

**CLAIMS SETTLEMENT PRACTICES, DISPUTE RESOLUTION MECHANISM,  
AND  
FEE SCHEDULE NOTICE**

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 notice is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in the following laws: 1) Title 28 of the California Code of Regulations - Sections 1300.71, 1300.71.31, and 1300.71.38; and 2) Knox-Keene Act – Sections 1371.30 and 1371.31.

**I. Claim Submission Instructions:**

- A. Sending Claims to Sharp Health Plan: Send claims for services provided to Sharp Health Plan members to your contracted Plan Medical Group (PMG). If you are contracted directly with Sharp Health Plan, send claims to:

**Sharp Health Plan  
P.O. Box 939036  
San Diego, CA 92193-9036**

- B. Claim Submission Requirements: The following is a list of timeliness requirements, supplemental information and documentation required when submitting claims to Sharp Health Plan:
1. Contracted providers must submit claims within 90 days or according to your agreement terms. Non-contracted providers have 180 days after the date of service to submit a claim. Claims submitted outside of these time frames may be denied as untimely.
  2. Submit claims with all reasonably relevant information to determine payer liability and to ensure timely processing and payment.
  3. Non-contracted providers must submit a completed IRS Form W-9 with all claims.
  4. If Sharp Health Plan is the secondary payor, then providers must submit the primary payor Explanation of Benefits (EOB) documentation with applicable claims in order to coordinate benefits.
- C. Claim Receipt Verification: Sharp Health Plan will acknowledge the date of claim receipt within two (2) business days of the date of receipt of an

electronic claim and within fifteen (15) business days of the date of receipt of a hard copy claim. The following is an alternate list of methods by which a provider can readily confirm receipt of claim and recorded date of receipt.

1. Call to inquire about a Claims Verification form to Sharp Health Plan Customer Care at (858) 499-8300 or toll free at (800) 359-2002.
2. Fax a Claims Status Verification form to Customer Care to (619) 740-8571.

D. Sharp Health Plan Payment and Billing Policies: Sharp Health Plan billing and payment policies are consistent with Current Procedural Terminology (CPT) guidelines, and standards accepted by nationally recognized medical societies and organizations federal regulatory bodies and major credentialing organizations.

1. Sharp Health Plan utilizes proprietary Claims Check software that reviews billing codes for appropriateness and adjusts claim payments accordingly.
2. Reimbursement for immunizations and injectable medications are in accordance with CPT guidelines and applicable state laws or regulations.

E. Claims Scanning: Sharp Health Plan scans claims using Optical Character Recognition (OCR) to capture claims information directly from claim forms.

1. OCR output is largely dependent on the accuracy and legibility of the claim form submitted, therefore claim forms must:
  - a) Be legible. Change typewriter ribbon/PC printer cartridge frequently, if necessary. Laser printers are recommended.
  - b) Contain black ink.
  - c) Contain Pica, Courier 10 or Courier 12 font type.
  - d) Contain all capital letters.
2. Claim forms should not have:
  - a) Broken characters
  - b) Script
  - c) Stylized print
  - d) Italic print
  - e) Mini-font

- f) Proportional pitch (use only typefaces that have the same width for each character)
- g) Dot-matrix font
- h) Liquid correction fluid
- i) Data touching box edges or running outside of numbered boxes (instead, center claim information in each box). Exception: when using the 8-digit date format, information may be typed over the dotted lines shown in date fields (e.g., item 24a)
- j) More than six service lines per claim (use a new form for additional services)
- k) Narrative descriptions of procedures, modifiers, or diagnoses (CPT, Modifier or ICD-10 CM codes are sufficient)
- l) Stickers or rubber stamps displaying information (provider's name and address) or making requests ("tracer" or "corrected billing")
- m) Special characters (e.g., hyphens, periods, parentheses, dollar signs and ditto marks)
- n) Handwritten claims
- o) Attachments on pieces of paper smaller than 8 ½" x 11"

3. Claim forms must be:

- a) Original CMS-1500 (12/12) or UB-04 forms printed in red "drop out" ink with the printed information on back. Photocopies are not acceptable.
- b) 8 ½" x 11" paper size, with the printer pin-feed edges removed at the perforations
- c) Free from crumples, tears, or excessive creases. Submit claims in standard #10 envelopes or larger.
- d) Printed on 20-22 pound paper to keep information on the back from showing through.
- e) Clean and free from stains, tear-off pad glue, notations, circles or scribbles, strikeouts, crossed out information or liquid correction fluid.

