Sharp Rees-Stealy Medical Group, Inc.
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 and POS products where Sharp Rees-Strealy Medical Group ("SRS") 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 SRS. Claims for services provided to members assigned to SRS must be sent to the following:

Via Mail: SRS
P.O. Box 939035
San Diego, CA 92193

B. Calling SRS Regarding Claims. For claim filing requirements or status inquiries, you may contact SRS by calling: (858) 499-2410

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

(i) Claims timeliness is ninety (90) days from date of service and one hundred and eighty (180) days for non-contracted providers.
(ii) Claims supplemental information is any reasonably relevant, accurate and material information that enables a claims adjudicator to determine the claim in question requires a significantly separate adjudication process. (Example: operative reports when billing with modifier –50).
(iii) Claims documentation is a complete and accurate Centers for Medicare and Medicaid Services (CMS) 1500 form or its successors adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic form or UB 92 data set or its successor formats adopted by the NUCC submitted on the designated paper or electronic form.
(iv) More detailed information regarding SRS claims submission requirements can be found at www.sharp/srsproviders.

D. SRS Payment and Billing Policies. - SRS billing and payment policies are consistent with Current Procedural Terminology (CPT) guidelines, and standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies and major credentialing organizations.

- SRS utilizes proprietary Claims Check software that reviews billing codes for appropriateness and adjusts claim payments accordingly.

- Reimbursement for immunizations and injectable medications are in accord with CPT guidelines and applicable state law/regulation.

E. Claims Scanning - SRS scans claims using Optical Character Recognition (OCR) to capture claims information directly from claim forms.

OCR output is largely dependent on the accuracy and legibility of the claim form submitted, therefore claim forms must:

- Be legible. Change typewriter ribbon/PC printer cartridge frequently, if necessary. Laser printers are recommended;
- Contain Black Ink;
- Contain Pica, Courier 10, or Courier 12 font type; and
- Contain CAPITAL letters.

Claim forms should not have:

- Broken characters;
- Script;
- Stylized print;
- Italic print;
- Mini-font;
- Proportional pitch (use only typefaces that have the same width for each character). Avoid Dot Matrix font;
- Liquid correction fluid changes;
- Data touching box edges or running outside of numbered boxes (instead, center claim information in each box). Exception: when using the 8-digit date format, information may be typed over the dotted lines shown in date fields, i.e., Item 24a.
- More than six service lines per claim (use a new form for additional services);
- Narrative descriptions of procedure, narrative description of modifier or narrative description of diagnosis (the CPT, Modifier or ICD-9 CM codes are sufficient);
- Stickers or rubber stamps (such as "tracer", "corrected billing," provider name and address, etc);
- Special characters (i.e., hyphens, periods, parentheses, dollar signs and ditto marks);
- Handwritten claims; or
- Attachments smaller than 8 ½" x 11".

The claim form must be:

- An original CMS-1500 (12/90) or UB 92 printed in red "drop out" ink with the printed information on back (photocopies are not acceptable);
- Size – 8 ½" x 11" with the printer pin-feed edges removed at the perforations;
- Free from crumples, tears, or excessive creases (to avoid this, submit claims in an envelope that is full letter size or larger);
- Thick enough (20-22lbs.) to keep information on the back from showing through; and
- Clean and free from stains, tear-off pad glue, notations, circles or scribbles, strikeovers, crossed out information or white out.

F. Modifiers - SRS recognizes modifiers in accordance with CPT guidelines.

- Modifier 25: Significant, Separately Identifiable Evaluation and Management (E & M) service by the Same Physician on the Same Day of the Procedure or Other

Service. A provider may need to indicate that on the day a procedure or service was performed the patient's condition required a significant, separately identifiable E & M service above and beyond the other service provided, or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E & M service may be prompted by the symptom or condition for which the procedure and/ or service was provided. As such, different diagnoses are not required for reporting of the E & M services on the same day. (This modifier is not used to report an E&M service that resulted in a decision to perform major surgery). The patient's records must contain information to support the use of modifier 25.

Visits by the same physician on the same day as a surgical procedure with 000 or 010 days postoperative or endoscopy procedures that are related to the standard preoperative evaluation or recovery from the procedure are included in the global reimbursement for the procedure. However, if a significant separately identifiable service is performed and is clearly documented in the patient's records, payment can be made for the visit when billed with modifier 25. This modifier is not used to report an E&M service that resulted in a decision to perform surgery (see modifier 57 below).

On a case-by-case basis medical records may be requested to validate documentation.

