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AB1455 Department of Managed Health Care Title 28, Sections 1300.71 and 1300.71.38
Claims Settlement Practices and Dispute Resolution Mechanism

Purpose:

PacifiCare Health Systems and associated specialty companies will be required to implement Assembly Bill 1455 for PacifiCare of California members, effective January 1, 2004. This bill will regiment how health plans and associated providers administer contracts, process claims, and executes disputes. Successful implementation will require both internal and external (delegated providers') system and process modifications. Finally, the health plan will be held accountable for submitting quarterly and annual claims processing and provider dispute reports (including delegated activities) to the Department of Managed Health Care (DMHC).

**Key Internal Requirements- PacifiCare Of California:**

| Required Modifications | Challenges/Barriers | Action Required |
|---|---|---|
| • Claims - Interest | System modifications - Funding/resource issues | • Interest from prorated to non-prorated |
| • Claims - Acknowledgements | System modifications - Funding/resource issues | • Acknowledgement of all claims received within specified time frames: 2 day electronic; 15 day paper<br>• Increased calls to CS from providers requesting to know if the claim was received and when. |
| • Claims - EOP Language | System modifications - Funding/resource issues | • Include provider dispute language on EOPs |
| • Claims – Status Codes | | • Provide better documentation of status for clarity when needing additional information (This means increased status codes for NICE) |
| • Claims – Auto Debit | System modifications - Funding/resource issues | • Reduction in our ability to auto debit overpayments to only those providers whose contracts allow for auto debit or for providers who would permit by agreement to allow us to auto debit. |
| • Claims – Group Returns | System modifications - Funding/resource issues | • Group returned claims must be forwarded to the appropriate capitated provider within ten (10) working days from the receipt of the claim incorrectly sent to the plan. |
| • Claims - Reasonable and Customary | Cash Flow Issues | • AB 1455 specifies that R&C values be updated at least annually and take into consideration, among other items, the prevailing provider rates charged in the general geographic area in which the services were rendered. This could have significant impact to the bottom line. |

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**Key Internal Requirements- PacifiCare Of California (Continued):**

| Required Modifications | Challenges/Barriers | Action Required |
|---|---|---|
| • Claims - P & P Modifications | | • All Policies and Procedures will need to be reviewed to assure compliance with the law.<br>• Assure that no claims practice, policy or procedure results in repeated delays in the adjudication and correct reimbursement of provider claims. (Demonstrable and unjust payment pattern)<br>• Failure to contest or deny a claim or portion thereof, within the timeframes (30 or 45 working days) at least 95% of the time for affected claims over the course of any three-month period. |
| • Claims - IBNR Calculations | | • Claims are currently Pended or denied if not paid within the designated time frames (according the ERISA and CMS). |
| • Provider Dispute Resolution (PDR) - Definition Changes | | • Disputes will include " any reconsideration request which is submitted in accordance with the submission requirements. |
| • PDR - Submission Requirements | | • Disputes must be submitted to the plan or plans capitated provider within 365 days after the time for contesting or denying the claim has expired<br>• Disputes must be submitted in writing and include the minimum information contained in the regulation. |
| • PDR - Acknowledgements | System modifications – Funding/Resources | • Disputes must be acknowledged with specific timeframes. 15 working days for paper and 2 working days for electronic submissions. |
| • PDR - Resolutions Decision TAT | | • A determination must be reached and communicated in writing within 45 working days after the date of receipt of the complete dispute. |
| • PDR – Interest/Penalties | System modifications – Funding/Resources | • Any interest or penalties must be paid within 5 working days of the issuance of the written determination based upon the receipt date of the initial complete claim. |
| • PDR - System Tracking | System modifications – Funding/Resources | • A new system to track disputes is being developed. This system will be able to capture and communicate the original claim number and reporting requirements. |
| • PDR – P & P Modifications | | • All of the current workflow and policies and procedures are being reviewed and revised to ensure compliance with the changes to the regulation. |

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## Key Internal Requirements- PacifiCare Of California (Continued):

| Required Modifications | Challenges/Barriers | Action Required |
|---|---|---|
| • PDR – Reporting | System modifications - Funding/resource issues | • PCC is working with ICE and the DMHC on the revised reporting format, which will expand the previous PDR reports submitted to the DMHC. |
| • Provider Over Site Audits - | | • The additional requirements for both claims processing and provider disputes will entail developing further auditing procedures to ensure compliance with 1455 |
| • Contracts– | | • Contracts will need to have auto debit language<br>• Notice amendments will be necessary<br>• Any addenda's to the original contract must be communicated 45 days prior to 1/1/04 |

