From: Smith, Nicoleta
Sent: Wednesday, June 13, 2007 7:12 PM
To: Cignarale, Anthony; Masters,Robert; Brunelle, Steven; Love, Barbara
Subject: FW: PLHIC Information for Today's Conference Call
Attachments: n8701!.DOC; PPO PDR Policy SB367.doc; PDR Process Flow.vsd; cocc initial enrollent.pdf; eob version3 imr.pdf; CDI issues List_042707 (2).xls

FYI
-----Original Message-----
From: Diaz, Jean [mailto:Jean.Diaz@phs.com]
Sent: Wednesday, June 13, 2007 12:00 PM
To: Smith, Nicoleta
Cc: Ridge, Valerie J
Subject: PLHIC Information for Today's Conference Call

Nicoleta,

Based on last week's discussion, please see the enclosed information for today's conference call at 2:00pm.
thanks

<<n8701!.DOC>> Response letter

<<PPO PDR Policy SB367.doc>> <<PDR Process Flow.vsd>> Attachment 1
<<cocc initial enrollent.pdf>> Attachment 2

<<eob version3 imr.pdf>> Attachment 3

<<CDI issues List_042707 (2).xls>> Attachment 4

Jean Diaz
Director, Regulatory Affairs

Direct Line (714) 226-3081
Fax# 866-383-0428 or (714) 226-3014

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PacifiCare®
A UnitedHealthcare Company

SENT ELECTRONIC MESSAGE

June 13, 2007

Nicoleta Smith
Supervising Compliance Officer
State of California
Department of Insurance
300 South Spring Street
Los Angeles, CA 90013

RE: Follow-Up Questions

Dear Ms. Smith:

On behalf of PacifiCare Life and Health Insurance Company ("PLHIC" or "the Company"), I would like to take this opportunity to respond to the questions that you asked on our conference call on June 6, 2007 which can be discussed further during our conference call today.

1. **Have you finished all of the rework projects which you initially advised would be completed by the end of April, and then moved to the end of May?**

We previously communicated that we would provide a listing of the specific claims to be reviewed and a date upon which the reprocessing would be completed by the end of May. Related to retro contracts, we will complete all reprocessing by July 31, 2007 and will provide a list of those claims that were reviewed (not all of them may require additional payment) at that time. We have already provided all of the claims detail related to a significant portion of the rework project.

2. **How many physicians were involved with the rework projects stated in issue #1 and the resolution?**

On June 15, 2007, we will produce a file for the CDI (Craig Dixon, Chief Field Claims Bureau) that lists all physicians contracted with United from January 1, 2006 to March 31, 2007. This file will also show the number of physicians impacted by retroactive contract loads.

3. **Please provide a copy of flowchart and P&P for Provider Dispute Resolution Process**

Enclosed as Attachment 1 are copies of flowcharts and P&P related to Provider Dispute Resolution Process.

4. **Please provide a copy of flowchart for COCC process**

Enclosed as Attachment 2 is a copy of flowchart for the COCC process.

5. **Please provide an explanation of the 1799 report received on June 1, 2007.**

We had previously sent spreadsheets related to reworks for the COCC. In those spreadsheets, there were numerous claims that did not have any claim payment information. The CDI requested further research on this missing information to determine if a payment was made or not. If not, also provide the reason why. The spreadsheet sent on June 1, 2007 by Valerie Ridge, provides the requested information.

6. **Please provide copy of the final EOB version**

Enclosed as Attachment 3 is a copy of the final EOB (version 3) which was put into production as of June 8th.

7. **Please provide a report of all CAPs completed**

Enclosed as Attachment 4 is a draft report of CAPs completed. This report will be updated periodically and provided to the CDI.

8. **Please provide copies of contracts, EOBs, and list of claim rework details as requested in the specific CDI letters**

We are pulling the previously received CDI letters which were specific provider issues and attempting to pull copies of EOBs and list of claim rework details.

Thank you once again for the opportunity to update me on the above issues. If you have any questions or would like additional information, please feel free to contact me at (714) 226-3081.

