Non-Contract Provider Dispute and Appeals Process For Post-Service Claim Payment Issues

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Introduction:
MediExcel Health Plan's (MEHP) dispute and appeals processes ensure that non-contract provider disputes and appeals are handled in a fast, fair, and cost-effective manner.

Non-Contracted Provider Dispute means a non-contracted provider's written notice to MEHP 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, contested, or disputing a request for reimbursement of an overpayment of a claim.

Whenever a non-contract provider claim is denied, contested, or adjusted (claim not paid at 100% of billed charges) and/or a billed service (s) is denied or not covered, MEHP will inform the non-contract provider in writing of the availability of the claim Payment Dispute Resolution (PDR) process for a reconsideration request for the review of the adjudication of the claim (s).

MEHP's PDR process is available for use by non-contract providers who disagree with MEHP's initial and/or second-level review determination.

(*Please note: contract providers follow the contract provider's agreement/contract with MEHP.*)

Claim Dispute Processing

There are three levels of Claim Disputes:

- Initial/First Level Dispute Requests – processed by MEHP
- Second Level Dispute Requests – processed by MEHP
- Independent Dispute Resolution Process (IDRP) processed by the DMHC

Initial/First Level Dispute Requests – processed by MEHP:

- The dispute must be submitted in written form with all pertinent information and documentation the provider wishes for MEHP to consider in the PDR request

- All providers have a 365 day deadline to submit their dispute resolution request from MEHP's latest date of action that triggered the dispute (normally the claims payment or the EOB.) If the provider dispute resolution request is postmarked more than 365 calendar days from the date after MEHP's most recent action, the dispute shall be denied in writing due to late submission.

- MEHP paid for a different service or more appropriate code than what was billed, often referred to as down-coding of claims.

- A copy of the template form is found at the end of this document. You may use any format as long as the required information is provided.

- MEHP shall send you an acknowledgement letter within fifteen (15) working days after the receipt of the PDR request.

- When no additional information is required from the provider, the dispute request is processed, and a resolution letter is sent by MEHP to the provider within thirty (30) working days from the date the dispute was received by MEHP.

- The provider may amend the initial dispute request with additional information/documentation (for MEHP to consider along with the initial dispute request) within thirty (30) working days of the initial dispute request date received by MEHP.

- If the provider dispute request arrives at MEHP and has incomplete information that prevents MEHP from properly determining the resolution of the disputed case, MEHP shall send a follow-up letter to the provider requesting additional reasonably needed information. The MEHP follow-up letter shall be sent within fifteen (15) working days of the provider dispute request original received date.

- If the provider fails to submit the requested additional documentation/information within thirty (30) working days of MEHP's follow-up letter date, MEHP may close the dispute request and send the provider a letter.

- Once the requested information is received by MEHP from the provider, the dispute request is processed, and a resolution letter is sent by MEHP to the provider within

ten (10) working days from the date the additional information was received by MEHP.

- If MEHP needs to make additional payment to the provider, such payment shall be made within five (5) working days from the date of the resolution letter.

- Any payment exceeding five (5) working days from the resolution letter date shall include interest and a late fee.

Address to Submitting an Initial/First Level Non-Contract Provider Dispute/Appeal

Non-contract providers must mail a written request to MEHP at:

MediExcel Health Plan
Provider Dispute Resolution
750 Medical Center Court, Suite 2
Chula Vista, CA 91911
Fax: (978) 522-3777

Second Level Dispute Requests – processed by MEHP:

- If the provider is not satisfied with the resolution from the first level PDR request, the provider may submit a second level PDR request to MEHP. Similarly to the first level PDR request from the latest date of the first PDR action.

- If the PDR request is postmarked more than 365 calendar days from the latest date after MEHP's most recent action (normally the claims payment or the EOB) regarding the first level PDR, the second level PDR request shall be denied in writing due to late submission.

- After a written second level PDR request is received by MEHP, an acknowledgment letter is sent to the provider within fifteen (15) working days.

