Provider Disputes

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Introduction

If you have a dispute regarding a claim you submitted to HPSM, you may participate in HPSM's Provider Dispute Resolution (PDR). This process applies to all lines of business for contracted as well as non-contracted providers with one exception. This exception is for non-contracted providers who have a dispute regarding a claim for services provided a CareAdvantage member. In this case, the dispute must be resolved following federal guidelines that apply to Medicare managed care plans which are described at the end of this Section.

If a provider is dissatisfied with aspects of HPSM's operations, or with another providers, or member's activities or behaviors, the provider may contact HPSM's Provider Services Department at **650-616-2106**.

If a provider wants to submit an appeal of a denial of a service authorization on behalf of a member, please refer to the Member Complaints Section of this Manual. HPSM's PDR process must not be used to resolve member appeals of pre-service authorization denials. Such appeals should be submitted through the member appeals process described in Section 3 of this Manual.

Provider Dispute Resolution Process

HPSM offers the Provider Dispute Resolution (PDR) for Providers to resolve claims issues. This process includes a written notice to HPSM requesting reconsideration of a claim or a bundled group of substantially similar claims. You can address any of the following concerns through HPSM's Provider Dispute Resolution Process:

- Claims believed to be inappropriately denied, adjusted, or contested.
- Resolution of a billing determination or other contract dispute.
- Disagreement with a request for reimbursement of an overpayment of a claim.
- If a claim has been underpaid.
- A procedure was denied as inclusive to another procedure in error.
- Utilization management decisions once a service has been provided. NOTE: The PDR process should not be used to request retro-authorization. Instead, retro authorization requests should be submitted directly to HPSM's Health Services department.

If the dispute is not about a claim, a Provider should provide a clear explanation of the issue. If a provider dispute is submitted on behalf of a member or group of members, the dispute will be resolved through the member grievance process and not through the provider dispute resolution process. HPSM will, however, verify the member's authorization to proceed with the grievance.

Providers should submit their dispute through submission of a Provider Dispute Resolution Request form. The form requests the following information:

- Provider name
- NPI billed on claim
- Provider contact information
- Identification of the disputed item, including
  - The original HPSM claim number
  - Date of service
  - A clear description of the basis upon which the Provider believes the payment amount, request for additional information, request for the overpayment of a claim, denial, adjustment or other actions is incorrect.

A sample of the Provider Dispute Resolution form is included in this section. The form is also available on HPSM's website at www.hpsm.org. You may FAX your PDR request to: 650-829-2051 or if you want to print the form and send it via the US mail please send your PDR to the address below:

Health Plan of San Mateo
Attn: Provider Disputes
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

Time Period for Submission

Provider disputes should be sent within 365 days of the date when a claim was denied. However, if a Provider resubmits a claim with additional information and the claim is denied, the 365 days will be calculated from the denial of the resubmitted claim. HPSM will return any provider dispute that is lacking the information required (as previously noted) if it is not readily accessible to HPSM. In this case, HPSM will clearly identify in writing the missing information necessary to resolve the dispute. A provider may submit an amended provider dispute within 30 working days of the date of receipt of a returned provider dispute requesting additional information. If the additional information is not submitted, the dispute will be closed.

Time Frames for Resolution

HPSM will send an acknowledgement letter to the Provider within 15 working days of receipt of the dispute mail.

HPSM will resolve a provider dispute or amended provider dispute and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days for Medi-Cal and 60 calendar days for CareAdvantage disputes from Contracted providers after the date of receipt of the provider dispute or the amended provider dispute. If an investigation shows that a claim was originally denied or paid incorrectly due to HPSM error, any interest and penalty due for late payment will be included in the claim payment. Payment will be made within 5 working days from the issuance of HPSM's

determination. If the dispute involves an issue of medical necessity or utilization management for a service that has not been provided, the Provider should appeal this through HPSM's Appeal Process. To understand how to appeal, please refer to the Member Complaints Section of this Manual. The chart on page 6 shows the PDR process described above.

Non-Contracted Provider Disputes —CareAdvantage Only

Non-Contracted providers who want to submit a CareAdvantage Appeal of a benefit determination on behalf of a member, must submit the appeal to the Grievance and Appeals Department according to Section 3 of this Manual. However, unlike other lines of business, providers must sign a waiver of liability statement attesting that they waive any right to collect payment from the member in order for HPSM to process the appeal. The G&A time frames differ from 60 days perhaps best to remove language??