## Key Internal Requirements- PacifiCare Specialty Companies:

| Required Modifications | Challenges/Barriers | Action Required |
|---|---|---|
| • Claims - Overpayment | System modifications - Funding/resource issues | • AB 1455 requires that providers receive written notification from PBH for reimbursement of an overpayment and be given 30 days to repay. While we have already started requesting repayments in this manner, only half of the examining staff has been trained on this procedure. Until the PCA enhancement is added to Facets functionality, this process will continue to require manual follow up. AB 1455 also delays receipt of refunds.<br>• One way to reduce the need to send written requests for refunds and be allowed to recover automatically from the next payment due the provider is to have providers agree to automatic recoveries. |
| • Claims - Acknowledgements | System modifications - Funding/resource issues | • Acknowledgement of all claims received within specified time frames: 2 day electronic; 15 day paper<br>• Increased calls to CS from providers requesting to know if the claim was received and when. |
| • Claims - Reasonable and Customary | Cash Flow Issues | • AB 1455 specifies that R&C values be updated at least annually and take into consideration, among other items, the prevailing provider rates charged in the general geographic area in which the services were rendered. This could have significant impact to the bottom line. |

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**Key Internal Requirements- PacifiCare Specialty Companies:**

| Required Modifications | Challenges/Barriers | Action Required |
|---|---|---|
| • Claims – Coordination of Benefits | | • AB 1455 requires Plans to allow providers 90 days from the date they receive the primary carrier's EOB to submit claim to the secondary carrier. To date, PBH have been working on a 45-day submission timeframe. Change simply widens the submission timeline but will have minimal impact on operations. |
| • Claims – Request for additional information | System modifications may result in funding/resource issues | • AB 1455 addresses requesting medical records in association with emergency claims more frequently than 20% of the time. As we anticipate requesting more medical records with the PPO population who will use unauthorized emergency services, we will need to document why emergency records were required to determine our liability (why the billing and diagnosis was insufficient. |
| • PDR – Acknowledgements | System modifications may result in funding/resource issues | • Disputes must be acknowledged with specific timeframes. 15 working days for paper and 2 working days for electronic submissions. |
| • PDR - Submission Requirements/TAT | | • Disputes must be submitted to the plan within 365 days after the time for contesting or denying the claim has expired<br>• Disputes must be submitted in writing and include the minimum information contained in the regulation.<br>• Disputes must be resolved within 45 working days after the date of receipt of the complete dispute. |
| • PDR – Reporting | | • Develop a revised reporting format, which will expand the requirements according to AB1455 |
| • PDR – Interest/Penalties | System modifications – Funding/Resources | • Any interest or penalties must be paid within 5 working days of the issuance of the written determination based upon the receipt date of the initial complete claim. |
| • PDR Internal Audits - | | • The additional requirements for both claims processing and provider disputes will entail developing further internal auditing procedures to ensure compliance with 1455 |
| • Contracts– | | • Contracts need to include overpayment /refund auto debit language<br>• Notice amendments will be necessary<br>• Any addenda's to the original contract must be communicated 45 days prior to 1/1/04 |

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**Key External Requirements (Delegated Providers):**

In an effort to simplify implementation, improve compliance, and realize cost savings health plans and providers have agreed to work collaboratively to ensure compliance with AB1455 implementation. The Industry Collaborative Efforts (ICE) committee has been established to coordinate the successful implementation of AB1455. These committees are responsible for developing a standard interpretation and implementation through out the industry.

| Required Modifications | Challenges/Barriers | Action Required |
|---|---|---|
| • Provider Dispute Resolution (PDR) - | | • The regulation includes provisions and requirements defining the need for a PDR process for any provider delegated to pay claims |
| • PDR – System Tracking | System modifications - Funding/resource issues | • Each delegated provider will need to implement a tracking system that includes categories of PDR consistent with the regulation. ICE is working on sample reporting formats that will ensure delegated providers submit information necessary for the HealthPlans complete Annual DMHC reporting. |
| • PDR – P & P Modifications | | • ICE is establishing sample policies and procedures compliant with the regulation. Training on the new PDR process is scheduled to roll out to the delegated provider via ICE in October 2003. |
| • Contracts - | | • ICE has established a contract team to coordinate and draft a notice amendment compliant with AB14555 regulations. |
| • Claims – Acknowledgement | Potential cash flow issues if the provider does not send an automatic acknowledgement and must process/pay claims with in 15 days | • Over 95% of our providers are compliant with the 45 working-day claims processing time frame. Some providers, that do not have a two-step claims process, may have to: (1) Re-allocate staff to front-load claims so that they can acknowledge that a claim is received, (2) Provider will have to modify their systems to automatically send an acknowledgement letter for all claims received, within 15 days .If not the provider will be forced to process all their hard copy claims within 15 days – to meet the acknowledgement requirement. |
| • Claims - Reporting | | • Providers currently report claims processing for commercial claims. This reporting may change, but anticipate minimal impact. |



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**Key External Requirements (Delegated Providers):**

| Required Modifications | Challenges/Barriers | Action Required |
|---|---|---|
| • Claims – Forwarding | | • Most providers currently have a policy in place due to the requirement for senior claims. They may have to shift processes to apply to the commercial line of business. |

The greatest concern at this time would be compliance from the PacifiCare specialty companies: PacifiCare Behavioral Health, PacifiCare Dental and Vision.

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