- The PDR request must be submitted in written form to MEHP with all pertinent information and documentation the provider wishes for MEHP to consider in the PDR request.

- A copy of template form is found at the end of this document. You may use any format as long as the required information is provided.

- When no additional information is required from the provider, the PDR request is processed, and a resolution letter is sent by MEHP to the provider within thirty (30) working days from the date the dispute was received by MEHP.

- The provider may amend the second-level review PDR request with additional information/documentation for MEHP to consider within thirty (30) working days of

the second level dispute request date received by MEHP.

- If the second level PDR request arrives at MEHP and has incomplete information that prevents MEHP from properly determining the resolution of the disputed case, MEHP shall send a follow-up letter to the provider requesting additional reasonably needed information. The MEHP follow-up letter shall be sent within fifteen (15) working days of the provider dispute request original received date.

- If the provider fails to submit the requested additional documentation/information within thirty (30) working days of MEHP's follow-up letter date, MEHP may close the second level PDR request and send the provider a letter.

- Once the requested information is received by MEHP from the provider, the PDR request is processed, and a resolution letter is sent by MEHP to the provider within ten (10) working days from the date the additional information was received by MEHP.

- If MEHP needs to make additional payment to the provider, such payment shall be made within five (5) working days from the date of the resolution letter.

- Any payment exceeding five (5) working days from the resolution letter date shall include interest and a late fee.

Address to Submitting a Second Level Non-Contract Provider Dispute or Appeal

Non-contract providers must mail a written request to MEHP at:

MediExcel Health Plan
Provider Dispute Resolution
750 Medical Center Court, Suite 2
Chula Vista, CA 91911
Fax: (978) 522-3777

Provider Dispute Resolution Request Form

Instructions:
Complete this form in full. Information with an asterisk (*) is required. Be specific when completing the Description of Dispute and Expected Outcome. Provide supporting documentation for your appeal.

Mail the completed form to:
MediExcel Health Plan
Provider Dispute/Appeal
750 Medical Center Court, Suite 2
Chula Vista, CA 91911

Or fax the complete form to:
(978) 522-3777

Provider Name: _____ Provider Tax ID#: _____

Address: _____

Provider Type: ☐ MD ☐ Mental Hospital ☐ Hospital ☐ Ambulance ☐ Urgent Care

Other (please specify): _____

Claim Information (please indicate): ☐ Single ☐ Multiple "LIKE" Claims (please provide listing) # of claims _____

*Patient Name: _____ *Date of Birth: _____

*Health Plan ID: _____ Patient Account Number: _____

Original Claim ID # (if multiple cases, provide listing): _____

*Service Date (From/To): _____ / _____

Original Claim Amount Billed:_____ Original Claim Amount Paid:_____

Dispute Type:

☐ Claim seeking resolution for billing determination

☐ Appeal for medical necessity

☐ Other

***Description of Dispute:**

***Expected Outcome:**

***Contact Information:**

Name: _____ Title: _____

Telephone #: _____ E-mail: _____

☐ Check if additional information is attached (please include contact information on additional information sheets)

DMHC Independent Dispute Resolution Process (IDRP)

If the provider disagrees with either of MEHP's first level or second level dispute resolution response(s), or if MEHP fails to respond to the provider's dispute within 45 working days, the provider may submit a provider complaint through the CA Department of Managed Health Care (DMHC) website. (*See link below.*)

https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan.aspx

Submission Guidelines for Non-Contract Provider Disputes:

Required Information *(See the following page for required documentation)*

Non-Contracted Provider Information:

- Non-Contracted Provider's Name
- Non-Contracted Provider's Tax ID #/Medicare ID #
- Non-Contract Provider's Address
- Non-Contract Provider Type (specify type – MD, Hospital, Ambulance, DME, etc.)
- Non-Contract Provider's Contact Name
- Non-Contract Provider's Contact Title
- Non-Contract Provider's Contact Phone #
- Non-Contract Provider's Contact Fax #

Member Information:

- Patient's Name (First, Middle, Last)
- Patient's Date of Birth
- Health Plan Name
- Patient's Account/ID #