Thank you,

Jean Diaz
Director, Regulatory Affairs, PacifiCare

CDI00017378

PacifiCare®

PPO Claims

Subject: **California Provider Dispute Resolution (PDR) Process**	LOB: ☐ CO ☐ SH ☐ POS ☐ NW ☒ PPO
Policy No.:	Date Issued: 08/21/06	Page 1 of 9
Review / Revision Dates: 3/23/07; 5/43/07	
Originated By: Geneva Casey and Lois Norket	
Management Approval: Raynee Andrews, Director	

Identify other departments affected by this procedure, if applicable.

☒ Appeals	☐ Credentialing	☒ Network Management
☐ Benefits Interpretation	☒ Customer Service	☐ Quality Improvement
☐ Case Management	☐ Health Improvement	☐ Retention
☒ Claims	☐ Health Data Analysis	☒ Utilization Management
☐ Clinical Accountability	☐ Health Services	☐ Corporate
☐ Clinical Management	☒ Legal/Regulatory	☐ Membership Accounting
☒ Clinical Review	☐ Pharmacy	☒ Mail Response Team

Indicate below, any regulatory or accrediting standards or requirements addressed by this policy.	
☒ OTHER:	California Senate Bills, SB367 &SB634

Policy: The Claims Rework Team (CRT) implemented a standardized procedure for handling contracted and non-contracted provider disputes. This procedure outlines the Provider Dispute Resolution process, including the roles and responsibilities of affected areas, to ensure PacifiCare's compliance with the established state and federal regulations.

Purpose: To ensure PacifiCare provides a fast, fair, and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes as outlined in Senate Bills SB367 and SB634 (SB367 & SB634).

This Policy is confidential and proprietary to PacifiCare of California and is not to be distributed or copied to any person or entity other than employees of PacifiCare Health Systems.

Acronyms:

C-CAST	Claims Contract Analysis and Support Team
CPD	Clinical Provider Dispute
CPR	Customer Provider Research
CRT	Claims Rework Team
EDI	Electronic Data Interchange
EOP	Explanation of Payment
MRT	Mail Research Team
NM	Network Management
PDR	Provider Dispute Resolution
REVA	Request Evaluation Application

Definitions:

Clean Claim (CO): A complete (clean) claim that provides "reasonably relevant information" and "information necessary to determine payer liability".

Clinical Dispute: A dispute requesting reconsideration of an underpayment or denial of payment based on medical necessity or utilization management.

Contract Dispute: A dispute requesting reconsideration of an underpayment or denial of payment based on contractual or benefit interpretation or a dispute related to the performance of the contract.

Date of Receipt: The date when the provider dispute or amended provider dispute is first received by PacifiCare.

Formal Dispute: A provider's written request for reconsideration of the initial claim determination or the performance of the contract, that meets the regulatory criteria outlined in SB367 & SB634.

Overpayment and Recovery Dispute: A provider's written request for reconsideration of a request for reimbursement of an overpayment or recovered payment.

Pre-Service Dispute: A dispute resulting from the denial of a requested medical service prior to the service being rendered.

Provider Dispute: A contracted or non-contracted provider's written notice challenging an underpayment, denial of payment, non-action on a claim, or a bundled group of substantially similar multiple claims that are individually numbered meeting the regulatory criteria outlined in SB367 &SB634.

Request Evaluation Application (REVA): Tracking, reporting, and processing tool used to capture inventory of rework.

Working Days: Monday through Friday, excluding recognized federal holidays.

Procedure:

1.0 Claims Reworks Team

1.1 The Claims Reworks Team (CRT) was established to provide a fast, fair, and cost-effective dispute resolution process to acknowledge and resolve contracted and non-contracted provider disputes.

1.2 PacifiCare will not discriminate, retaliate against or charge a provider for submitting a provider dispute.

1.3 The provider dispute process cannot be deemed as arbitration.

1.4 PacifiCare will inform providers of the provider dispute process and instruct them on how to file a provider dispute on every Explanation of Payment (EOP) mailed, the PacifiCare website, and through the Customer Service Department as requested.

