CALIFORNIA MEDICAL ASSOCIATION

October 17, 2019

Sara Durston, Acting Deputy Director of Policy and Stakeholder Relations
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Submitted electronically to Sara.Durston@dmhc.ca.gov

Re: A.B. 72 Uniform Written Procedures and Guidelines

Dear Ms. Durston:

I am writing on behalf of the California Medical Association (CMA) to follow up on our August 20, 2019 meeting. As we discussed, CMA's Center for Economic Services has assisted our affected physician members with their IDRP applications. While many of these requests are currently pending, several physicians have received decisions from the Department regarding their requests for additional reimbursement through IDRP. The decisions have all favored the payor and have refused to recognize any of the evidence submitted by the physicians to support their requests for reimbursement above the A.B. 72 interim rate. CMA is concerned that if other decisions follow the same approach, the IDRP process will be illusory, making the statute's default rate a de facto fee schedule rather than an interim rate that is subject to appeal.

In July 2019, CMA submitted a letter to the Department objecting to the first IDRP decision we reviewed and requesting that the Department address several procedural and substantive issues raised by the decision. During our August 2019 meeting with the Department, you offered CMA the opportunity to provide feedback and specific recommendations for how to improve IDRP to ensure that it provides physicians with a meaningful avenue to appeal the A.B. 72 interim payment. We appreciate this opportunity and have provided specific suggestions in the attached redlined version of the Department's A.B. 72 Uniform Written Procedures and Guidelines ("Guidelines"), each of which is discussed below.

Qualifications of Reviewer

The current Guidelines fail to specify the qualifications of the reviewer making the IDRP decision. Each of the IDRP decisions CMA has reviewed have been conducted by a billing and coding expert. These decisions have focused exclusively on rate evidence and have dismissed any other evidence submitted, reflecting a lack of understanding as to the relevance of any of the other factors set forth in 28 C.C.R. §1300.71(a)(3)(B). For example, in nearly every decision CMA reviewed, the reviewer stated that "while the Provider describes their training, qualifications, and experience, they do not provide any methodology or

evidence to explain how their usual and customary charges might have been computed with regard to these elements."[1] In other decisions the reviewers spend multiple pages describing the extensive documentation submitted by the physician only to conclude that "the documents submitted by the Provider were not relevant or helpful to determining an appropriate reimbursement amount."[2]

Accordingly, CMA recommends that the Department amend the Guidelines to specify that the reviewer have training and experience in health care billing, reimbursement, and usual and customary charges, all of which is necessary to evaluate the appropriate reimbursement amount. Moreover, we urge that, like the model adopted by New York to implement its surprise billing dispute resolution process, claims involving services provided by a physician be reviewed in consultation with a California-licensed physician of the same or similar specialty as the physician whose services are subject to review. A consultation with a physician will ensure that the review gives fully-informed consideration to the relevance of the evidence submitted in support of each factor. We have proposed language to effectuate these changes in the attached document at 4.1.3 and 4.1.4.

Objective of Review and Burden of Proof

While the Department directs the reviewer in the qualification memorandum to determine the appropriate reimbursement amount, the Guidelines fail to clearly direct the reviewer as to the objective of the review or to explain the burden of proof to be used in the IDRP. As CMA and the Department agreed during our August 2019 meeting, the purpose of IDRP and the objective of the reviewer is to determine the appropriate reimbursement amount based on the factors set forth in 28 C.C.R §1300.71(a)(3)(B)(i)-(vi) ("the *Gould* factors"). In each of the IDRP decisions CMA has reviewed, the reviewers, rather than conducting a de novo review, are looking first to whether the payor's reimbursement was consistent with Health & Safety Code §1371.31(a)(1) and next asking whether that amount constitutes appropriate reimbursement without considering the *Gould* factors. The decisions consistently state that the evidence submitted by the physician "does not support the use of provider charges as payment standards," but fails to indicate what evidence supports the use of the payor's reimbursement as a payment standard. This approach unfairly places the burden of proof on the physician to overcome the apparent assumption that the payor's reimbursement was appropriate. Accordingly, CMA urges the Department to adopt the language proposed in Sections 4.3.2 – 4.3.3 and 4.3.8 of the Guidelines to clarify the objective of IDRP and to clarify that the burden of proof should be equal on both parties.