Non-Contracted providers, who want to submit a dispute regarding a payment decision, must submit the dispute through the Provider Dispute Resolution process.

Corrected Claims

Corrections by providers to previously submitted claims are not considered provider disputes. Corrections can be submitted using one of the following options.

Rebill Claims

Most denied claims and service lines can be rebilled as a new claim or updated/corrected as long as the claim is submitted in a timely manner.

Rebill when HPSM denies a claim because of incorrect information supplied on the claim form. In such cases you can rebill these claims by submitting a new claim form that has corrected the issue that triggered the denial. For example, you can rebill for claims that HPSM denied because of:

- Lack of required information (e.g., NDC, primary insurance information, rendering NPI, modifiers, medical records/invoice and HIPPS codes)
- Invalid data (e.g., ICD-10 codes or sets, invalid modifier for the service/item)

How to rebill claims

You can rebill HPSM using the same method used to submit claims. *Please submit denials requesting additional documentation on paper and address to:*

Health Plan of San Mateo
Attn: Claims Processing

801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

Submission timeframes

- Medi-Cal: Rebill within 6 months of service date
- CareAdvantage and HealthWorx: Within 12 months of service date

Updates or corrections to claims

Update or correct claims when you want to change a claim that has already been processed. For example, you can correct or update claim(s) or claim line(s) when you want to:

- Make changes to paid service line(s)
- Report overpayments (including retro application of share of cost deductions)
- Request reimbursement for a claim or service line that was originally denied as a duplicate

How to correct or update claims

1. Complete the Claims Correction Request Form completely: be sure to include all the required information
2. Attach a copy of the corrected CMS-1500 or UB-04 form
3. Submit the form to HPSM by fax or mail:

   Fax: **650-829-2051**

   Mail: Health Plan of San Mateo
   Attn: Claim Corrections
   801 Gateway Blvd., Suite 100
   South San Francisco, CA 94080

Additional information

- Be sure to only submit corrections or updates *after* receiving the final disposition of the claim in question
- Providers are encouraged to use the rebill process noted above when possible as this will expedite reimbursement
- To check the status of a claim call **650-616-2056** or email claimsinquiries@hpsm.org
- To submit a formal appeal or dispute use the standard appeal or dispute process, not the Claim Correction Request form

PROVIDER DISPUTE MECHANISM – Page 1

Written Provider Dispute Rec'd

- provider name
- provider ID#
- provider contact info

Is dispute regarding a claim or request for reimbursement of overpayment?

YES

For Contracted & Noncontracted Providers

- clear ID of the disputed item
- date of service
- clear explanation of basis for provider's feeling pymt request denial contest or pymt adj is incorrect

NO

For Contracted Providers

- clear explanation of issue and provider's position thereon

Is dispute being submitted on behalf of enrollee?

- name & ID of enrollee
- clear expl of disputed item
- date of service
- provider's position thereon