Claim Information:

- Original Claim #
- Dates of Service (from/to)
- Original Claim Amount Billed
- Original Claim Amount Paid

Dispute/Appeal Type	Required Documentation
Rate/Fee Dispute – dispute request for a claim that was paid or denied at an incorrect fee	• copy of fee schedule in effect during the dates of service • copay of claim
Coding Edit Revise – request for a claim that was denied or adjusted for CCI edit or bunding	• appropriate supporting documentation, i.e., OP report, path report • letter stating rationale for complication • copy of claim
Medical Necessity/Utilization Management Decision – request for a claim that was denied on initial medical necessity review	• appropriate medical records, i.e., ER, H&P, discharge summary (do **NOT** send daily notes unless requested) • rational for service performed • copy of claim

Information Regarding DMHC
Independent Dispute Resolution Process (IDRP)

What should I do if I have a problem getting paid by a payor?

The Knox-Keene Act and its implementing regulations require each health care service plan to provide "a fast, fair and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan." You are required to first try to resolve your concern directly with the health care service plan through its Provider Dispute Resolution mechanism. If you disagree with the payor's dispute resolution response, or if the payor fails to respond to your dispute within **45 working days**, you may submit a provider complaint through the CA Department of Managed Health Care (DMHC) website.

https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan.aspx

What is the Department doing to resolve problems with providers not getting paid?

The DMHC reviews all complaints submitted by providers regarding problems with health plans and payors. We look for patterns or systemic problems and address them with individual health plans or payors through a number of oversight tools, including financial audits and medical surveys. Additionally, the DMHC can take enforcement action against health plans found to violate the law. To date, the DMHC Provider Complaint Section& has recovered more than $125,000,000 in payments to providers.

What does the review process consist of?

An initial review is performed on all electronically filed provider complaints. This review is based on the information provided within each complaint form. Data provided in these forms will be analyzed to look for evidence of "unfair payment patterns." It will also be used to identify common types of payment issues. This data will provide the basis for DMHC investigations and potential actions to address unfair payment patterns.

Further review of a provider complaint may be initiated based on available resources and consistent with DMHC priorities. This process will require a verification of the facts presented in the electronically filed complaint by comparing it with backup documentation. When further review of a complaint has been initiated, the DMHC will open a case file and will request the provider to submit additional backup documentation relevant to the case.

Upon receipt of the documentation, the DMHC may determine whether there is non-compliance with the provisions of the Knox-Keene Act and its Regulations.

What do I need to do to file a complaint with the DMHC?

Before you file a complaint with the DMHC, you should submit a request for dispute resolution through your payor's Provider Dispute Resolution mechanism. Then, if you

disagree with the response, complete and submit an electronic Provider Complaint Application with the DMHC.

Is the Provider Complaint process in place of taking legal action?

The DMHC's Provider Complaint process does not take the place of a civil action or other available legal remedies. We cannot give legal advice or act as your attorney. The complaint process should not be considered a way to gather facts in preparation for any potential legal action. You can take legal action at any time during the complaint process. In the event that the claims comprising your complaint are in litigation, the DMHC may at its discretion suspend or delay its investigation until the civil adjudication of those claims has been completed.

General Information

The California Department of Managed Health Care (DMHC) established an Emergency Services Independent Dispute Resolution Process (IDRP) to afford noncontracted providers who deliver Emergency Medical Treatment & Active Labor Act (EMTALA) required emergency services a fast, fair, and cost-effective way to resolve claim payment disputes with health care service plans or capitated providers concerning the "reasonable and customary" value of services rendered.

Participation in the Emergency Services IDRP is voluntary and, while the process is non-binding, DMHC feels that IDRP decisions may offer providers and payers a fast, fair, and cost-effective alternative to other slower and more costly legal remedies. As such, the parties are encouraged to comply with the decision issued by the Emergency Services IDRP External Reviewer.

For more information regarding the DMHC Emergency Services IDRP and how to file a claim.

Do I Qualify?