[1] *See* Applications #BR19-000002, BR19-000009, BR19-000010, BR19-000013, BR19-000014, BR19-000017, BR19-000018, and BR19-000025.
[2] *See* Applications #BR19-000009, BR19-000010, BR19-000018, and BR19-000025.

Submission and Consideration of Rate Information

It is imperative that the Department provide clear guidance to parties to IDRP on how to submit contracted rate information and direct the reviewer as to how it must consider redacted contracted rate information. In our July 2019 letter, CMA explained that in order to comply with their contractual obligations as well as with the existing Guidelines, physicians must redact any rate information they submit in support of their IDRP claims. As we discussed during our August 2019 meeting, physicians cannot simply redact the payor's name from an Explanation of Benefits or a contract because each payor's typeface, layout, and design are easily identifiable by other payors. Thus, the only way a physician can submit rate information for the purposes of IDRP is to submit an unidentified list of contracted rates, which the reviewer has failed to treat as credible evidence in each of the IDRP decisions CMA has reviewed. In order to allow physicians a meaningful opportunity to participate in IDRP while complying with their contractual obligations, CMA urges the Department to permit physicians to submit a de-identified list of contracted rates they receive from other payors along with an attestation as to the veracity of the rates. To this end, we suggest the addition of the proposed language in Section 1.9.4 of the Guidelines. Alternatively, the Department could specify in the Guidelines that physicians, like payors, may submit an average of their contracted commercial rates as evidence of the appropriate reimbursement amount.

Consideration of Evidence

Additional guidance is necessary to instruct the reviewers as to how certain evidence is relevant to determine the appropriate reimbursement amount. In several of the IDRP decisions CMA has read, the reviewers dismissed as irrelevant evidence regarding inadequate physician networks and the payors' unwillingness to contract with physicians.[3] The only evidence the reviewers gave any consideration to was the average contracted rate submitted by the payors to the Department. Similarly, the Guidance must direct the reviewers that they may not consider any information not submitted as evidence. CMA's review of these IDRP decisions reveals that the reviewer made unsubstantiated conclusions about the payors' average contract rates based on information that was not part of the evidence submitted.[4] We propose the addition of Sections 4.3.4-4.3.6 and 4.3.9-4.3.10 to address these issues and discuss each in more detail below.

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[3] *See* Applications BR19-000002, BR19-000013, BR19-000014, BR19-000017, BR19-000018, and BR19-000040 ("...Online Directory Search Results are submitted to support the Provider's assertions that the Payor may not be meeting network adequacy standards, and they have no relevance to the determination of an appropriate conversion factor.").

[4] *See* Applications #BR19-000002, BR19-000013, BR19-000014, BR19-000017, BR19000040 ("As indicated above, the submitted evidence does not support the use of provider charges as payment standards in this case, and the Payor's average conversion rate provides a payment standard that takes into account market activity in the provider's geographic region.").

Network Adequacy

The capacity of a payor's network to provide access to services subject to IDRP is relevant to the determination of the appropriate reimbursement amount because it reflects the economics of the market in that region. If a payor cannot find any physicians to participate in its network and provide these services in a certain region, that may be evidence that prevailing provider rates in the region are greater than the amount the payor is offering physicians and that the payor's reimbursement amount for the services is inappropriately low. Accordingly, CMA urges the addition of the proposed language in Section 4.3.9, which directs the reviewer that evidence of a payor's failure to maintain a provider network sufficient to provide the services subject to IDRP is relevant to its determination of the appropriate reimbursement amount.

Attempts to Contract

While the intent of A.B. 72 was to take patients out of the middle of payment disputes between providers and payors, in setting a payment standard for noncontracted care, it has had the unintended consequence of disincentivizing payors from contracting with physicians. CMA has received numerous reports of payors refusing to contract with physicians and relying on A.B. 72's interim payment standard and the contracts between physicians and hospitals to provide care to enrollees. A.B. 72 was not intended to provide payors with the ability to close their panels, refuse to renew existing contracts, offer take it or leave it contracts, or allow payors to slash contracted reimbursement rates that are above the A.B. 72 interim rate. Evidence of good faith efforts made by a physician to contract with a payor and evidence of bad faith on behalf of the payor are relevant to the determination of the appropriate amount of reimbursement because they demonstrate that the payor's rate is not reflective of the fair market value for services, but rather reflects what it can pay when it has unlimited leverage. CMA urges the Department to incorporate the proposed language in Section 4.3.10 to specify that evidence of good faith attempts by a physician to contract with a payor is relevant to the determination of the appropriate reimbursement amount.

Average Contracted Rate

The payors involved in several of the IDRP decisions CMA reviewed submitted as evidence statements indicating that the average contracted rate is what they filed with the Department. Many of these payors provided no documentary evidence to support how they calculated that rate, provided no explanation of what they meant by "average contracted rate," and provided no explanation of the context in which it submitted the information to the Department. Yet, in each of the IDRP decisions CMA reviewed, the payors' statements as to their average contracted rates was the only evidence deemed relevant and credible by the reviewer.[5] In order to ensure that evidence submitted by both

[5] *See* Applications #BR19-000002, BR19-000013, BR19-000014, BR19-000017, BR19000040 ("As indicated above, the submitted evidence does not support the use of provider charges as payment standards in

parties is given equal consideration and that deference not be given to information submitted by payors, it is critical that the Department provide additional guidance to the reviewers. CMA has proposed language that addresses the appropriate treatment of average contracted rate information in Section 4.3.4 of the attached document.

As we discussed during our August 2019 meeting with the Department, although Health & Safety Code §1371.31(a)(2) requires that payors submit their average contracted rates to the Department by geographic region, the Guidelines fail to direct the reviewer that only average contracted rates for the geographic region where the services subject to IDRP are relevant to the determination of the appropriate reimbursement amount. CMA understood the Department to agree with our position that average contracted rate evidence would only be relevant to the determination of the appropriate reimbursement amount if it were for the geographic region in which the services subject to the IDRP were provided. Accordingly, CMA offers the proposed language in Section 4.3.5 to provide the reviewer direction on this point.

Consideration of Information Not Submitted

In several of the IDRP decisions CMA has read, the reviewer explains that the average contracted rate "takes into account market activity in the provider's geographic region." For at least one of the IDRP decisions CMA reviewed, the evidence submitted by the payor does not contain any explanation of what is meant by "average contracted rate" nor does it explain how the average contracted rate takes into account market activity in the geographic region. The average contracted rate itself does not definitively demonstrate that the payor's rates are the fair or appropriate reimbursement amount for services. CMA recommends that in order to ensure only information in evidence is considered by the reviewer in making its determination as to the appropriate amount of reimbursement, the Guidelines specify that any information not submitted by either party shall not be considered. To that end, we suggest several changes to the Guidelines, specifically the amendment to Sections 3.2.4 and 3.2.5 and the addition of the language in Section 4.3.6.

FAIR Health

During our August 2019 meeting, CMA discussed with the Department that while the Legislature declined to use FAIR Health as a benchmark for the interim payment amount, the database contains reimbursement rate information that could be valuable to an IDRP reviewer in determining the appropriate reimbursement amount. The FAIR Health database is maintained by an independent non-profit company that serves as a clearinghouse for information about claims for services of health care professionals. It was created as a result of litigation and a New York Attorney General investigation that

this case, and the Payor's average conversion rate provides a payment standard that takes into account market activity in the provider's geographic region.").

revealed that insurers and their Ingenix company manipulated their provider claims and the rates database they used to price out-of-network care, shortchanging the nation's patients by hundreds of millions of dollars. The settlement agreements required the insurance companies to finance an objective database of doctors' fees that patients and insurers nationally could rely on. It is updated at least twice per year using submissions from health insurers about how much physicians charged for a service in a particular location. In recent years, FAIR Health has added to its database information about how much payors actually reimburse ("allowed amount") for a particular service in a particular region. It is regarded as one of the most clear, concise, and accurate cost databases and could provide IDRP reviewers with an objective understanding of what constitutes an appropriate reimbursement amount for a particular service in a particular region. Accordingly, CMA urges the Department adopted the language proposed in Section 4.3.11 to direct the review organization that it may consult the FAIR Health database to obtain information regarding provider charges and allowed amounts for the same services provided in the same geographic region as the services subject to the IDRP.

