PIONEER PROVIDER NETWORK, A MEDICAL GROUP, INC.

CLAIMS SETTLEMENT PRACTICE & DISPUTE RESOLUTION MECHANISM
DOWNSTREAM PROVIDER NOTICE

As required by Assembly Bill 1455, effective January 1, 2004, 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 information notice is intended to inform you of your rights, responsibilities and related procedures as they relate to claim settlement practices and claim disputes for commercial HMO and POS products where Pioneer Provider Network (PPN) is delegated to perform claims payment and provider dispute resolution processes (where PPN has financial risk). Unless otherwise provided 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.

I. CLAIM SUBMISSION INSTRUCTIONS

A. Sending Paper Claims to Pioneer Provider Network: There are two different addresses for submission of paper claims for services provided to members assigned to PPN. The address depends on the product line of the member, as follows:

CLAIMS ADDRESSES FOR PIONEER PROVIDER NETWORK

For Medicare and Commercial hardcopy paper claims mail to:

Pioneer Provider Network c/o McKesson BPS
1901 N. Solar Drive, Suite 105
Oxnard, CA 93036-2642

For Medi-Cal and Medi-Medi (Dual Eligibles) in Health Net, LA Care, Brand New Day or Molina, submit hardcopy paper claims mail to:

Pioneer Provider Network c/o MedPoint Management
P.O. Box 571870
Tarzana, CA 91357

Note: Pioneer Medical Group (PMG) is not the same entity as Pioneer Provider Network (PPN). PMG does not have financial responsibility for any claims. Do not send claims to PMG addresses. Claims sent to any address not in this notice will not be forwarded to the above PPN claims management companies

B. Sending Electronic Claims to Pioneer Provider Network: Electronic claims are preferred over paper claims. For electronic claim submissions, we recommend you use Office Ally as your clearinghouse. If you already use Office Ally, you do not need to do anything.

If you don’t use Office Ally already, it is simple to join, and there is no cost to you. Go to www.officeally.com or call 866-575-4120 (Option 3). To enroll with Office Ally, fill out
the Online Enrollment Form. After you have completed the enrollment form, there is a Provider Authorization Signature Page and the Business Associate Agreement that must be printed, signed, and faxed to Office Ally at 360-314-2184.

If you use another clearing house, contact your current clearinghouse, and tell them that they will need to forward your Pioneer Provider Network as follows:

Medicare and Commercial claims to Office Ally using the Payor ID: PPNZZ

Medi-Cal and Medi-Medi (Dual Eligible) claims in Health Net, LA Care, Brand New Day or Molina to Office Ally using the Payor ID: MPM18

Almost all clearinghouses feed claims back and forth to each other, so you likely won’t have to do anything more than make that phone call. If you run into a problem, please feel free to call Office Ally directly at 866-575-4120 and select option #3.

C. Calling Pioneer Regarding Claims: For claim filing requirements or status inquiries, you may telephone PPN, based on the product line of the member, as follows:

Commercial and Medicare Claims: 888-720-2323

Medi-Cal & Medi-Medi (Dual Eligibles) in Health Net, LA Care, Brand New Day or Molina: 866-243-8564

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

1) Claims must be submitted on a CMS 1500 or UB 04 claim form (or its successor form) within ninety (90) days following the provision of Covered Services or payment may be denied. PPN shall make reasonable exceptions to timely filing due to circumstances beyond the provider’s control, as required by law or regulation.

2) The claim should be “clean” and include complete billing information, including provider name, billing address, tax ID number, appropriate diagnosis (ICD-9) and procedure (CPT-4 / HCPCS) codes, date of service, etc., along with patient information including name, date of birth, health plan name and ID number, etc. If possible, please include the authorization number that is relevant to the date of service and type of service rendered, on the claim.

3) PPN utilizes the nationally recognized coding structure known as the AMA’s Current Procedural Terminology (CPT-4) and the Healthcare Common Procedure Coding System (HCPCS) for basic coding and description of services provided, in conjunction with the CMS payment guidelines. As annual changes are made to the CPT-4 and HCPCS codes, Group shall use best efforts to update the coding structure.

4) PPN reserves the right to request reasonably relevant information to determine the nature, cost, and its liability for the services rendered. This information may also
include medical records necessary to approval of codes billed, in accordance with PPN’s Payment Policies (also displayed with this notice).

D. Claim Receipt Verification: For verification of claim receipt by PPN you may request verification via phone or fax, depending on the member’s plan product line, as follows:

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<td>Commercial and Medicare Claims:</td>
<td>888-720-2323</td>
<td>805-988-5163</td>
</tr>
<tr>
<td>Medi-Cal &amp; Medi-Medi (Dual Eligibles) in Health Net, LA Care, Brand New Day or Molina:</td>
<td>866-243-8564</td>
<td>818-466-6534</td>
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II. DISPUTE RESOLUTION PROCESS FOR CONTRACTED PROVIDERS

This is Pioneer Provider Network’s (PPN) formal process for handling of provider disputes concerning Commercial Member claims or other issues. **This formal dispute process does not apply to Medicare or Medi-Cal claims issues**, but you may nonetheless submit appeals under our **Informal Appeals Process**.