F. Modifiers: Sharp Health Plan recognizes modifiers in accordance with CPT guidelines.

- 1. Modifier 25: Significant, Separately Identifiable Evaluation and Management (E & M) service by the Same Physician on the Same Day of the Procedure or Other Service – A provider may need to indicate that on the day a procedure or service was performed the patient's condition required a significant, separately unidentifiable E & M service above and beyond the other service provided, or

beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E & M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E & M services on the same day. (This modifier is not used to report an E&M service that resulted in a decision to perform major surgery.) The patient's records must contain information to support the use of modifier 25. Visits by the same physician on the same day as a surgical procedure with 000 or 010 days postoperative or endoscopy procedures that are related to the standard preoperative evaluation or recovery from the procedure are included in the global reimbursement for the procedure. However, if a significant separately identifiable service is performed and is clearly documented in the patient's records, payment can be made for the visit when billed with modifier 25. This modifier is not used to report an E&M service that resulted in a decision to perform surgery (see modifier 57 below). On a case-by-case basis medical records may be requested to validate documentation.

2. **Modifier 26: Split Global, Professional (26) & Technical Component (TC)** – Only certain services include a technical and professional component. Many Fee Schedules include separate allowances for these services. Certain procedures are a combination of a physician component (professional) and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number. Sharp Health Plan recognizes only patient specific professional services billed with modifier 26.
3. **Modifier 50: Bilateral Procedure** - Procedures performed on both sides of the body or body area during the same operative session and on the same day are called bilateral procedures. Procedures which are usually performed as bilateral procedures or the code descriptor specifically states that the procedure is bilateral, should not be reported with bilateral modifiers. Use of modifier 50 indicates that a procedure is bilateral, indicating that the procedure is performed twice during the same operative session. When billing for bilateral services the quantity in the “UNITS” field should always be one (1). Bilateral procedures are reimbursed at 150% of the contracted allowable.
4. **Modifier 51: Multiple Procedures**- When the same provider performs multiple procedures, other than E/M services, at the same session, the primary procedure or service may be reported as listed. Appending the modifier 51 to the additional procedure or service

code(s) may identify the additional procedure(s) or service(s). The payment for procedures billed with a modifier 51 will be reduced to 50% of the contracted allowable.

5. **Modifier 57: Decision to Perform Surgery** – An evaluation and management service that resulted in the initial decision to perform the surgery.
6. **Modifier 59: Distinct Procedural Service** - Under certain circumstances, the provider may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encounters or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Document the explanation for the use of modifier 59 in Box 19 of the CMS 1500 or Box 84 of the UB92. Include medical records such as operative reports if the documentation can support the use of modifier 59.
7. **Modifier 80: Assistant Surgeon** - Surgical assistant services are identified by adding the modifier 80 to the procedure. Procedures with a modifier 80 appended will be paid at 16% of the contracted allowable amount.
8. **Global Surgical Package** - The CPT codes that represent readily identifiable surgical procedures include, on a procedure-by-procedure basis, a variety of services. The following services are always included in the global reimbursement rate, in addition to the surgical procedure:
  - a) local infiltration, metacarpal/metatarsal/digital block or topical anesthesia;
  - b) subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical);
  - c) immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
  - d) writing orders;
  - e) evaluating the patient in the post-anesthesia recovery area; and
  - f) typical postoperative care.

9. Follow-up care for therapeutic surgical procedures includes only that care which is usually a part of the surgical service.

## II. Provider Dispute Resolution Process

- A. Definition of a Provider Dispute. A provider dispute is a provider's written notice to Sharp 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 bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each provider dispute must contain, at a minimum, the Provider's name, identification number, contact information, and:
  1. If the provider dispute concerns a claim or a request from Sharp Health Plan for reimbursement of a claim overpayment, the provider must submit a clear identification of the disputed item, the date of service and an explanation of the basis of the dispute (e.g. incorrect payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect).
  2. If the provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue.
  3. If the 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 Provider Dispute to Sharp Health Plan. Provider disputes submitted to Sharp Health Plan must include the information listed in Section II.A., above, for each provider dispute. Sharp Health Plan's Provider Dispute Resolution Form can be found online at [www.sharphealthplan.com](http://www.sharphealthplan.com), or you can call our Customer Care department at (858) 499-8300 or toll free at (800) 359-2002 to request a copy. Send completed Provider Dispute Resolution Forms to:

**Sharp Health Plan**  
**Attention: Provider Dispute Resolution**  
**8520 Tech Way, Suite 200**  
**San Diego, CA 92123-1450**

