Provider Claims & Dispute Resolution Compliance Summary

California Code of Regulations (CCR), Title 28, Sections 1300.71 and 1300.71.38 (AB 1455 Regulations) – Claim Settlement Practices and Provider Dispute Resolution Mechanism

Effective Date: Jan. 1, 2004

Blue Shield of California (Blue Shield) Plans affected: HMO, POS, IFP and PPO *(Not Applicable to Blue Shield Medicare+Choice – Medicare HMO)*

Blue Shield of California Life & Health Service Plan Company (Blue Shield Life) Plans affected: PPO and Short Term Health

The Office of Administrative Law approved the regulations required by AB 1455 on July 24, 2003, with an effective date of Aug. 25, 2003. Health plans and capitated providers must be fully compliant with the regulations by Jan. 1, 2004. By statutes, many of the same requirements were made applicable to insurers effective January 1, 2006.

The AB 14455 address claims processing and the provider dispute resolution mechanism. Within the claims processing component, in addition to defining unjust payment practices, the regulations cite specific information that must be disclosed to contracting providers on or before Jan. 1, 2004. Blue Shield provides the required disclosures to contracting providers by posting the information on Provider Connection, our provider Web site. To access Provider Connection, log on to **www.blueshieldca.com** and click on the 'Provider Connection' button in the section 'For Employers, Providers and Producers' on the home page. The disclosures are located in the Claims Resources section.

The following information lists the requirements in the California Code of Regulations that Blue Shield has implemented, by major categories.

Claim Settlement Practices:

Acknowledgement of claims:

Electronic submissions: the EDI validation report has been modified to include information regarding rejected and accepted claims;

Paper submissions: providers can verify receipt of claims within 15 working days of the receipt date by calling Blue Shield.

- Time period for submission of a claims:
  Within 180 days of the date of service, or the time period stated in the contract, whichever is greater; or, when Blue Shield is the secondary payer, within 90 days of the date of payment or date of notice from the primary payer
- Notice of appeal rights:
  Blue Shield will issue an Explanation of Benefits (EOB) for each provider-submitted claim. Each EOB will notify providers of the availability of the provider appeal process and provide instructions for filing an appeal.

Claim Settlement Practices

- Time for contesting, denying, adjusting or paying claims:
  - PPO – within 30 working days (42 calendar days) from the original receipt date.
  - POS opt-out (Levels II, III) – within 30 working days (42 calendar days) from the original receipt date.
  - POS in-network (Level I) - within 45 working days (63 calendar days) from the original receipt date.
  - HMO - within 45 working days (63 calendar days) from the original receipt date.

Interest will automatically be issued when processing exceeds the timeframes stated above.

- Incorrect submissions:

  Within 10 working days of the original receipt date, Blue Shield will forward capitated claims, which were incorrectly sent to Blue Shield, to the correct IPA/medical group

Provider Notification

Blue Shield will disclose, as required by the regulations, the following information:

- Directions for the electronic or paper submission of claims;
- Fee Schedule, including detailed payment policies and rules, non-standard coding methodology;
- The identity of the office responsible for receiving and resolving provider disputes;
- Directions for the submission of provider appeals, including instructions to submit bundled appeals.

The required disclosures are available on Provider Connection, Blue Shield's provider Web site. Provider Connection is accessible through **www.blueshieldca.com.**

Provider Dispute Mechanism

Blue Shield's Provider Appeal Resolution Process has been updated to ensure compliance with the AB 1455 regulations and the Insurance Code requirements. The updated Provider Appeal Resolution Process is described in detail and is available on Provider Connection, Blue Shield's provider Web site, **in the Claims section.** Provider Connection is accessible through **www.blueshieldca.com.**

Highlights of the changes:

- Appeals must be submitted **in writing** to the designated submission address;
- Initial appeals must be submitted within 365 days of Blue Shield's determination or lack of action;
- Blue Shield will acknowledge the receipt of an appeal within 15 working days of receipt of the appeal at the designated submission address;
- Blue Shield will provide written determination within 45 working days (63 calendar days) of the receipt of the appeal at the designated submission address.

Enforcement

The regulations establish investigation and enforcement procedures and include specific measurements to determine if a plan or capitated provider is engaging in an 'unfair payment practice.' Additionally, the regulations require contracts to include provisions requiring capitated providers to comply with the regulations.

Provider Impact / Required Action

Blue Shield has amended our HMO IPA/medical group agreement to (1) modify existing provisions that conflict with the requirements/prohibitions of the regulations, like timely appeal and (2) add new provisions required by the regulations.