1.5 Once a claim is coded as a Provider Dispute, it will remain a Provider Dispute through the entire dispute process.

2.0 PDR Submission Requirements

2.1 A dispute must be sent in writing (mail or fax) regarding a date of service on or after January 1, 2006 for a PPO commercial member. Correspondence may be sent to:

PacifiCare
Provider Dispute Resolution
P. O. Box 6035
Cypress, CA 90630

2.2 The provider dispute must include the following regulatory requirements:

- Provider name
- PacifiCare claim number
- Provider contact information
- Date of service
- Clear explanation of the provider's interpretation of payment methodology
- Documents to support the provider dispute position

2.3 Request Evaluation Application (REVA) is used to track provider disputes.

2.4 If a provider is appealing on behalf of a member, the appeal will be forwarded to the Appeals and Grievance Department and processed as a member appeal.

2.5 If a provider dispute is incomplete based on the requirements set forth in SB367 & SB634, an additional information letter will be forwarded to the submitter. A provider dispute cannot be returned to the submitter to request information previously received by PacifiCare.

2.6 If a provider dispute is not received at the designated address but mailed elsewhere within PacifiCare, the dispute will be forwarded in a timely manner to the designated address and/or mailstop for processing.

Note: If the provider dispute is not addressing a claim or request for the return of an overpayment, the provider should submit a clear explanation of the inquiry including a statement documenting their position. PacifiCare does not accept Provider Disputes through Electronic Data Interchange (EDI).

3.0 Timeframes

3.1 The provider dispute submission deadline is three hundred and sixty-five (365) calendar days from date of last action (last action is deemed as payment, denial or non-action).

3.2 A written acknowledgement letter will be sent to the submitter within fifteen (15) working days of receipt of the dispute by the Mail Research Team (MRT) via REVA. Refer to Attachment A.

3.3 If a provider dispute is incomplete based on the requirements set forth in SB367 & SB634, an additional information letter will be sent to the submitter within forty-five (45) working days via REVA. The request will clearly identify missing information needed to resolve dispute. Refer to Attachment B.

3.4 If the provider dispute is upheld, a detailed written determination will be sent to the submitter within forty-five (45) working days of receipt of the dispute. Refer to Attachment C.

3.5 If the provider dispute is overturned within forty-five (45) working days of receipt of the dispute, an additional payment will be paid within five (5) working days from the date of determination with the reason for the overturn listed on the Explanation of Payment. If the additional payment is made after forty-five (45) working days of receipt of the dispute, an additional payment will be made and include any interest or penalties due. A determination letter with the reason for the overturn will be sent within five (5) working days from the date of determination. Refer to Attachment D.

4.0 Contract Disputes

4.1 Contract disputes will be forwarded to the Claims Contract Analysis and Support Team (C-CAST) by the Claims Rework Team (CRT) for contract clarification.

4.2 If a Provider Dispute is submitted with a hard copy contract and it conflicts with the one in the claims system, the CRT will forward the issue directly to C-CAST for review.

4.3 C-CAST will complete the review within fifteen (15) working days from the date received by CRT.

4.4 The CRT Team will send a closure letter if the dispute is upheld.

4.5 If the provider dispute is overturned, CRT will re-process the claim to pay the additional amount including any applicable interest and penalties and send an overturn letter through REVA. (See section 3.5 Processing Overturns (Interest and Penalties))

5.0 Clinical Disputes

5.1 Clinical disputes will be forwarded to Clinical Provider Dispute (CPD) by the Claims Examiner to review issues of medical necessity or utilization management.

5.2 CPD will complete the review within ten (10) working days from receipt by the Claims Examiner and advise them of the outcome.

5.3 The Claims Examiner will send the closure letter if the dispute is upheld.

5.4 The Claims Examiner will re-process the claim to pay the additional amount including any applicable interest and penalties and send an Explanation of Payment and/or determination letter, whichever is applicable. (See section 3.5 Processing Overturns (Interest and Penalties))

Note: Pre-service disputes are always handled through Medical Management, not through the provider dispute process.