- Modifier 26 - Split Global, Professional (26) & Technical Component (TC) – Only certain services include a technical and professional component. Many Fee Schedules include separate allowances for these services. Certain procedures are a combination of a physician component (professional) and a technical component. When the physician component is reported separately, the service may be identified by adding modifier "26" to the usual procedure number. SRS recognizes only patient specific professional services billed with Modifier 26.

- Modifier 50: Bilateral Procedure - Procedures performed on both sides of the body or body area during the same operative session and on the same day are called bilateral procedures. Procedures which are usually performed as bilateral procedures or the code descriptor specifically states that the procedure is bilateral, should not be reported with bilateral modifiers. Use of modifier 50 indicates that a procedure is bilateral, indicating that the procedure is performed twice during the same operative session. When billing for bilateral services the quantity in the units field should always be one. Bilateral procedures are reimbursed at 150% of the contracted allowable.

- Modifier 51: Multiple procedures- when the same provider performs multiple procedures, other than E/M services, at the same session, the primary procedure or service may be reported as listed. Appending the modifier 51 to the additional procedure or service code(s) may identify the additional procedure(s) or service(s). The payment for procedures billed with a modifier 51 will be reduced to 50% of the contracted allowable.

- Modifier 57: Decision to Perform Surgery – An evaluation and management service that resulted in the initial decision to perform the surgery.

- Modifier 59: Distinct Procedural Service - Under certain circumstances, the provider may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encounters or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Document in Box 19 of the CMS 1500 the explanation for the use of modifier 59 or Box 84 of the UB92. Include medical records such as operative reports if the documentation can support the use of modifier 59.

- Modifier 80: Assistant Surgeon - Surgical assistant services are identified by adding the modifier 80 to the procedure. Procedures with a modifier 80 appended will be paid at 16% of the contracted allowable amount.

G. Global Surgical Package - The CPT codes that represent readily identifiable surgical procedures include, on a procedure-by-procedure basis, a variety of services. The following services are always included in the global reimbursement rate, in addition to the surgical procedure:

- 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 and other physicians;
- writing orders;
- evaluating the patient in the post-anesthesia recovery area; and
- typical postoperative care.

Follow-up care for therapeutic surgical procedures includes only that care which is usually a part of the surgical service.

H. Claim Receipt Verification. For verification of claim receipt by SRS, please do the following:

Call: (858) 499-2410

Use the SRS web-based electronic system (IDX Outreach). If you do not have access and are interested in obtaining access, contact the contracts department at 858-499-5505.

II. Dispute Resolution Process for Contracted Providers

A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to SRS 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 SRS 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 SRS. Contracted provider disputes submitted to SRS 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 SRS Provider Dispute Resolution Department at the following:

Via Mail: SRS
Provider Dispute Resolution
P.O. Box 939035
San Diego, CA 92193

C. Time Period for Submission of Provider Disputes.

(i) Contracted provider disputes must be received by SRS within three hundred sixty five (365) days from SRS'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 SRS's inaction, contracted provider disputes must be received by SRS within three hundred sixty five (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 SRS within thirty (30) working days of your receipt of a returned contracted provider dispute.

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

Paper contracted provider disputes will be acknowledged by SRS within fifteen (15) Working Days of the Date of Receipt by SRS.

E. Contact SRS 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 SRS at: (858) 499-2410.

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
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. SRS 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, SRS 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 SRS 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 SRS 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 SRS determines that it has overpaid a claim, SRS 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 SRS 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 SRS's notice of overpayment of a claim, the provider, within thirty (30) Working Days of the receipt of the notice of overpayment of a claim, must send written notice to SRS stating the basis upon which the provider believes that the claim was not overpaid. SRS will process the contested notice in accordance with SRS's contracted provider dispute resolution process described in Section II above.

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

D. Offsets to payments. SRS may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse SRS within the timeframe set forth in Section IV.C., above, and (ii) SRS's contract with the provider specifically authorizes SRS 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, SRS 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. Fee Schedules

A. If the basis of your fee schedule is Medicare, see the Medicare website which we have provided below for your convenience.

http://www.medicarenhic.com/

B. If the basis of your fee schedule is not Medicare, please see your agreement. If after reviewing your agreement and the claims payment policies and rules you still have questions, please contact your contracts representative.

VI. Contractual timeframes

A. Assembly Bill 1455 mandates that your claim submission timeframe cannot not be less than ninety (90) days from the date of service. In the event your agreement has a claims submission timeframe less than ninety (90) days or has no reference to a claims submission timeframe, your claims submission timeframe shall now be ninety (90) days effective January 1, 2004.

B. Any other timeframes which do not meet the minimums requirements outlined in Assembly Bill 1455 shall be considered to now be those timeframes required by law.