San Diego Physicians Medical Group/Scripps Physicians Medical Group ("SDPMG/SPMG")

CLAIMS SETTLEMENT PRACTICES

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 commercial HMO, POS, and, where applicable, PPO products where San Diego Physicians Medical Group/Scripps Physicians Medical Group (SDPMG/SPMG) is delegated to perform claims payment and provider dispute resolution processes. 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 SDPMG/SPMG. Claims for services provided to members assigned to SDPMG/SPMG must be sent to the following:

Via Mail:	San Diego Physicians Medical Group/Scripps Physicians Medical Group c/o SCPMCS P.O. Box 7250 La Verne, CA. 91750
Via Clearinghouse:	Through Office Ally using Payor ID "SCP01" Contact OA: (360) 975-7000 or info@officeally.com

B. Calling SDPMG/SPMG Regarding Claims. For claim filing requirements or status inquiries, you may contact SDPMG/SPMG by calling: (858) 824-7000.

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

1. Claims must be submitted within ninety (90) days of the date of service.
2. Paper Claims must be submitted on a RED CMS-1500 form, or a UB-04 (or current version).
3. Claims must contain the following information:
    a. Insured's name (as shown on the ID card)
    b. Insured's address
    c. Member ID/Policy ID Number (as shown on the ID card)
    d. Patient's name
    e. Patient's date of birth
    f. Diagnosis consistent with services rendered and current ICD-10 code(s) Principal or Primary Diagnosis Code cannot be an External Cause of Injury Code (s) (includes V, W, X, and Y codes).

g. Itemized charges, with current CPT or UB-04 billing codes, modifiers (required for anesthesia claims), units, and description of procedure(s)
h. Date(s) of service
i. Insurance carrier
j. Authorization number (if applicable)
k. Rendering Provider's name and Individual National Practitioner Identification ("NPI"). Only one Rendering Provider may be listed per claim.
l. Provider's physical address
m. Provider's Federal Tax ID number, billing address and Organizational NPI.
n. Referring provider's name and NPI (if different from rendering provider).
o. Location of service including physical address and applicable NPI (if different from rendering provider location). See Section D.
p. Other insurance information (if applicable)
q. Accident details (if applicable)
r. NDC Codes & drug units are required when drugs are billed with codes in the following ranges: A9513, A9543, A9606, C9014 – C9497, G9033, J0001 - J9999, Q0090 - Q9995, S0020 – S5001 and 90281 – 90284, 90379 – 90399.

4. Claims for surgical services not prior authorized must be accompanied by an operative report.
5. Claims for Hospital Emergency Department services must be accompanied by an Emergency Treatment Record or Emergency Room Report.
6. Claims for supplies or medications reimbursed on cost must be accompanied by a current invoice for the supply or medication.
7. Claims with modifiers identifying review is required must have documentation to support the use of the modifier(s).
8. Claims for additional services not listed on the authorization must be accompanied by applicable portions of the patient's medical records that justify the performance of additional services.
9. Claims for consultations or office visits billed at a higher code than authorized must be accompanied by the consult report or applicable portions of the patient's medical record that justify the higher level of service.
10. Claims where SDPMG/SPMG is the secondary payor must be accompanied by an Explanation of Benefits or Remittance Advice from the primary payor.

D. Facility provider (box 32/32a on CMS-1500): This is the location at which the services were provided. Required **IF** service location is different than the billing location. Name, address, and *Organizational NPI* is required when submitting facility information. Address and NPI should be specific to that location and different than the billing address/NPI. If the facility is the same as the billing, then facility information should be omitted. NOTE: If claim is billed with a

place of service other than the rendering physician's office (e.g 21, 22, 23) the facility information is expected.

E. Claim Receipt Verification. For verification of claim receipt by SDPMG/SPMG, please do the following:

Via telephone: (858) 824-7000
Via Website: mso.scpmcs.org
(Please call the above number to request a User ID.)

II. **Claim Overpayments**

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

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

D. Offsets to payments. SDPMG/SPMG may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse SDPMG/SPMG within the timeframe set forth in Section IV.C., above, and (ii) SDPMG/SPMG's contract with the provider specifically authorizes SDPMG/SPMG to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. If an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, SDPMG/SPMG 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.

For further information on the AB1455 Regulation, please refer to the Department of Managed Health Care's website address: www.dmhc.ca.gov/library/regulations/existing" and see the table for "Claims Settlement Practices/Dispute Resolution Mechanism" for a copy of the specific provisions.