Annual Plan Claims Payment and Dispute Resolution Mechanism Report

Details	**Step 1**	Step 2	Step 3	Step 4

* Indicates a Required Field

The Plan is required to complete this section (Step 1) to report the claim activity and compliance status of the plan (including the activity for each of its claims processing organizations and capitated providers (Step 3)) for claim activity from 10/1-9/30. **To ensure your data is not lost, please save your work every 20 minutes (or less). The "Save" button is located at the bottom of each form.**

	Quarter Ended 12/31/05	Quarter Ended 3/31/06	Quarter Ended 6/30/06	Quarter Ended 9/30/06
Total number of Commercial and Healthy Families (HMO) claims paid, denied, adjusted or contested during the reporting period (FN1) *				
Total number of Commercial and Health Families (HMO) claims paid, denied, adjusted or contested within 45 working days *				
Total number of PPO/POS/Specialized claims paid, denied, adjusted or contested during the reporting period *				
Total number of PPO/POS/Specialized claims paid, denied, adjusted or contested within 30 working days. *				
Total number of Medi-Cal claims paid, denied, adjusted or contested during the reporting period *				
Total number of Medi-Cal claims paid, denied, adjusted or contested within 30 calendar days. *				
Total number of Medi-Cal claims paid, denied, adjusted or contested within 45 working days. *				
Total number of claims that were PAID or ADJUSTED during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of those claims PAID or ADJUSTED within 45 working days (Commercial, Healthy Families	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006

and Medi-Cal) or 30 working days (PPO, POS and Specialized) during the reporting period.				
Total number of claims PAID or ADJUSTED beyond 45 working days (Commercial, Healthy Families and Medi-Cal) or 30 working days (PPO, POS and Specialized) that included the payment of applicable interest and/or penalty during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of emergency service (FN2) claims paid, denied, adjusted or contested during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of those emergency service claims PAID or ADJUSTED within 45 working days (Commercial, Healthy Families, and Medi-Cal) or 30 working days (PPO, POS and Specialized) during the reporting period.	Required as of Q4 2006	Required as of 4Q 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of claims received during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006

Plan's Compliance with the Following:

By checking "yes or no", the health plan is attesting to the following questions:
Was the health plan compliant...

Yes	No	
☐	☐	With the handling misdirected claims consistent with sections 1300.71(b)(2)(A) and (B)?
☐	☐	With accepting late claims consistent with section 1300.71(b)(4)?
☐	☐	With providing an accurate and clear written explanation of the specific reason for denying, adjusting, or contesting a claim consistent with section 1300.71(d)(1)?
☐	☐	With contesting or denying a claim, or portion thereof, within the timeframes of section 1300.71(h) and section 1371 or 1371.35?
☐	☐	With providing the Notice of Provider Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b)?

☐ ☐ With requesting reimbursement of an overpayment of a claim consistent with the provisions of 1300.71(b)(5) and (d)(3), (4), (5), and (6)?

☐ ☐ With rescinding or modifying health care services after the provider rendered services pursuant to the capitated provider's authorization (Health and Safety Code section 1371.8; CCR section 1300.71(a)(8)(T))?

☐ ☐ With imposing a deadline for receipt of a claim no less than 90 days after the date of service for contracted providers pursuant to CCR section 1300.71(b)(1)?

☐ ☐ With imposing a deadline for receipt of a claim no less than 180 days after the date of service for non-contracted providers pursuant to CCR section 1300.71(b)(1)?

☐ ☐ With requesting medical records to determine payor liability consistent with CCR section 1300.71(a)(8)(H)?

☐ ☐ With requesting emergency services and professional provider medical records to determine payor liability consistent with CCR section 1300.71(a)(8)(I)?

Disclosure of Emerging Claims Payment Deficiencies

Did the Plan disclose any deficiencies in the "Quarterly Claims Settlement Practices Report (in the previous four quarters or more)?

○ Yes ● No

Was the Plan required to institute a corrective action plan (in the previous four quarters)?

○ Yes ● No

If the response was "Yes" to either question, provide a summary on any established or documented patterns of claims payment deficiencies, outlining the corrective action that has been undertaken, and explain how the corrective action (instituted) has assisted the plan to comply with the rules and regulations.

Save

(FN1) For reporting purposes, an adjusted claim is a claim that the payor reimburses at a different rate than the provider's billed charges. Post-payment adjustments, which result from the reconsideration of the original claim payment after the claimant's inquiry or submission of a dispute are not included here, but should be included in the Annual Dispute Resolution Mechanism Report.

(FN2) For purposes of this report, emergency services claims are defined as "Services with a 'Place of Service Code' of ER (emergency room) on the CMS 1500 or the UB 92 claim form".

Annual Plan Claims Payment and Dispute Resolution Mechanism Report

* Indicates a Required Field

Provide a summary disposition of all provider disputes and resolutions that were processed from October 1 - September 30. **To ensure your data is not lost, please save your work every 20 minutes (or less). The "Save" button is located at the bottom of each form.**

	Total Number in Favor of Provider	Total Number in Favor of Plan	Total Number with Pending Resolution
Total Number of Claims Payment/Billing Disputes			
- Number of contracted claims payment disputes *			
- Number of non-contracted claims payment disputes *			
Total Number of Utilization Management Disputes *			
Total Number of Other Disputes			

	Total
Total Number of Claim Payment/Billing Disputes	
- Professional Providers *	
- Institutional Providers *	
- Other Providers *	
Total Number of Disputes to Plan	
Total disputes resolved within 45 working days *	
Total disputes resulting in written determination *	

Provide an informative summary on any emerging or established patterns of provider disputes and demonstrate how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality of care assurance system (process) and quality of patient care (results):

Save

AAA TEST RBO

Return to Step 3 Organization Listing

Identify and complete the report for claims payment and compliance status of each payor for claim activity from 10/1-9/30. **To ensure your data is not lost, please save your work every 20 minutes (or less). The "Save" button is located at the bottom of each form.**

	Quarter Ended 12/31/05	Quarter Ended 3/31/06	Quarter Ended 6/30/06	Quarter Ended 9/30/06
Total number of Commercial and Healthy Families (HMO) claims paid, denied, adjusted or contested during the reporting period (FN1) *				
Total number of Commercial and Health Families (HMO) claims paid, denied, adjusted or contested within 45 working days *				
Total number of PPO/POS/Specialized claims paid, denied, adjusted or contested during the reporting period *				
Total number of PPO/POS/Specialized claims paid, denied, adjusted or contested within 30 working days. *				
Total number of Medi-Cal claims paid, denied, adjusted or contested during the reporting period. *				
Total number of Medi-Cal claims paid, denied, adjusted or contested within 30 calendar days. *				
Total number of Medi-Cal claims paid, denied, adjusted or contested within 45 working days. *				
Total number of claims that were PAID or ADJUSTED during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of those claims PAID or ADJUSTED within 45 working days (Commercial Healthy Families, and Medi-Cal) or 30 working days (PPO, POS and Specialized) during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006

Total number of claims PAID or ADJUSTED beyond 45 working days (Commercial, Healthy Families and Medi-Cal) or 30 working days (PPO, POS and Specialized) that included the payment of applicable interest and/or penalty during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of emergency service (FN2) claims paid, denied, adjusted or contested during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of those emergency service claims PAID or ADJUSTED within 45 working days (Commercial, Healthy Families and Medi-Cal) or 30 working days (PPO, POS and Specialized) during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of claims received during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006

Payor's Compliance with the Following:

The Payor's compliance with the following questions should be based on the health plan's audit of the payor:

Date of Audit by Health Plan: ________________________

Was this section audited for compliance?		If yes, was the payor compliant?		If no, state reason for not auditing	
Yes	No	Yes	No		
☐	☐	☐	☐	________ ________	Did the health plan audit the payors procedure and/or practice for handling of misdirected claims consistent with sections 1300.71(b)(2)(A) and (B)?
☐	☐	☐	☐	________ ________	Did the health plan audit the payors procedure and/or practice for accepting late claims consistent with section 1300.71(b)(4)?
☐	☐	☐	☐	________ ________	Did the health plan audit the payors procedure and/or practice for providing an accurate and clear written explanation of the specific reason for denying, adjusting, or contesting a claim consistent with section 1300.71(d)(1)?
☐	☐	☐	☐	________ ________	Did the health plan audit the payors procedure and/or practice for contesting or denying a claim, or portion thereof, within the timeframes of section 1300.71(h) and section 1371 or 1371.35?

☐ ☐ ☐ ☐ ______ ______ Did the health plan audit the payors procedure and/or practice for providing the Notice of Provider Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b)?

☐ ☐ ☐ ☐ ______ ______ Did the health plan audit the payors procedure and/or practice for requesting reimbursement of an overpayment of a claim consistent with the provisions of 1300.71(b)(5) and (d)(3), (4), (5), and (6)?

☐ ☐ ☐ ☐ ______ ______ Did the health plan audit the payors procedure and/or practice for rescinding or modifying health care services after the provider rendered services pursuant to the capitated provider's authorization (Health and Safety Code section 1371.8; CCR section 1300.71(a)(8)(T))?

☐ ☐ ☐ ☐ ______ ______ Did the health plan audit the payors procedure and/or practice for imposing a deadline for receipt of a claim no less than 90 days after the date of service for contracted providers pursuant to CCR section 1300.71(b)(1)?

☐ ☐ ☐ ☐ ______ ______ Did the health plan audit the payors procedure and/or practice for imposing a deadline for receipt of a claim no less than 180 days after the date of service for non-contracted providers pursuant to CCR section 1300.71(b)(1)?

☐ ☐ ☐ ☐ ______ ______ Did the health plan audit the payors procedure and/or practice for requesting medical records to determine payor liability consistent with CCR section 1300.71(a)(8)(H)?

☐ ☐ ☐ ☐ ______ ______ Did the health plan audit the payors procedure and/or practice for requesting emergency services and professional provider medical records to determine payor liability consistent with CCR section 1300.71(a)(8)(I)?

Disclosure of Emerging Claims Payment Deficiencies

Did the payor disclose any deficiencies in the "Quarterly Claims Settlement Practices Report (in the previous four quarters or more)?

☐ Yes ☒ No

Was the payor required to institute a corrective action plan (in the previous four quarters)?

☐ Yes ☒ No

If the response was "Yes" to either question, provide a summary on any established or documented patterns of claims payment deficiencies, outlining the corrective action that has been undertaken, and explain how the corrective action (instituted) has assisted the payor to comply with the rules and regulations.

Save

(FN1) For reporting purposes, an adjusted claim is a claim that the payor reimburses at a different rate than the provider's billed charges. Post-payment adjustments, which result from the reconsideration of the original claim payment after the claimant's inquiry or submission of a dispute are not included here, but should be included in the Annual Dispute Resolution Mechanism Report.

(FN2) For purposes of this report, emergency service claims are defined as "Services with a 'Place of Service Code' of ER (emergency room) on the CMS 1500 or the UB 92 claim form".

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Return to Step 3 Organization Listing

Provide the payor's summary disposition of all provider disputes and resolutions that were processed from October 1 - September 30. **To ensure your data is not lost, please save your work every 20 minutes (or less). The "Save" button is located at the bottom of each form.**

	Total Number in Favor of Provider	Total Number in Favor of Payor	Total Number with Pending Resolution
Total Number of Claims Payment/Billing Disputes			
- Number of contracted claims payment disputes *			
- Number of non-contracted claims payment disputes *			
Total Number of Utilization Management Disputes *			
Total Number of Other Disputes*			

	Total
Total Number of Claim Payment/Billing Disputes	
- Professional Providers *	
- Institutional Providers *	
- Other Providers *	
Total Number of Disputes to Payor	
Total disputes resolved within 45 working days *	
Total disputes resulting in written determination *	

Provide an informative summary on any emerging or established patterns of provider disputes and demonstrate how that information has been used to improve the payor's administrative capacity, payor-provider relations, claim payment procedures, quality of care assurance system (process) and quality of patient care (results):