6.0 Processing Overturns (Interest and Penalties)

6.1 Payment and any applicable interest and penalties will be processed within five (5) working days from the issue date on the written determination.

6.2 Interest and penalties on overturned provider disputes will be calculated beginning forty-five (45) working days from the date of receipt of the original clean claim.

7.0 Record Retention

7.1 Provider disputes and corresponding documentation will be maintained for a period of no less than five (5) years. All documents will be imaged to the claim number or in the case that there is no claim number, to the member's ID number.

7.2 A minimum of the last two (2) years documentation are to be easily accessible. The previous three (3) years will be stored, warehoused, or placed on microfilm. Stored documentation will be available within five (5) working days of a received request.

8.0 Report Requirements

8.1 The Operations Control Department will provide the required yearly reports as requested by the California Department of Insurance.

Attachment A: Acknowledgement Letter

PacifiCare®
A UnitedHealthcare Company

P.O. Box 6098
Cypress, CA 90630

Today's Date

Provider Name
Contact Name
Street Address
City, State, Zip

Member Name:
Member ID/Claim:
DOS:
Billed Charges:
Account/PCN:
Request ID:

Dear Business Office Manager,

PacifiCare is in receipt of your request for review of the above mentioned claim and is sending this letter as a written acknowledgement. The PacifiCare standard dispute resolution process was developed to ensure the timely response and resolution of provider disputes. The Provider Dispute Resolution Process is not intended to provide a mechanism for re-negotiation of the terms of the provider agreement, but rather provides an avenue by which a provider may submit a dispute once a prior determination has been made.

PacifiCare will review your dispute request and all pertinent documentation. A PacifiCare Plan Medical Director will review all quality of care, medically necessary services or clinically related disputes. A Network Management Regional Director will review contractual disputes. The PacifiCare Claims Department will review claim adjudication issues.

PacifiCare will send a written determination to you within forty-five (45) working days of receipt of the dispute, (or as expeditiously as the situation requires), dependent upon receipt of all necessary information. If additional information is needed, the 45 working day turnaround time will begin upon receipt of the additional information.

If a member has filed an appeal regarding the same dispute, the dispute will be handled through the PacifiCare Member Appeals process. Additionally, a dispute for which the Center for Health Dispute Resolution (CHDR) or an independent review organization (IRO) has made a determination is not eligible for the PacifiCare Provider Dispute Process. PacifiCare will uphold the CHDR or IRO decision.

If you have any questions or concerns, please call (866) 316-9776 and choose the "claims" option.

Sincerely,

Provider Dispute Resolution Team
Claims Department

Attachment B: Additional Information Request Letter

P.O. Box 6098
Cypress, CA 90630

Today's Date

Provider Name
Contact Name
Street Address
City, State, Zip

Member Name:
Member ID/Claim:
DOS:
Billed Charges:
Account/PCN:
Request ID:

Dear Business Office Manager,

On |*Enter date dispute was received*| PacifiCare received in writing a formal dispute regarding the above referenced member. In order for PacifiCare to perform an extensive review, you must send the following information:

|*Enter additional information needed*|

You must send the information within thirty (30) working days to the following address:

PacifiCare Provider Dispute
P.O. Box 6098
Cypress, CA 90630

To help us expedite this process, please return a copy of this letter with your additional information. If you have any questions or concerns, please call (866)316-9776 and choose the "claims" option.

Sincerely,

Provider Dispute Resolution Team
Claims Department

Attachment C: Uphold Determination Letter

PacifiCare®
A UnitedHealthcare Company

P.O. Box 6098
Cypress, CA 90630

Today's Date

Provider Name
Contact Name
Provider Street Address
Provider City, State, Zip

Member Name:
Member ID/Claim:
DOS:
Billed Charges:
Account/PCN:
Request ID:

Dear Office Manager:

PacifiCare has reviewed your dispute regarding the above referenced member. After careful consideration of the case and all supporting documentation, the decision has been made to uphold the initial determination. The basis for the decision is as follows:

|*Enter the reason for the uphold determination (please be specific).*|

If you are a contracted provider and your contract supports an additional level of review, please contact the appropriate Provider Service/Network Management representative at PacifiCare.