[For Medi-Cal & Medi-Medi members managed by MedPoint Management, please go to this website and look for the “PPN PDR Form”: http://www.medpointmanagement.com/mpm/ProviderAB1455 ]

Use of this formal “PDR” process for Commercial plan members ensures we will acknowledge and respond to your dispute in the timeframes required by law. Alternatively, you may contact us with your claim and authorization questions or submit claims appeals under our **Informal Provider Appeals** process at these numbers or at the addresses for claims shown in Section I:

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This process is also available to non-contracted providers with claim or payment disputes for commercial claims (see section III).

A. Definition of Provider Dispute: A contracted provider dispute ("Provider Dispute") is a provider’s written notice to PPN challenging, appealing or requesting reconsideration of a claim (or a bundled PPN of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested by PPN; or seeking resolution of a PPN billing determination or other contract dispute); or disputing a request from PPN for reimbursement of an overpayment of a claim; or any other contract dispute.

Provider Disputes do **not** include health plan Member appeals or grievances, which must be processed by the Member’s health plan, nor do they include re-submitted claims identified as “tracers.” If PPN has made a billing determination that a claim is the
financial responsibility of the Member’s health plan, PPN shall forward the claim to the plan, so notifying the provider, and the provider shall seek compensation from the Plan. The provider may not submit a dispute to PPN for Plan-responsibility claims until and unless the Plan disagrees with this determination.

To qualify for this procedure, a Provider Dispute must contain, at a minimum the following information: provider’s name; provider’s identification number, provider’s contact information, and:

If the Provider Dispute concerns a claim or a request for reimbursement of an overpayment of a claim from PPN, the following must be provided:

1) A clear identification of the disputed item
2) The date of service
3) A clear explanation of the basis upon which you believe that payment amount, request for additional information, request for reimbursement for the overpayment of a claim, denial, adjustment or other action is incorrect.
4) 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

If a contracted provider dispute involves Member or Members in PPN:

1) The name and identification number(s) of the Member(s)
2) A clear explanation of the disputed item, including the date of service and
3) Provider’s position on the dispute.

B. Submitting a Provider Dispute to PPN: Provider Disputes (Commercial & Medicare only) must be sent to the attention of: Provider Dispute Resolution / Pioneer Provider Network, at the following addresses:

   Via E-mail: pdr@mckesson.com
   Via Mail: 1901 N. Solar Dr. #200
             Oxnard, CA 93036
   Via Delivery: 1901 N. Solar Dr. #265
                 Oxnard, CA 93036
   Via Fax: (805) 988-5161

For Medi-Cal & Medi-Medi members managed by MedPoint Management, please go to this website and look for the “PPN PDR Form”
http://www.medpointmanagement.com/mpm/ProviderAB1455

C. Time Period for Submission of Provider Disputes:

1) Provider Disputes must be received by PPN within 365 days from PPN’s action that led to the dispute (or the most recent action if there are multiple disputes).
2) In the case of inaction, contracted provider disputes must be received by PPN within 365 days after the time PPN is allowed for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

3) Provider Disputes that do not include all required information as set forth above in Section A may be returned to the submitter for completion. An amended Provider Dispute, which includes the missing information may be submitted to PPN within thirty (30) working days of your receipt of a returned incomplete Provider Dispute.

D. **Acknowledgment of Provider Disputes**: PPN will acknowledge receipt of all Provider Disputes as follows:

1) PPN will acknowledge electronic contracted provider disputes within two (2) working days of the date of receipt by PPN.
2) PPN will acknowledge paper contracted provider disputes within fifteen (15) working days of the date of receipt by PPN.

E **Contacting PPN Regarding Provider Disputes**: All inquiries regarding the status of a Provider Dispute that has been submitted, must be directed to PPN one of the addresses shown in Section B, above or by telephoning this number: **(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:

1) Sort by Health Plan (each plan should be submitted separately)
2) Sort disputes by similar issue / type
3) Provide cover sheet for each batch
4) Number each cover sheet
5) 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**: PPN 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 Provider Dispute or the amended Provider Dispute, as applicable.

**Past Due Payments**: If the Provider Dispute involves a claim and is determined in whole or in part in favor of the provider, PPN 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.

III. **DISPUTE RESOLUTION PROCESS FOR NON-CONTRACTED PROVIDERS.**

This is Pioneer Provider Network’s (PPN) formal process for handling of provider disputes from Non-Contracted Providers concerning **Commercial** Member claims. Non-
contracted providers may only use this process for payment issues. **This formal dispute process does not apply to Medicare or Medi-Cal claims issues.**

For Medi-Cal (including dual eligibles if Medi-Cal HMO is secondary) or Healthy Families issues or claims, please go to this website and look for the “PPN PDR Form”: [http://www.medpointmanagement.com/mpm/ProviderAB1455](http://www.medpointmanagement.com/mpm/ProviderAB1455)

For **Medicare** claim disputes by non-contracted providers, see section C. below.

