SeaView IPA, Professional Corporation d/b/a:

SEAVIEW IPA

CLAIM SUBMISSION & PROVIDER DISPUTE RESOLUTION

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 ("commercial HMO plans"). In addition, the Center for Medicare and Medicaid Services (CMS) announced new rules in 2010 pertaining to non-contracted provider payment disputes under Medicare Advantage plans.

This informational notice is intended to inform Providers of your rights, responsibilities and related procedures concerning both claim submission to and claim disputes with SeaView IPA for HMO plans This is also to inform you about SeaView IPA's Provider Dispute Resolution processes. Unless otherwise defined 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.

Providers are not required to submit disputes in writing and may, alternatively, telephone SeaView at **(805) 604-3325** with inquiries or concerns; in which case SeaView will respond to the inquiry or concern by following SeaView's standard customer service procedures, in lieu of the Provider Dispute Resolution Process outlined below.

Timeframes set forth in this procedure are intended to promote timely handling of provider disputes. Failure by SeaView IPA to meet any of the specified timeframes or to meet and confer with the provider shall not be construed to mean that the dispute has been resolved in the provider's favor; but rather shall be deemed an exhaustion of SeaView IPA's internal appeals process, thus freeing the provider to proceed with other remedies available under their contract with SeaView.

1. Claim Submission Instructions:

A. Sending Claims to SeaView: Claims for services provided to members assigned to SeaView must be sent to the following within ninety (90) days following the date of service. SeaView will make all reasonable exceptions to this deadline due to circumstances beyond the provider's control (e.g., SeaView is the secondary payor and provider had to first bill the primary payor, or provider did not have proper insurance information on the patient:

Via Mail: 1901 N. Solar Dr. #215
Oxnard, CA 93036

B. Calling SeaView Regarding Claims: For claim filing requirements or status inquiries, you may contact SeaView by **(Please call for information on submission of electronic claims)**

Via Web Site: www.svipa.com

Via Telephone: (805) 604-3325

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

Provider shall bill SeaView and/or plan for all Covered Services rendered to an Enrollee. Provider shall submit to SeaView and/or Plan a CMS 1500 or UB 04 claim form (or its successor form).

To expedite processing, claim should include complete billing information, including provider

name, billing address, tax ID number, appropriate diagnosis (ICD-10) and procedure (CPT-4 / HCPCS) codes, date of service, along with patient information including name, date of birth, health plan name and ID number.

D. Claim Receipt Verification: For verification of claim receipt by SeaView, please do the following:

Via Web Site: www.svipa.com

Via Telephone: (805) 604-3325

2. Dispute Resolution Process for Non-Contracted Providers:

Non-contracted providers may submit disputes only as regards payment issues. To do so, the provider would either follow the procedure below for contracted provider disputes **concerning Commercial plans only**, or may use SeaView's informal process by calling **(805) 604-3325 or** write to us or fax your payment dispute. Please make note of the documentation requirements below for disputes of the payment rate.

Non-Contracted Providers Disputing Our Payment Rate (commercial claims only). There are two different laws for commercial member payments to non-contracted providers:

- Assembly Bill 72: Is a California law that applies only to non-contracted *professionals* who render services in a *facility that is contracted to the member's health plan, unless the services are classified as emergency care.* For services not subject to AB 72, see the AB 1455 "Reasonable and Customary Value" information below. The "AB 72" payment rate is to be the greater of SeaView IPA's:
  - Average Contract Rate (ACR) as determined by SeaView IPA in accordance with regulatory requirements or
  - 125% of the Medicare Allowable Rate.
- Assembly Bill 1455: Applies to commercial non-contracted provider claims not otherwise subject to AB 72 above. SeaView's payment rate is the "Reasonable and Customary Value." If the non-contracted provider disputes that SeaView IPA has allowed Reasonable & Customary Value as its payment rate for services rendered, the provider must include information supporting their Reasonable & Customary Value demand (see below list). Disputes solely on the grounds that SeaView IPA has not paid the provider at the provider's billed charges, without supporting justification, will not be considered complete disputes and will not be processed:

  (i) your training, qualifications and length of time in practice;
  (ii) the nature of the services provided (medical record if applicable);
  (iii) the fees usually charged by you and the fees usually paid to you for these services by all payers, including government payers;
  (iv) the prevailing rates of other similarly qualified physicians in your specialty in your geographic area;
  (v) other aspects of the economics of your practice that are relevant;
  (vi) any unusual circumstances in the case; and
  (vii) any other matter pertinent to a determination of reasonable and customary value.

  The above information requirement is consistent with state regulations set forth in California Code of Regulations, Title 28, Sec.1300.71, inclusive of subsection 1300.71 (a) (3) (B) also referred to as the "Gould Criteria" as well as California case law [*Children's Hospital Central California v. Blue Cross of California*, 226 Cal.App.4th 1260 (2014)], the findings of which were also endorsed by the DMHC, California law has been clarified in that a number of factors, including rates actually received and accepted by the provider for similar services by all payers,

including government payers, are relevant in determining reasonable and customary value. In a March 11, 2015 letter, DMHC specifically states, "*The Children's Hospital case held that in determining quantum meruit cases the courts should consider a wide variety of evidence, including evidence of agreements to pay and accept a particular price*." The DMHC (the "Department") further states, "…*the Department's current regulation contains a non-exhaustive list of factors that should be take[n] into consideration. This is not an exclusive list. If applicable, other factors, such as those considered under the common law theory of quantum meruit, may be appropriately applied when determining the reasonable and customary rate."*

Special Notes for *Medicare* Payment Disputes from Non-Contracted Providers: For payment disputes involving Medicare Advantage member claims, non-contracted providers have the right to dispute claims only as follows:

A. Zero ($0) Payments: If the claim was denied in total, you may dispute this directly with the member's health plan. This would technically be a Member Appeal which we are not delegated to handle. See our website notice titled "Medicare Advantage Non-Contracted Provider Payment Appeal Process."

