth
- Patient's insurance company name
- Patient's ID number
- Date of Service(s)
- Place of Service
- CPT code(s) and/or HCPCS
- ICD-9 code(s)
- NDC Number for drugs where contract rates is a percentage of AWP
- Name of Rendering Physician
- State License number of Rendering Physician must be present in box 24k
- Itemized Charges
- Tax I.D. Number
- Authorization Number
- No more than six lines of service on one claim
- For referred and/or ordered services, the name of the referring or ordering physician and the NPI or UPIN numbers must be present in box 17 and 17A
- Emergency Services shall include any necessary medical records to make a proper determination of the emergency service rendered.
- If Provider is understood to be and identified as a 'Patient Permit' provider, a copy of the patient permit must be attached to the HCFA 1500 form
- If member was treated under the Blue Shield Direct Access + Program (refer to Provider Manual for additional information), a copy of the member's ID card must be provided.

For Institutional Providers:

- Claims must be submitted on UB92 Claim Form with all entries stated as mandatory by NUBC and required by federal statute and regulations and any state-designated data requirements included in statutes or regulations.
- Appropriate Revenue, CPT, ICD-9, and HCPCS
- Copies of invoices when billing for miscellaneous drugs and/or supplies
- Patient's name
- Patient's address
- Patient's date of birth
- Patient's insurance company name
- Patient's ID number
- Date of Service(s)
- Place of Service
- CPT code(s)

- ICD-9 code(s)
 - Name of Admitting Physician
 - Charges
 - Tax I.D. Number
 - Emergency Services shall include any necessary medical records to make a proper determination of the emergency service rendered
- D. Claim Receipt Verification. Prospect Medical Group will automatically provide a claim receipt verification for each and every claim that is received and in the same manner in which the claim was provided:
- i. Electronic claims will be acknowledged by Prospect Medical Group within two (2) Working Days of the Date of Receipt by Prospect Medical Group.
 - ii. Paper claims will be acknowledged by Prospect Medical Group within fifteen (15) Working Days of the Date of Receipt by Prospect Medical Group.

If you have any questions regarding the claims receipt acknowledgement process, call 1-800-708-3230.

II. Dispute Resolution Process for Contracted Providers

- A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to Prospect 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 Prospect Medical Group to a contracted provider the following must be provided: a clear identification of the disputed item (including original claim number), 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 Prospect Medical Group. Contracted provider disputes submitted to Prospect 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 Provider Relations Department at Prospect Medical Group at the following:

Via Mail: **Prospect Medical Group
P.O. Box 11466
Santa Ana, CA 92711-1466
Attn: Provider Disputes Department**

Via Physical Delivery: **Prospect Medical Group
1920 E. 17th St., Ste. 200
Santa Ana, CA 92705
Attn: Provider Disputes Department**

Via e-mail: **providerdisputes@prospectmedical.com**
Please Note, do not submit any dispute via email that would contain Protected Health Information (PHI) as outlined by the HIPAA Privacy Act.*

Via Fax: **(714) 667-8154**

C. Time Period for Submission of Provider Disputes.

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

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

- i. Electronic contracted provider disputes will be acknowledged by Prospect Medical Group within two (2) Working Days of the Date of Receipt by Prospect Medical Group.
- ii. Paper contracted provider disputes will be acknowledged by Prospect Medical Group within fifteen (15) Working Days of the Date of Receipt by Prospect Medical Group.

E. Contact Prospect 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 Prospect Medical Group at: (714) 347-5868.

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:

- i. Sort provider disputes by similar issue and separate into batches. (Please ensure that if dispute is related to Claims, then it must include the required information contained in Section II.(A). for each claim.)
- 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 Contracted Provider Dispute. Prospect 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.

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, Prospect 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.

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 Prospect 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 Prospect 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.

C. Medicare appeals for non-contracted providers. Submission of first level written Provider Dispute must be filed within a minimum of 120 calendar days after notice of initial determination. A second level written request for Independent Payment Dispute Decision (PDD) to C2C Solutions, Inc. (C2C) by email, fax or mail within 180 calendar days of written notice from the payer. Instructions and forms are located at www.C2Cinc.com.

Non-contracted providers have the right to request a reconsideration for denial of payment within 60 calendar days from the remittance notification date to file the reconsideration. A signed Waiver of Liability from holding the enrollee harmless regardless of the outcome of the appeal is required and can be found under Appendix 7 at the following link:
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf>.

IV. Claim Overpayments

- A. Notice of Overpayment of a Claim. If Prospect Medical Group determines that it has overpaid a claim, Prospect 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 Prospect 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 Prospect 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 Prospect Medical Group stating the basis upon which the provider believes that the claim was not overpaid. Prospect Medical Group will process the contested notice in accordance with Prospect Medical Group's contracted provider dispute resolution process described in Section II above.
- C. No Contest. If the provider does not contest Prospect Medical Group's notice of overpayment of a claim, the provider must reimburse Prospect Medical Group within thirty (30) Working Days of the provider's receipt of the notice of overpayment of a claim.
- D. Offsets to payments. Prospect 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 Prospect Medical Group within the timeframe set forth in Section IV.C., above, and (ii) Prospect Medical Group's contract with the provider specifically authorizes Prospect 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, Prospect 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.