

**Humboldt Del Norte Independent Practice Association
And Humboldt Del Norte Foundation for Medical Care
Claims Settlement Practices and Dispute Resolutions 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 procedures as they relate to claim settlement practices and claim disputes for commercial HMO, POS and, PPO plans where the Humboldt IPA/Foundation is delegated to perform claims payment and provider dispute resolution processes.

I. Claim submission instructions

A. Sending Claims to Humboldt IPA/Foundation. Claims for services provided to members assigned to Humboldt IPA/Foundation contracted health plans must be sent to the following:

Mail: Humboldt IPA/Foundation, P.O. Box 1395, Eureka, CA 95502-1395
Office: Humboldt IPA/Foundation, 3100 Edgewood Rd, Eureka, CA 95502-1395
Fax: (707) 442-2047

Clearinghouse: Contact your clearinghouse partner for instructions and submit using the below payor identification for the member’s health plan

Health Plan	Office Ally 949-464-9129 x215	ProxyMed 888-994-7888	WebMD 877-496-3263
Blue Lake Rancheria	hdnfc	IP061	94154
CaliforniaCare	hdnfc	IP059	94154
PALCO/Britt Lumber Co.	hdnfc	IP101	94154
St. Joseph Hospital	hdnfc	IP062	94154
Trinidad Rancheria	hdnfc	IP060	94154

B. Contacting Humboldt IPA/Foundation Regarding Claims. For Claim filing requirements or status inquiries, you may contact Humboldt IPA/Foundation’s Customer Services Department at:

Telephone: (707) 443-4563 or, toll free at (866) 443-4563
Email: csr@hdnfmc.com
Fax: (707) 442-2047
Web site hdnfmc.com

C. Claims Submission Requirements. The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by the Humboldt IPA/Foundation as required by Assembly Bill 1455.

Claims Filing Timeframe

Humboldt IPA/Foundation will accept claims from contracting providers if they are submitted within 90 calendar days from the date of service except as described below. If Humboldt IPA/Foundation is not the primary payer under coordination of benefits (COB) rules, the claim submission period begins on the date the primary payer has paid or denied the claim. Claims not received within the timely filing period will be denied. If a claim is denied for timely filing but the provider can demonstrate “good cause for delay” through the provider dispute resolution process, Humboldt IPA/Foundation will accept and adjudicate the claim as if it had been submitted within the provider’s claim filing timeframe.

Complete Claims Definition

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

Claims Submission Information Instructions

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

Patient's ID number	Enter ID number as it appears on the patient's ID card. Social security numbers are not to be used as per SB168.
Patient's last name and first name	Enter name exactly as it appears on the patient's ID card. Do not use nicknames or special symbols.
Patient date of birth	Do not include "/" or "-".
Employer group number	
Referring provider name	Only for non-primary care providers.
Rendering provider name	Type the provider's name. Please do not cover the typed name when signing.
Rendering Provider's Tax ID or Social Security number	No spaces or "- " are necessary.
ICD-9 Diagnosis Codes	Include required digits. Decimal points are optional.
Date(s) of Service	Enter both From and To dates.
Place of Service	Use the current 2-digit CMS codes (Professional claims only).
Type of Service	Use the current 2-digit CMS codes (Professional claims only).
CPT or HCPCS Code (professional claims) OR UB-92 Revenue code with description (hospital claims)	Current year codes required. Deleted codes will be rejected. Use only standard modifiers.
# of days or units per service line (professional claims only)	Enter actual quantity. "010" will be read as "10".
Billed Charge	
Authorization number, if required	Include medical records if necessary.
Locum Tenens Physicians	Indicate physician for whom they are providing coverage.
Primary payer remittance advice	Only when submitting secondary claim for payment.
Injury information	Only when submitting claim for injury-related services.
Invoice	Only when billing DME, orthotics and supplies.
Medical Records	<ul style="list-style-type: none">• When service billed requires authorization and it does not match the service authorized or is in addition to service authorized.• When an unlisted (XXX99) code is being billed.

Date of Receipt

Date of receipt is the business day when a claim is first delivered, electronically or physically, to the Humboldt IPA/Foundation's designated address.

Reimbursement of Claims

Humboldt IPA/Foundation will reimburse each claim, or portion thereof, according to the agreed upon contract rate no later than 45 business days after receipt of the claim unless the claim is contested or denied. Humboldt IPA/Foundation reserves the right to adjudicate claims using reasonable payment policies and non-standard coding methodologies that are consistent with standards accepted by nationally recognized medical organization, federal regulatory bodies and major credentialing organizations.