Non-contracted providers who deliver EMTALA-required emergency services ("providers") working with health care service plans or capitated providers ("payers") are eligible to submit a IDRP concerning the "reasonable and customary" value of services rendered.

A provider may request review through the IDRP for an individual claim or for multiple claims (up to a total of 50 substantially similar claims.)

If you are a provider but these parameters don't apply to you, see how you can file a Complaint Against A Plan.

Eligible Claims

Eligible claim disputes are those disputes that are subject to DMHC jurisdiction and meet each of the following four criteria:

- The disputed claim is limited to emergency services rendered by non-contracted physicians or hospitals.
- The services were rendered within the last four years.
- The dispute is limited to disagreement concerning the reasonable and customary value of the services rendered.
- The provider has completed the payer's dispute resolution process.

Ineligible Claims

Disputes concerning claims that have not been submitted to the payer's dispute resolution process.

- Disputes concerning claims that are currently in arbitration or litigation in state or federal court.
- Late payment disputes.
- Interest payment disputes.
- Medi-Cal program claim disputes for which the State of California's "Fair Hearing Process" has commenced.
- Claim disputes that are not subject to DMHC jurisdiction.
- Claim disputes with health plans licensed or regulated by another state.
- Disputes regarding claims that do not involve covered benefits.
- Claims denied on the basis that the services were not medically necessary or were experimental/investigational in nature.

Steps for Filing

Upon receipt of the provider's request, the DMHC will review the provider's submission and then contact the payer to confirm their willingness to participate in the Emergency Services IDRP with regard to the disputed claim. If the payer declines to participate, the provider will be notified. If the payer elects to participate, information concerning the claims dispute is forwarded to the Emergency Services IDRP External Reviewer, who may request further documentation or information, as needed. (Except as required by law, documentation and information submitted to DMHC regarding disputed claims considered through the Emergency Services IDRP will remain confidential.)

Ordinarily, an Emergency Services IDRP decision will be issued within sixty (60) days of receipt of required provider and payer documentation.

Submit an Emergency Services IDRP Request

About the Decision Process

The Emergency Services IDRP utilizes a decision process that is similar to the "baseball style" model of arbitration. Accordingly, the Emergency Services IDRP External Reviewer is required to decide which figure (either the provider's billed amount, or the payer's paid amount) is most representative of the reasonable and customary value of the emergency services that were rendered. The Emergency Services IDRP External Reviewer cannot "split the difference" or choose a different amount (outside of those submitted by one of the parties). Note: under the Emergency Services IDRP, a hospital provider may elect to lower its billed amount in connection with the hospital's Emergency Services IDRP submission.

Complaint Fee Schedule

Currently, there is no Emergency Services IDRP complaint filing fee for individual physicians. For hospital providers, the number of disputed claims listed on the Emergency Services IDRP Request Form determines the filing fee. Substantially similar claims can be aggregated up to fifty (50) in a single Emergency Services IDRP Request Form.

"Substantially similar" claims are those that involve the same or similar services and the same payer. Fees are subject to change without notice.

1 individual claim - $100.00
2 to 10 claims - $200.00
11 to 25 claims - $400.00
26 to 50 claims - $600.00

Legal Action Questions

Does the Help Center act as my attorney?

No. The Help Center does not give legal advice or act as your attorney. We will review your issue through our IMR or Consumer Complaint process and let you know if your health plan must provide the service or item you are requesting.

How will my complaint be decided?

Your IMR will be decided by qualified, independent clinicians who are not employed by your health plan. Your complaint will be decided by experienced analysts, nurse consultants, or lawyers. The Help Center will send you and your health plan a letter that explains our decision. If the complaint is decided in your favor, we will require your health plan to provide or pay for the service, or do whatever is needed to resolve the complaint. If the complaint is not decided in your favor, you cannot appeal the decision. However, you may still be able to take legal action and may want to speak with a private attorney.

Link for submitting a Provider Complaint against MediExcel Health Plan

California Department of Managed Health Care > File a Complaint > Provider Complaint Against a Plan

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