If you have any further questions, you may call (866) 316-9776 and choose the "claims" option.

Sincerely,

Provider Dispute Resolution Team
Claims Department

Attachment D: Overturn Determination Letter (if paid after 45 days)

PacifiCare®
A UnitedHealthcare Company

P.O. Box 6098
Cypress, CA 90630

Today's Date

Provider Name
Contact Name
Provider Street Address
Provider City, State, Zip

Member Name:
Member ID/Claim:
DOS:
Billed Charges:
Account/PCN:
Request ID:

Dear Office Manager:

PacifiCare received a provider dispute regarding the claim referenced above. Upon careful review of this dispute, we have determined that the initial claim decision is being overturned and payment will be made.

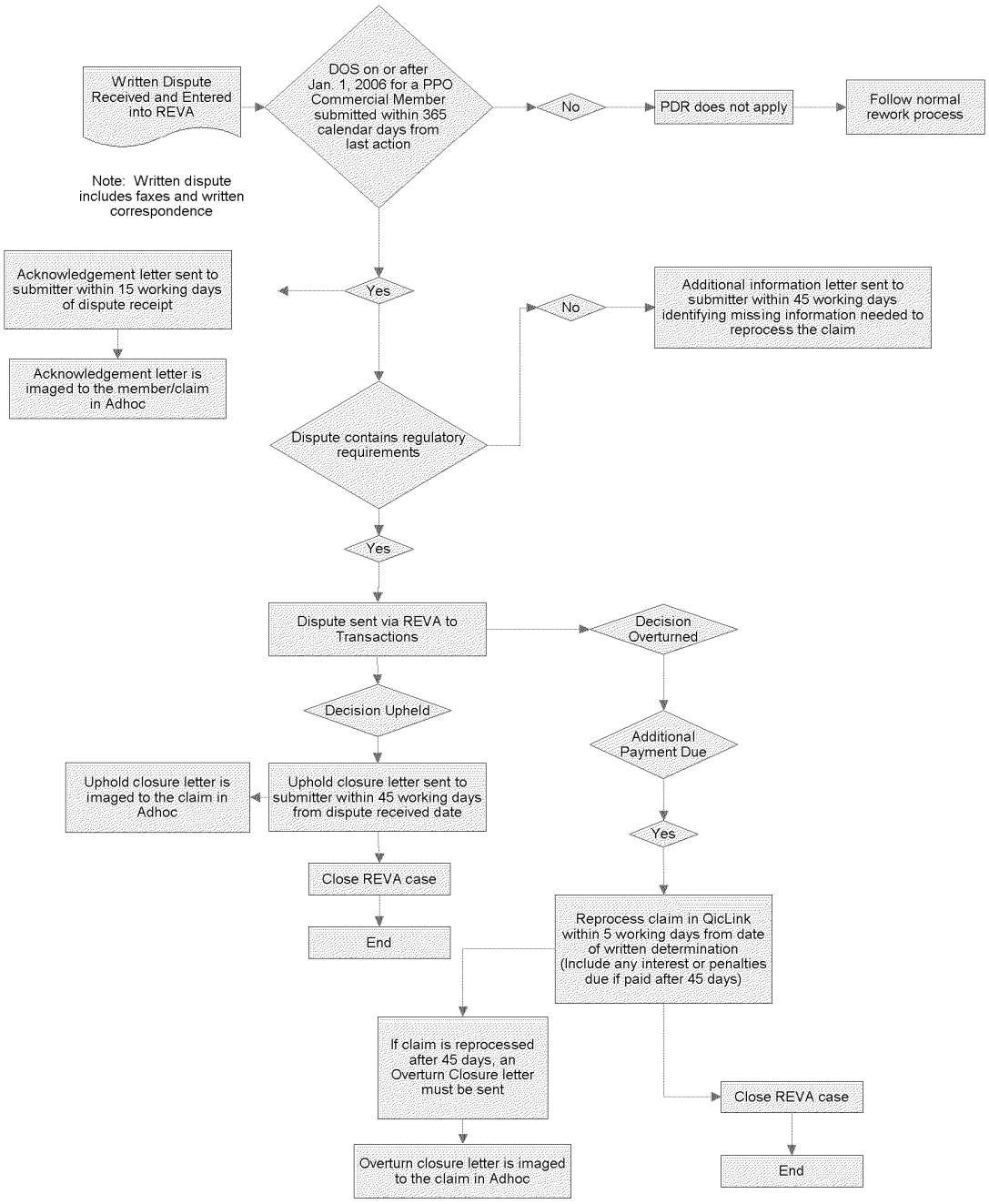
An additional payment of $|*Enter the additional amount paid.*| was made for |*Enter the type of service.*| services.