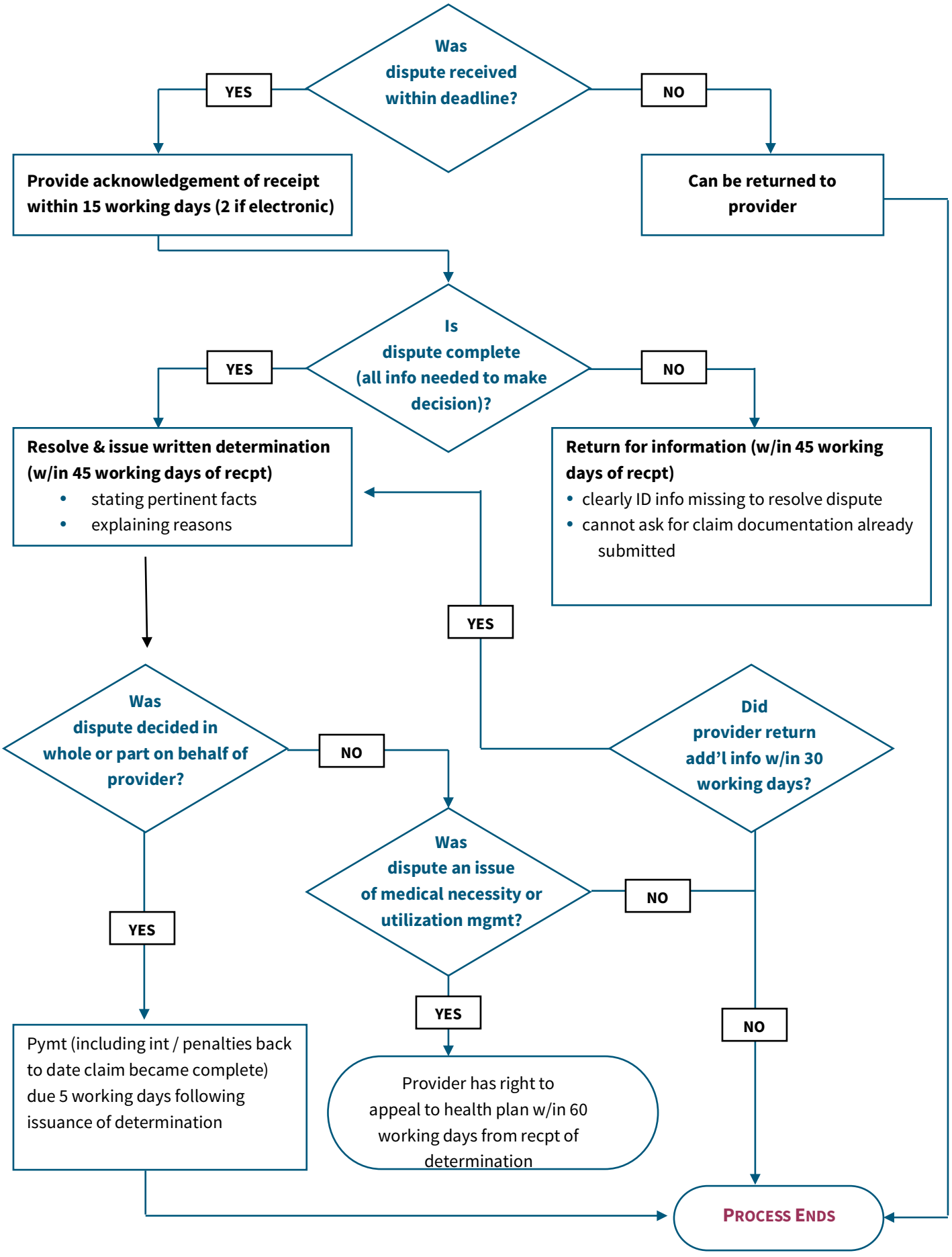
YES

Refer Dispute to HPSM's Grievance Process

- HPSM may verify the member's authorization to proceed with the grievance

NO

Date Stamp the dispute when received and process as a Provider Dispute (**SEE PAGE 2**).


Was dispute received within deadline?
YES
NO
Provide acknowledgement of receipt within 15 working days (2 if electronic)
Can be returned to provider
Is dispute complete (all info needed to make decision)?
YES
NO
Resolve & issue written determination (w/in 45 working days of recpt)
• stating pertinent facts
• explaining reasons
Return for information (w/in 45 working days of recpt)
• clearly ID info missing to resolve dispute
• cannot ask for claim documentation already submitted
YES
Was dispute decided in whole or part on behalf of provider?
NO
Did provider return add'l info w/in 30 working days?
Was dispute an issue of medical necessity or utilization mgmt?
NO
YES
YES
NO
Pymt (including int / penalties back to date claim became complete) due 5 working days following issuance of determination
Provider has right to appeal to health plan w/in 60 working days from recpt of determination
PROCESS ENDS

PROVIDER DISPUTE RESOLUTION REQUEST

By submitting this form, I agree not to bill the member(s) named on it.
***Initial here and sign at bottom of form*: _____**

INSTRUCTIONS

- **For routine follow-up,** please contact Health Plan of San Mateo's Claims Department at (650) 616-2056.
- **To request dispute resolution**, please complete the form below. **Fields with an asterisk (*) are required.**
- Be specific when completing the *Description of Dispute* and *Expected Outcome*.
- Provide additional information to support the description of the dispute. You do not need to include a copy of a claim that was previously processed.
- **Fax** the front and the back of the completed form to **(650) 829-2051** or **mail** it to:
  Attn: Provider Disputes
  Health Plan of San Mateo
  701 Gateway Boulevard, Suite 400
  South San Francisco, CA 94080

