Scripps Physicians Medical Group
DISPUTE RESOLUTION MECHANISM
NON-CONTRACTED MEDICARE ADVANTAGE MEMBER CLAIMS

A. Definition of Non-Contracted CMS Provider Appeal. Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) in writing of a Medicare Advantage plan payment denial determination, in whole or in part, including issues related to bundling, level of care, or down-coding of services/DRG. Any claim paid in whole or part can result in an appeal.

B. Definition of Non-Contracted CMS Provider Payment Dispute. Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may dispute a service via telephone or in writing that the provider contends has been paid at less than the amount that would have been paid under original Medicare for Medicare Advantage claim(s).

C. Sending a Provider Dispute to SPMG. Provider disputes submitted to SPMG must include the information listed in Section II.B., above, for each provider dispute. All provider disputes must be sent to the attention of *Provider Disputes* at the following:

Via Mail: Scripps Physicians Medical Group
c/o SCPMCS
P.O. Box 7250
Laverne, CA. 91750

D. Time Period for Submission of Non-Contracted CMS Provider Appeals and Disputes.

1. Submission of a Non-Contracted Senior Appeal must be received by the health plan within 60 calendar days from the date of the explanation of benefits issued by SCPMCS.
It must be submitted in writing, and must include at a minimum a signed Waiver of Liability form holding the member harmless (obtainable at https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip). Scripps Physicians Medical Group is not delegated by the health plans to process any appeals received from non-contracted providers and must forward them to the health plans within ten calendar days of receipt.

2. Submission of first level non-contracted provider payment disputes must be received by SPMG within 125 calendar days from the date of the explanation of benefits issues by SPMG.

3. If a provider dispute is denied due to untimely submission the provider has up to 180 calendar days from the date of the denial letter to provide additional documentation for good cause of untimely filing.

4. Provider disputes that do not include necessary documentation for review the provider will be notified of what documentation is required. The provider will have 14 calendar days to submit the requested documentation.

E. Time Period for Resolution and Written Determination Non-Contracted CMS Provider Dispute.

SPMG will issue a written determination stating the pertinent facts and explaining the reasons for its determination within thirty (30) Calendar Days after the Date of Receipt of the provider dispute. The resolution letter must also inform the provider of their right to a Second Level process with the Health Plan.

F. Second Level Provider Payment Dispute

The non-contracted provider's request for a Second Level review is to be sent to the Health Plan address indicated below. Requests for Plans without a specific review address should be sent to the address on the Member's identification card.

Aetna Medicare Health Plan
P.O. Box 14067
Lexington, KY 40512

Alignment Health Plan
PO Box 14012
Orange, CA 92863

Anthem Blue Cross
Grievances and Appeals
OH0205-A537 Mail Location
4361 Irwin Simpson Rd
Mason, OH 45040-9398

Blue Shield 65 Plus HMO
PO Box 927
6300 Canoga Avenue
Woodland Hills, CA. 91365-9856
Phone: 1 (800) 776-4466
Fax: 916–350-6510

Promise Health Plan
Attn: Provider Dispute Dept.
PO Box 3829
Montebello, CA. 90640

Health Net
PO Box 10406
Van Nuys, CA. 91410

SCAN Health Plan
P.O. Box 22698
Long Beach, CA 90801