- C. Period for Submission of Provider Disputes: Provider disputes must be received by Sharp Health Plan within 365 days from Sharp Health Plan's action that led to the dispute (or the most recent action if there are multiple actions) or
1. In the case of Sharp Health Plan's inaction, provider disputes must be received by Sharp Health Plan within 365 days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
  2. Provider disputes that do not include all required information as set forth above in Section II.A may be returned to the submitter for completion. An amended provider dispute that includes the missing information may be submitted to Sharp Health Plan within 30 business days of your receipt of a returned contracted provider dispute.
- D. Acknowledgment of Provider Disputes: Sharp Health Plan will acknowledge receipt of all provider disputes as follows:
1. Electronic provider disputes will be acknowledged by Sharp Health Plan within two (2) business days of the date of receipt by Sharp Health Plan.
  2. Paper provider disputes will be acknowledged by Sharp Health Plan within fifteen (15) business days of the date of receipt by Sharp Health Plan.
- E. Contact Sharp Health Plan Regarding Provider Disputes: All inquiries regarding the status of a provider dispute or about filing a provider dispute must be directed to Sharp Health Plan's Provider Relations department at: 858-499-8330.
- F. Instructions for Filing Substantially Similar 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 proper format. Please submit similar disputes as follows:
1. Sort provider disputes by similar issue.
  2. Provide a coversheet for each batch.
  3. Number each coversheet.
  4. 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 Provider Dispute: Sharp Health Plan will issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45

business days after the date of receipt of the provider dispute or the amended provider dispute.

- H. Past Due Payments: If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, Sharp Health Plan will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) business days of the issuance of the written determination.
- I. Independent Dispute Resolution Process: A non-contracted health professional who provides non-emergency services at a Sharp Health Plan contracted facility shall complete Sharp Health Plan's Provider Dispute Resolution Process outlined above prior to initiating the Independent Dispute Resolution Process.

### **III. Claim Overpayments**

- A. Notice of Overpayment of a Claim: If Sharp Health Plan determines that it has overpaid a claim, they 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 an explanation of the basis upon which Sharp Health Plan 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 Sharp Health Plan's notice of overpayment of a claim, the provider, within 30 business days of the receipt of the notice of overpayment of a claim, must send written notice to Sharp Health Plan stating the basis upon which the provider believes that the claim was not overpaid. Sharp Health Plan will process the contested notice in accordance with Sharp Health Plan's contracted provider dispute resolution process described in Section II above.
- C. No Contest: If the provider does not contest Sharp Health Plan's notice of overpayment of a claim, the provider must reimburse Sharp Health Plan within 30 business days of the provider's receipt of the notice of overpayment of a claim.
- D. Offsets to Payments: Sharp Health Plan may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when
  1. The provider fails to reimburse Sharp Health Plan within the timeframe set forth in Section IV.C., above, and
  2. Sharp Health Plan's contract with the provider specifically authorizes Sharp Health Plan to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. 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, Sharp Health Plan 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.

#### **IV. Fee Schedules**

- A. Effective January 1, 2010, the following fee schedules may be used as the basis for Sharp Health Plan's payments to you as a provider.

The Medicare Fee Schedule can be found online at: <https://www.noridianmedicare.com/>. The Durable Medical Equipment, Prosthetics/Orthotics and Supplies Fee Schedule (DMEPOS) can be found at: <https://www.noridianmedicare.com/>. Please refer to Appendices A through E of your Agreement with Sharp Health Plan for details on how these fee schedules and other mutually-agreed upon payment rates are used to determine your reimbursement.

- B. Unless otherwise agreed by Sharp Health Plan and a non-contracted individual health professional, Sharp Health Plan may reimburse the non-contracted individual health professional, who provides non-emergency services at a Sharp Health Plan contracted facility the greater of the following: 1) average contracted rate; or 2) 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered. The "average contracted rate" means the claims-volume weighted average of the contracted commercial rates that Sharp Health Plan paid for the same or similar services in the geographic region in the applicable calendar year. (The applicable calendar year is two years prior to the year in which the health care service was rendered.)

- C. For questions regarding fee schedules, contact:  
Sharp Health Plan  
Attention: Contracting Department  
8520 Tech Way, Suite 200  
San Diego, CA 92123-1450  
Phone: (858) 499-8377  
Fax: (858) 636-2276

#### **V. Notification of Amendments to Sharp Health Plan's Claims Settlement and Dispute Resolution Processes**

- A. Sharp Health Plan shall provide 45 days advance notice to contracted providers of any material revision to its Claims Settlement Processes, Dispute Resolution Mechanism and Fee Schedules.
- B. For further information regarding AB1455 Regulations, please refer to the California Department of Managed Health Care's website: <http://wpsso.dmhca.gov/regulations/>.