

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. 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:

Electronic Submission: EDI

Via Mail: Health Plan of San Joaquin
P. O. Box 30490
Stockton, CA 95213-30490

Via Physical Delivery: Health Plan of San Joaquin
7751 South Manthey Road
French Camp, CA 95231

B. Submission Requirements, Supplemental Information and Documentation for Claims

Claims must be submitted for payment within 365 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.

C. Receipt Verification for Claims Submitted

HPSJ will acknowledge claims received electronically (EDI) within two (2) working days of receipt of the claim. Paper claims received will be acknowledged within fifteen (15) working days of receipt of the claim. Alternatively, you can call customer service (209) 942-6340 for verification of claim receipt by HPSJ.

D. Calling HPSJ Regarding Claims

For claim filing requirements or status inquiries you may contact HPSJ by calling customer service at (209) 942-6340.

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II. Dispute Resolution Process for Contracted and Non-Contracted Providers

A. Definition of Provider Dispute

A provider dispute is a provider's written notice to HPSJ challenging, appealing or requesting reconsideration of a claim that has been paid, denied, or adjusted.

Disputes come in one of five categories:

- Appeal of Medical Necessity/Utilization Management Decision
- Contract Dispute
- Recovery Dispute
- Requested Additional Documentation
- Seeking Resolution of a Billing Determination

Each provider dispute submitted must contain, at a minimum the following information:

- Provider's Name
- Provider's Identification Number
- Health Plan Id Number
- Patient's Name and Date of Birth
- Original Claim Id
- Service From/To Date
- Description of Dispute

Note: 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.

B. Submission Requirements for Provider Disputes to HPSJ

- Contracted Providers must submit a provider dispute online on DRE
Electronic Submission: Doctors Referral Express (DRE)
<https://provider.hpsj.com/dre/default.aspx>
- Non-Contracted Providers disputes must be sent to the attention of the Claims Department at:

Mail

Health Plan of San Joaquin
P. O. Box 30490
Stockton, CA
95213-30490

Physical Delivery

Health Plan of San Joaquin
7751 South Manthey Road
French Camp, CA
95231

Note: Failure to submit the provider dispute through DRE or on the HPSJ PDR form will be returned for completion and may result in a delay of processing and potentially could fall outside of the dispute processing guidelines set by DMHC.

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C. Time Period for Submission of Provider Disputes

- Provider disputes must be received by HPSJ within 365 calendar days after the last date of action that led to the dispute.
- Once a determination has been provided and additional documentation has been requested a new provider dispute which includes the missing information may be submitted to HPSJ within thirty (30) working days of receipt.

D. Acknowledgment of Provider Disputes

HPSJ will acknowledge receipt of all provider disputes as follows:

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

E. Contact HPSJ Regarding Provider Disputes

All inquiries regarding the status of a provider dispute or about filing a provider dispute must be directed to customer service at (209)942-6340.

F. Time Period for Resolution and Written Determination of 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 provider dispute or the amended provider dispute.

G. Past Due Payments

If the provider dispute or amended 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.

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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 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 the provider fails to reimburse HPSJ within the timeframe set forth in Section III.C., above when 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.

PROVIDER DISPUTE RESOLUTION REQUEST (PDR)

Note: submission of this form constitutes agreement not to bill the patient



- Please complete the form with required fields identified with an asterisk.
- Be specific when completing the Description of Dispute and Expected Outcome sections.
- Provide additional information to support the dispute.
- Do not use this form if submitting a corrected claim.
- For questions on completing this form or status on PDR contact customer service at 209-942-6340.
- Mail the completed form to: Health Plan of San Joaquin
P.O. Box 30490
Stockton, CA 95213-30490

PROVIDER INFORMATION

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

CLAIM INFORMATION

* Patient Name:		* Date of Birth:	
* Health Plan ID Number:	Patient Account Number:	* Original Claim ID Number (ONLY ONE CLAIM PER PDR FORM):	
* Service "From/To" Date:	Original Claim Amount Billed:	Original Claim Amount Paid:	

DISPUTE TYPE

<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Recovery Dispute
<input type="checkbox"/> Contract Dispute	<input type="checkbox"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Requested Additional Documentation	

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

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

[] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED