EXPLANATION OF PAYMENT (EOP)/PROVIDER REMITTANCE ADVISE (PRA)/REMITTANCE ADVISE (RA) Language Requirement

CA COMMERCIAL CLAIMS (Non-Emergency Footnote)

1. Contracted Paid/Denied Claims:
   Under the Knox Keene Act, an eligible member to whom services were provided shall not be liable for any portion of the bill, except for applicable cost share, which may include deductible, co-insurance and/or copayments. The contracted provider should not bill the member or attempt to collect against the member, unless the member was not eligible at the time the services were rendered or non-emergency services were not authorized and/or directed by the participating medical group or primary care physician.

   Pursuant to the Knox Keene Act of the State of California, the enrollee to whom prior approved services were provided is not liable for any portion of the bill, except for co-payments, deductibles, other cost sharing components, or non-covered benefits as defined in the enrollee's Evidence of Coverage documents.

   In the event the member appeared eligible no more than 72 hours prior to services being rendered and an authorization or eligibility is provided that the specific provider relied upon to render services and the member later appears ineligible on date of services, Knox-Keene requires that the provider and member be held harmless and you cannot recover payment.

2. Non-Contracted (This is being sent to the provider and **NOT** the member)(these are all **non-ER** services)
   a. Paid Claims:
      For dates of services on or after July 1, 2017; non-contracted providers may **NOT** balance bill a member for non-emergency services when covered services are rendered in a Participating Facility. UnitedHealthcare has many participating specialists and regional facilities available to **the member's assigned Medical Group**. In the event **the member's assigned Medical Group** elects to use a non-participating Facility and **the member's assigned Medical Group** does not enter into a Letter of Agreement that protects the member, all authorized services for non-emergency providers must be paid at billed charges minus the member's applicable cost-sharing.

   b. Denied Claims:
      You may file a written appeal to: **The member's assigned Medical Group at P.O. Box 211624, Eagan, MN 55121** with a clear & concise reason for questioning/disputing the denial decision.

3. PDR Process (Contracted & Non-Contracted **Emergency Services** Claims)
   Under AB1455 if you feel there is an error in payment, you may dispute in writing to: **The member's assigned Medical Group at P.O. Box 211624, Eagan, MN 55121**. A complete description of the dispute process can be found at **the bottom of the Remittance Advice**.

   Pursuant to California Code of Regulations Title 28, Sections 1300.71 and 1300.71.38, a provider may file a written dispute to: **The member's assigned Medical Group** to challenge, appeal, or request for a reconsideration on a claim(s) that has been denied, adjusted, or contested.

   Provider Disputes must be filed to **the member's assigned Medical Group** within 365 days from the last date of written notification that led to the dispute. For instructions and forms for

submitting a dispute, view the bottom of the Remittance Advice or contact our Provider Services Department at **the phone number listed above on the Remittance Advice**.

The dispute request must include the following
information:
1. Name address and phone number of the provider of service;
2. Provider's tax id number
3. Patient name
4. Insurer's information
5. Date of service
6. A complete and accurate explanation of the issue supporting documentation including copies of claims, claim
   number, medical records, or supporting documentation to challenge reports, as necessary, from the initial
   adverse determination.

4. Non-Emergency Services Independent Dispute Resolution Process (AB 72 IDRP)

The law requires that the Department of Managed Health Care conduct an independent dispute resolution process (AB 72 IDRP) that allows a non-contracting provider who rendered services at, or as a result of services at, a contracting health facility, or a payor, to dispute whether payment of the specified rate was appropriate. Once a non-contracting provider or payor submits an AB 72 IDRP Application, the opposing party is required by law to participate in the AB 72 IDRP. AB 72 does not apply to emergency services and care.

Eligible Claims

Eligible claim disputes are those disputes that are subject to DMHC jurisdiction and meet **all** of the following criteria:

- The disputed claim must be for services rendered on or after July 1, 2017.
- The disputed claim must be for non-emergency services. If there is an unresolved dispute as to whether the health care service(s) at issue is non-emergent, the claim does not qualify for the AB 72 IDRP.
- The disputed claim must be for covered services provided at a contracting health facility, or provided as a result of covered services at a contracting health facility, by a non-contracting individual health professional.
- The non-contracting provider has completed the health plan or payor's Provider Dispute Resolution (PDR) process within the last 365 days.
- The non-contracting provider is not a dentist.
- The payor is not a Medi-Cal managed health care service plan or any other entity that enters into a contract with the State Department of Health Care Services

For more information or to submit a dispute under the IDRP process, please go the California Department of Managed Health Care's website at:

https://www.dmhc.ca.gov/fileacomplaint/providercomplaintagainstaplan/nonemergencyservicesindependentdisputeresolutionprocess.aspx