If you have any further questions, you may call (866) 316-9776 and choose the "claims" option.

Sincerely,

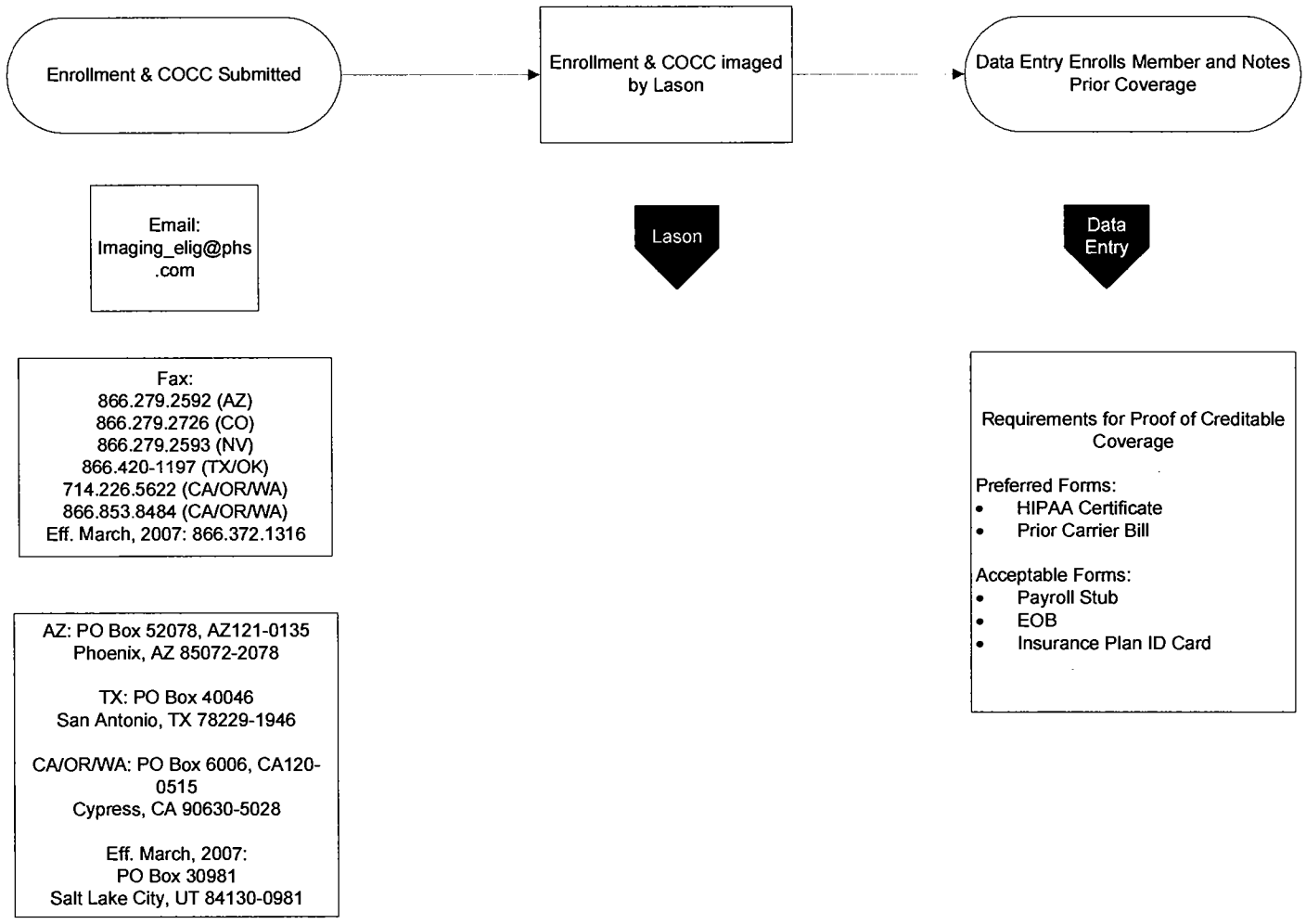
Provider Dispute Resolution Team
Claims Department