*Provider Name:	*NPI #:
Provider Address:	
Provider Type: ☐ PCP ☐ Specialist ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other (please specify):	
Line of Business: ☐ Medi-Cal ☐ CareAdvantage ☐ ☐ HealthWorx ☐ ACE ☐ Healthy Kids	☐ Contracted ☐ Non-Contracted ***(see back of form, for CareAdvantage only)***

*Claim Information ☐ Single ☐ Multiple "like" claims (complete a Supplemental Form) *Total number of claims:* _____

*Member Name	Date of Birth:	
*Member ID Number:	Original Claim ID Number (if multiple claims, use attached spreadsheet):	
Service "From/To" Dates **Required for Claim, Billing, and Reimbursement of Overpayment Disputes*	Original Claim Amount Billed:	Original Claim Amount Paid:

Dispute Type ☐ Denied Claim ☐ Underpayment of a Claim ☐ Request for Reimbursement of Overpayment ☐ Appeal of Medical Necessity / Utilization Management Decision ☐ Contract Dispute ☐ Other (please specify):

* Description of Dispute (continue on back if needed):

Expected Outcome:

Contact Name (please print)	Title	( ) Phone Number
Signature	Date	( ) Fax Number

☐ Check here if additional information is attached. *(Please do not staple additional information.)*

For Health Plan Use Only: Tracking #: Provider ID #:

HEALTH PLAN OF SAN MATEO PROVIDER DISPUTE RESOLUTION REQUEST (SIDE 2)

☐ **I am NOT a CareAdvantage Contracted Provider.** ***(Please complete and sign the waiver below.)***

☐ **I am a Contracted Provider.** ***(Please disregard the waiver.)***

HEALTH PLAN OF SAN MATEO
WAIVER OF LIABILITY STATEMENT

Member Name	Member ID / Member HIC Number
Provider Name	Dates of Service
Health Plan of San Mateo	
Health Plan	

As a provider of the mentioned member(s) , I hereby waive any right to collect payment from the mentioned member(s) for the mentioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature	Date
H5428_CA_3070_08 (approved 02/08/2008)	

Description of Dispute (continued)

For Health Plan Use Only: Tracking #: Provider ID #:

HealthPlan OF SAN MATEO

PROVIDER DISPUTE RESOLUTION REQUEST

Supplemental Form for Use with Multiple "Like" Claims

By submitting this form, I agree not to bill the member(s) named on it.

Initials of signatory on main form*: _____ *For CareAdvantage only, also see back of form.

This form provides additional information for the following dispute resolution request:

Provider Name	**To cross-reference this supplemental form with the main form, please give member's name from main form:**	**Date**

#	Member Last Name - - - - - - - - - - - - Member First Name	DOB	Health Plan ID #	Original Claim ID #	Service "From/To" Dates	Original Claim Amount Billed - - - - - - - - - - - Original Claim Amount Paid	Expected Outcome
1							
2							
3							
4							

☐ Check here if additional information is attached. *(Please do not staple additional information.)*
This is Supplemental Form # _____of _____ supplemental forms for this request.

For Health Plan Use Only
Tracking #:
Provider ID #:

HEALTH PLAN OF SAN MATEO
PROVIDER DISPUTE RESOLUTION REQUEST
SUPPLEMENTAL FORM (SIDE 2)

☐ **I am NOT a CareAdvantage Contracted Provider.** ***(Please complete and sign the waiver below.)***

☐ **I am a Contracted Provider.** ***(Please disregard the waiver.)***

HEALTH PLAN OF SAN MATEO
WAIVER OF LIABILITY STATEMENT

Member Name #1 from reverse side	Member ID / Member HIC Number
Member Name #2 from reverse side	Member ID / Member HIC Number
Member Name #3 from reverse side	Member ID / Member HIC Number
Member Name #4 from reverse side	Member ID / Member HIC Number
Member Name #5 from reverse side	Member ID / Member HIC Number
Provider Name	Dates of Service

Health Plan of San Mateo

Health Plan

As a provider of the mentioned member(s) , I hereby waive any right to collect payment from the mentioned member(s) for the mentioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature	Date

H5428_CA_3070_08 (approved 02/08/2008)

For Health Plan Use Only: Tracking #: Provider ID #: