Health Plan of San Joaquin

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 Health Plan of San Joaquin (HPSJ) members, to include Medi-Cal, Healthy Families, Healthy Kids and Healthy Connections. 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 HPSJ. Claims for services provided to HPSJ members must be sent to the following:

Via Mail:	Health Plan of San Joaquin P. O. Box 30490 Stockton, CA 95213-30490
Via Physical Delivery:	7751 South Manthey Road French Camp, CA. 95231
Via Fax:	(209) 942-6305
Electronic Submission: EDI	Doctors Referral Express (DRE)

B. Calling HPSJ Regarding Claims. For claim filing requirements or status inquiries, you may contact HPSJ by calling: (209) 942-6340

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

Claims must be submitted for payment within 150 days from the Date of Service. Health Plan claims and encounters are to be submitted on the HCFA 1500 or UB92 billing forms and include the minimum amount of itemized, accurate and material information in order for HPSJ to timely and accurately process the claim for payment.

D. Claim Receipt Verification. For verification of claim receipt by HPSJ, please call (209) 942-6340.

HPSJ will acknowledge receipt of papers claims within fifteen (15) Working Days of receipt of the claim. Claims received electronically (EDI or DRE) will be acknowledged within two (2) Working Days of receipt of the claim.

II. Dispute Resolution Process for Contracted Providers

A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to HPSJ 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 HPSJ 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. Submission Requirements for Contracted Provider Disputes to HPSJ. **Contracted provider disputes must be submitted to HPSJ on a Provider Dispute Resolution Request form. The form must include the information listed in Section II.A., above, *for each contracted provider dispute*. Failure to submit your provider disputes on the HPSJ Provider Dispute Resolution Request form may result in a delay of processing and will fall outside of the dispute processing guidelines set by DMHC.** All contracted provider disputes must be sent to the attention of the Claims Department at:

Via Mail:	Health Plan of San Joaquin P. O. Box 30490 Stockton, CA 95213-30490
Via Physical Delivery:	7751 South Manthey Road French Camp, CA. 95231
Via Fax:	(209) 461-2555 or 461-2487
Electronic Submission: EDI	Doctors Referral Express (DRE) https://provider.hpsj.com/dre/default.aspx

C. Time Period for Submission of Provider Disputes.

i. Contracted provider disputes must be received by HPSJ within 365 days after the last date of action that led to the dispute, or
ii. In the case of inaction, contracted provider disputes must be received within 365 days after the provider's time for contesting or denying the claim 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 you for completion. An amended contracted provider dispute which includes the missing information may be submitted to HPSJ within thirty (30) Working Days of your receipt of a returned contracted provider dispute.

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

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

E. Contact HPSJ 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 (209) 942-6340.

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. HPSJ 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, HPSJ 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. Claim Overpayments

A. Notice of Overpayment of a Claim. If it has been determined that a claim has been overpaid, HPSJ 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 HPSJ 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 HPSJ'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 HPSJ stating the basis upon which the provider believes that the claim was not overpaid. HPSJ will process the contested notice in accordance with the contracted provider dispute resolution process described in Section II above.

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

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

PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

Health Plan of San Joaquin

INSTRUCTIONS

- Please complete the below form. 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. Do not include a copy of a claim that was previously processed.
- For routine follow-up, please contact Member Services at 209-942-6340
- Mail the completed form to: Health Plan of San Joaquin
  P.O. Box 30490
  Stockton, CA 95213-30490

*PROVIDER NAME:	*PROVIDER TAX ID # / Medicare ID #:
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC
☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____
(please specify type of "other")

CLAIM INFORMATION ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet) *Number of claims*:_____

* Patient Name:		Date of Birth:
* Health Plan ID Number:	Patient Account Number:	Original Claim ID Number: (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE

☐ Claim
☐ Seeking Resolution Of A Billing Determination
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Contract Dispute

* DESCRIPTION OF DISPUTE:	EXPECTED OUTCOME:

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

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**

For Health Plan/RBO Use Only
TRACKING NUMBER _____ PROV ID# _____
CONTRACTED _____ NON-CONTRACTED _____

PROVIDER DISPUTE RESOLUCTION REQUEST

(For use with multiple "LIKE" claims)

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
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[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
(Please do not staple)