Use of this process ensures we will acknowledge and respond to your dispute in the timeframes required by law. Alternatively, you may contact us with your claim and authorization questions or submit claims appeals under our Informal Provider Appeals process at these numbers or at the addresses for claims shown in Section I:

**McKesson:**
- **Commercial Claims:**
  - **Phone:** 888-720-2323
  - **Fax:** 805-988-5163

For Medi-Cal & Medi-Medi members managed by MedPoint Management, please go to this website and look for the “PPN PDR Form”:
[http://www.medpointmanagement.com/mpm/ProviderAB1455](http://www.medpointmanagement.com/mpm/ProviderAB1455)

**MedPoint Management:**
- **Phone:** 818-466-6534
- **Fax:** 818-466-6534

**A. Definition of Non-Contracted Provider Dispute:** A non-contracted provider dispute is a non-contracted provider’s written notice to PPN challenging, appealing or requesting reconsideration of a claim (or a bundle of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain, at a minimum, the following information: the provider’s name, the provider’s identification number, contact information, and:

1) If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from PPN to provider, 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 the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect;

**Disputing the Allowed Fees:** If the non-contracted provider alleges that PPN has not allowed Reasonable & Customary Value in its payment for services rendered, the provider must include information supporting his/her Reasonable Value demand. Disputes solely on the grounds that PPN has not paid the provider at his/her “billed charges” without supporting justification will not be considered complete

(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.

2) If the non-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, provider’s position on the dispute, and an enrollee’s written authorization for provider to represent said enrollees.

3) If PPN voluntarily issues a supplemental payment to a non-contracted provider, which supplement PPN deems in excess of Reasonable & Customary Value, interest may not be applied to the supplemental amount.

B. **Dispute Resolution Process:** The dispute resolution process for non-contracted Providers is the same as the process for contracted Providers as set forth in sections 2.B., 2.C., 2.D., 2.E., 2.F., 2.G., and 2.H. above.

C. **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 as follows:

1. **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.”

2. **Payment Rate Dispute:** If we determine your claim is payable, Medicare law allows us to pay non-contracted providers at Medicare payment rates, pursuant to §§ 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 downcoded your claim inappropriately, you may appeal this directly to us within 125 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.
IV. CLAIM OVERPAYMENTS

A. Notice of Overpayment of a Claim: If PPN determines that it has overpaid a claim, PPN 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 a clear explanation of the basis upon which PPN 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 PPN’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 PPN stating the basis upon which the provider believes that the claim was not overpaid. PPN will process the contested notice in accordance with PPN’s contracted provider dispute resolution process described in Section II above.

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

D. Offsets to payments: PPN may only offset an uncontested notice of overpayment of a claim against provider’s current claim submission when;

1) The provider fails to reimburse PPN within the timeframe set forth in Section 4.C., above, and

2) PPN’s contract with the provider specifically authorizes PPN 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, PPN 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.

[Continued Next Page]
Purpose:
To establish a reasonable and customary value payment methodology for Pioneer Provider Network’s (PPN) payment of commercial claims to non-contracted providers, as outlined in AB 1455 and related regulations found in the California Code of Regulations, section 1300.71, and to hold members harmless from balance billing by non-contracted providers. (This policy is not applicable to Medicare, Medi-Cal or Healthy Families).

Hospital Based Physicians:
All non-contracted hospital based physicians will be paid according to the Group’s Reasonable & Customary Value (R & C) rates for services provided in relation to emergency services. Reasonable and Customary Value rates will be reviewed at least twice per year.

A claim received for a high-level emergency or trauma service requires attachment of medical records and information related to the experience and credentials of the physician. The claim, along with the supporting documents, will be reviewed by the Medical Director and a determination will be made by the Medical Director related to the appropriateness of the coding and a payment above the usual and customary rate may be made based upon his/her review.

All Other Non-Contracted Physicians:
Other non-contracted providers will be paid a “good faith payment” of Reasonable & Customary Value if records, provider credentials, and other necessary information* are not included with the claim. If there are records and credentials attached, or a dispute is received, medical records and information related to the skill, training and experience of the provider are required in order to make a final payment determination in accordance with all criteria set forth in AB 1455. As established by recent 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. Once this information is received, the Medical Director will review all information related to the physician and services and make a determination based on the information received and his/her review. The determination will be sent to the Provider.

*March 11, 2015. 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.”

Other:
The Explanation of Benefits (EOB) issued to the provider will include a statement that claims are paid under PPN’s usual and customary rates and/or will alert the physician if additional information (e.g. medical records, etc.) is required in to make a determination of reasonable value for services.
**Appeal Procedure:**

1. Provider must submit a written Provider Dispute form in compliance with AB 1455. The physician should supply medical records, information related to his/her special training and experience or credentials. A Provider Dispute form can be obtained via the instructions posted on the website www.pioneermedicalgroup.com under Contact Us.

2. All providers will receive notice of determination regarding their dispute within the timeframe required under AB 1455.