B. Payment Rate Dispute: If we determine your claim is payable, Medicare law allows us to pay non-contracted providers at Medicare payment rates, which currently includes a 2% "sequestration deduction" from the net amount (after member's copay) that would otherwise be payable (Citation: § 1852 (a) (2) (A) of the Social Security Act). If you believe we have not paid you in accordance with Medicare rates and guidelines, or if you believe we have down-coded your claim inappropriately, you may appeal this directly to us within 120 calendar days of our payment or last action on the claim (for good cause, exceptions to this deadline may be granted). Please note that we apply Medicare correct coding rules and reserve the right to audit your record prior to issuing or adjusting our payment (unlike Medicare carriers who often pay without question, but may perform retroactive audits). If you disagree with our appeal decision or if we fail to respond to your dispute within 30 days, you have a right to a second-level review, under certain conditions, by appealing directly to the member's health plan. You must file your appeal with the health plan within 180 days of our appeal decision or 180 days after expiration of the above 30 days, in the case of inaction on our part.

3. Dispute Resolution Process for Contracted Providers (Commercial Plans only):

A. Definition of Contracted Provider Dispute: A contracted provider dispute is a provider's written notice to SeaView and/or the **commercial** member's applicable health plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested; or seeking resolution of a billing determination or other contract dispute; or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum the following information: provider's name; provider's identification number, provider's contact information, and:

(i) If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from SeaView, the following must be provided: a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes that payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;

(ii) If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and

(iii) If the contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

B. Sending a Contracted Provider Dispute to SeaView: Contracted provider disputes submitted to SeaView must include the information listed in Section 3.A, above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of: **Provider Dispute Resolution / SeaView IPA**, at the following:

Via Mail:	1901 N. Solar Dr. #215 Oxnard, CA 93036
Via Delivery:	1901 N. Solar Dr. #245 Oxnard, CA 93036
Via E-mail:	oi_pdr@optum.com
Via Fax:	(805) 988-5161

C. Time Period for Submission of Provider Disputes:

(i) Contracted provider disputes must be received by SeaView within 365 days from SeaView's action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute **(Special Note for non-contracted provider payment disputes for Medicare Advantage: If your dispute is not filed with us by 125 days after receipt of our payment, you might not have the right to a second level appeal with the member's health plan.**

(ii) In the case of inaction on a claim, SeaView must receive Provider Disputes within 430 days, but no sooner than 60 days, after submission of the claim to SeaView. (Under our provider contracts, SeaView has 60 days to process a claim. This allows 365 days plus an additional 5 days beyond the 60 days.)

(iii) Contracted provider disputes that do not include all required information as set forth above in Section 3.A. may be returned to the submitter for completion. An amended contracted provider dispute, which includes the missing information may be submitted to SeaView within thirty (30) working days of your receipt of a returned contracted provider dispute.

D. Acknowledgment of Contracted Provider Disputes (Commercial plans only): SeaView will acknowledge receipt of all contracted provider disputes as follows:

(i) SeaView will acknowledge electronic contracted provider disputes within two (2) working days of the date of receipt by SeaView.

(ii) SeaView will acknowledge paper contracted provider disputes within fifteen (15) working days of the date of receipt by SeaView.

E. Contact SeaView Regarding Contracted Provider Disputes: All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to SeaView at:

Via Mail:	1901 N. Solar Dr. #215 Oxnard, CA 93036

Via Delivery:	1901 N. Solar Dr. #245 Oxnard, CA 93036
Via E-mail:	oi_pdr@optum.com
Via Fax:	(805) 988-5161
Via Telephone:	(805) 604-3325

F. Instructions for Filing Substantially Similar Contracted Provider Disputes: Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

(i) Sort by Health Plan (each plan should be submitted separately)
(ii) Sort disputes by similar issue / type
(iii) Provide cover sheet for each batch
(iv) Number each cover sheet
(v) Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheets.

G. Time Period for Resolution and Written Determination of Contracted Provider Dispute (Commercial Plans only): SeaView will issue written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the date of receipt of the contracted provider dispute or the amended contracted provider dispute; except in the case of non-contracted provider disputes concerning Medicare Advantage Member claims, in which case we will issue our determination within thirty (30) calendar days of receipt of your dispute. Please see Section 2 above for additional information on non-contracted provider payment disputes and second level appeals.

H. Past Due Payments: If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, SeaView will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination. If SeaView voluntarily issues a supplemental payment of a commercial claim to a non-contracted provider, which supplement SeaView deems in excess of Reasonable & Customary Value, interest may not be applied to the supplemental amount.

4. Claims Overpayments

A. Notice of Overpayment of a Claim: If SeaView determines that it has overpaid a claim, SeaView will notify the provider in writing within three hundred sixty-five (365) days following payment, 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 SeaView 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 SeaView's notice of overpayment of a claim, the provider, within thirty (30) working days of the receipt of the notice of overpayment of a claim, must send written notice to SeaView stating the basis upon which the provider believes that the claim was not overpaid. SeaView will process the contested notice in accordance with SeaView's contracted provider dispute resolution process described in Section 3 above.

C. No Contest: If the provider does not contest SeaView's notice of overpayment of a claim, the provider must reimburse SeaView within thirty (30) working days of the provider's receipt of the notice of overpayment of a claim.

D. Offsets to payments: SeaView may offset an uncontested notice of overpayment of a claim against the provider's current claim submissions if the provider fails to reimburse SeaView within the timeframe set forth above. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, SeaView will provide a detailed written explanation identifying the specific overpayment(s) that have been offset against the specific current claim or claims.