PPO PROVIDER DISPUTE (PDR) PROCESS
(California SB367)



COCC Processing – COCC Submitted with Initial Enrollment Form Overview

Submitted with Initial Enrollment Form



CDI00017390

PacifiCare®

Life and Health Insurance Company

KNOW YOUR RIGHTS

An Insured or the Insured's authorized representative (" Insured"), has the right to appeal adverse decisions regarding (1) contractual relationships, coverage, payment or reimbursement for health care services, or (2) Medical Necessity, effectiveness or efficiency.

The Company offers Standard review levels. For detailed information related to the review levels, please refer to your Certificate.

Insureds may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office and/or Insured's employee benefits representative. Insureds may have the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act if all required reviews of the claim have been completed and the claim has not been approved. Participation in any appeal process waives any privilege of confidentiality the Insured may have regarding medical records that any person examines or may examine in connection with the reviewed condition during the appeal process.

To request an Appeal:

1. Insureds must make an oral or written appeal request at the telephone number or address provided below within one year of the receipt date of the adverse decision notice. Insureds making oral requests will be sent a form (the "Appeal Form") to complete and return.
2. The Company will evaluate appeals of adverse decisions. A physician, in consultation with appropriate clinical peers, will evaluate all requests regarding Medical Necessity.
3. Insureds are responsible for providing any additional documentation supporting their reconsideration request with the written appeal request. The Company will evaluate a request based on the information in its possession.
4. The Company will issue a written determination notice to the Insured within 30 days of receiving a written appeal request. The notice will include the reason(s) for the Company's decision, the documentation on which the decision is based and the process for filing a formal appeal.

To request an Independent Medical Review (IMR)

You may also apply to the California Department of Insurance ("CDI") for an Independent Medical Review ("IMR") if you believe a health care service has been improperly denied, modified, or delayed by the Company and and the Company's decision involves the following: a) the medical necessity of a treatment; b) an experimental or investigational therapy for certain medical conditions; or c) a claims denial for emergency or urgent medical services. You or any person that you have designated to act as your advocate can request an IMR. No application or processing fees fees are charged for an IMR. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the Company regarding the disputed health care service. The IMR process is in addition to any other procedures or remedies that may be available.

Contact and Other Important Information:

Insureds may call the Company with questions regarding the claim determination. Additionally, the Department of Insurance can assist with questions about the health care appeals process or if an Insured believes that there has been a violation of the State's unfair practices or other similar state laws.

To contact the Company concerning Suspected Fraud or Irregular Billing Practices, call 1-866-686-6350.

Insurance Company

Appeals Department
P.O. Box 400046
San Antonio, TX 78229
(866) 316-9776
Monday - Friday (7:00 AM to 9:00 PM CST)

State Insurance Regulatory Agency

California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, CA 90013
Toll Free Number (800) 927-4357
Phone Number (213) 897-8921
TDD (800) 482-4833 Web Site www.insurance.ca.gov

Underwritten by Pacificare Life and Health Insurance Company