Interest on Late Payment of Claims

The late payment on a complete claim for emergency services that is neither contested nor denied will automatically include the greater of:

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

Late payments on all complete claims for non-emergency services will automatically include interest at the rate of 15 percent per annum for the period of time that the payment is late. If Humboldt IPA/Foundation 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 Humboldt IPA/Foundation fails to notify the provider of service in writing of a denied or contested claim, or portion thereof, and ultimately pays the claims in whole or part, computation of the interest will begin on the first calendar day after the applicable time period for denying or contesting claims has expired.

D. Claim Receipt Verification and Acknowledgement of Claims

Humboldt IPA/Foundation will provide claim receipt verification and acknowledgement of claims, whether or not the claims are complete, within two business days for electronically submitted claims. For all other claims submissions, Humboldt IPA/Foundation will provide an acknowledgement of claims receipt within 15 business days of receipt. A provider may verify receipt of claims and obtain an acknowledgement of claim receipt in the following manner:

Telephone: 707-443-4563 or toll free at 866-443-4563

Website: hdnfmc.com (Contact Customer Service for secure access information.)

II. Dispute Resolution Process for Contracted Providers

- A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to Humboldt IPA/Foundation 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:

- If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Humboldt IPA/Foundation 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;

- 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
- 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 Humboldt/IPA Foundation. Humboldt IPA/Foundation does not accept verbal provider disputes (e.g. via phone). Providers must submit disputes in writing on the PDR Request Form or in some other format that includes all the required information in Section II. A., above. Authorization requests received after the service has been billed and denied will be handled as a PDR. Blank PDR Request Forms will be mailed, e-mailed or faxed to providers upon request, or can be downloaded from the Foundation website at www.hdnfmc.com. All provider disputes must be sent to the attention of the Claims Manager, Humboldt IPA/Foundation at the following:

Mail: Humboldt IPA/Foundation, P.O. Box 1395, Eureka, CA 95502-1395
Office: Humboldt IPA/Foundation, 3100 Edgewood Rd, Eureka, CA 95502-1395
Fax: (707) 442-2047

C. Time Period for Submission of Provider Disputes.

- Contracted provider disputes must be received by Humboldt IPA/Foundation within 365 days from Humboldt IPA/Foundation's action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute, or
- In the case of Humboldt IPA/Foundation's inaction, contracted provider disputes must be received by Humboldt IPA/Foundation within 365 days of the date of service.
- Contracted provider disputes that do not include all required information as set forth above in Section III.B. may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to Humboldt IPA/Foundation within thirty (30) working days of your receipt of a returned contracted provider dispute.

D. Acknowledgment of Contracted Provider Disputes. Humboldt IPA/Foundation will acknowledge receipt of all contracted provider disputes as follows:

- Electronic contracted provider disputes will be acknowledged within two (2) working days of the date of receipt.
- Paper contracted provider disputes will be acknowledged within fifteen (15) working days of the date of receipt.

E. Contacting Humboldt IPA/Foundation 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 Humboldt IPA/Foundation at: (707) 443-4563 or toll free at (866) 443-4563.

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 by using the Humboldt IPA/Foundation's "Multiple Like Claims" PDR form or in some other format that includes all the required information in Section II. A., above.

- G. Time Period for Resolution and Written Determination of Contracted Provider Dispute. Humboldt IPA/Foundation 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, Humboldt IPA/Foundation 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 Humboldt IPA/Foundation 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:
- If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Humboldt IPA/Foundation 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;
 - 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. Non-contracted Provider 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 through H., above.

IV. Claim Overpayments

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

C. No Contest. If the provider does not contest Humboldt IPA/Foundation's notice of overpayment of a claim, the provider must reimburse Humboldt IPA/Foundation within thirty (30) working days of the provider's receipt of the notice of overpayment of a claim.

D. Offsets to payments. Humboldt IPA/Foundation may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when:

- (i) the provider fails to reimburse Humboldt IPA/Foundation within the timeframe set forth in Section IV.C., above, and
- (ii) Humboldt IPA/Foundation's contract with the provider specifically authorizes Humboldt IPA/Foundation 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, Humboldt IPA/Foundation 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.