Thank you for your prompt consideration of CMA's feedback on how to best ensure A.B. 72 IDRP functions, as the Legislature intended, to provide physicians with a meaningful opportunity to appeal for a higher reimbursement amount than the interim reimbursement amount described in the law. We look forward to working with the Department to address CMA's concerns and to implement our proposed amendments and additions to the Guidelines. To discuss this matter further, you may reach me by phone at (916) 551-2552 or by email at switorff@cmadocs.org.

Sincerely,

Stacey Wittorff
Legal Counsel
Center for Legal Affairs
California Medical Association

Attachment: CMA Proposed A.B. 72 Uniform Written Procedures and Guidelines

cc: **Dustin Corcoran**, Chief Executive Officer, California Medical Association (*via email to dcorcoran@cmadocs.org*)

Francisco J. Silva, Esq., General Counsel and Senior Vice President, California Medical Association (*via email to fsilva@cmadocs.org*)

Nancy Wong, Assistant Chief Counsel, Office of Legal Services, Department of Managed Health Care (*via email to nancy.wong@dmhc.ca.gov*)

Elizabeth Landsberg, Deputy Director, Help Center, Department of Managed Health Care (*via email to elizabeth.landsberg@dmhc.ca.gov*)

Mark Ghaly, MD, MPH, Secretary, California Health and Human Services Agency (via email at *mark.ghaly@chhs.ca.gov*)

HSC §1371.30(b)(1)[1]: The department shall establish uniform written procedures for the submission, receipt, processing, and resolution of claim payment disputes pursuant to this section and any other guidelines for implementing this section.

1 SUBMISSION

1.1 Required Filing of Delegated Entity Report by Licensed Health Plans

1.1.1 Licensed health care service plans may delegate payment function to various entities (Delegated Entities). The Department of Managed Health Care (DMHC) AB 72 Independent Dispute Resolution Process (IDRP) allows a health plan to name a delegated entity as the responsible payor for purposes of the IDRP. Once a delegated entity is named by the health plan, the delegated entity is required to participate in the IDRP (*see* HSC §1371.30(f)). Notwithstanding delegation, the health plan is ultimately responsible for implementing the IDRP decision (*see* HSC §1371.30(d)).

1.1.2 In order to conduct the IDRP, the DMHC will require all licensed health plans to submit electronically a current list of the health plan's delegated entities (hereinafter, "Delegated Entity Report"). If a health plan does not delegate payment function to any delegated entities, the Delegated Entity Report shall state that the health plan does not delegate payment function.

1.1.3 The Delegated Entity Report must be submitted electronically to the DMHC's Office of Plan Licensing (OPL) via the eFiling webportal pursuant to CCR §1300.41.8. The Delegated Entity Report must be submitted on an annual basis. Each health plan's first Delegated Entity Report must be submitted by November 15, 2017. Subsequent reports are due by November 15th of each year. In the event that there are no changes to a health plan's previously filed Delegated Entity report, the health plan is required to submit a Delegated Entity Report that states there are no changes to report.

1.1.4 At a minimum, the Delegated Entity Report must contain:

- The name and title of the individual(s), including at least one (1) alternate contact, at the health plan responsible for receiving and responding to communications from the DMHC for purposes of the IDRP, including the individual's e-mail address and direct telephone number, with extension, if applicable.
- The name of each delegated entity
- Accurate and current contact information for each delegated entity, including mailing address and telephone number.

[1] References to "HSC" are to the Knox-Keene Health Care Service Plan Act (Act), as codified in the California Health and Safety Code, Section 1340, et seq. References to "CCR" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 2, California Code of Regulations, beginning with Section 1300.43.

- The name and title of the individual(s), including at least one (1) alternate contact, at the delegated entity responsible for receiving and responding to communications from the DMHC for purposes of the IDRP, including the individual's e-mail address and direct telephone number, with extension, if applicable.

1.2 Registration

1.2.1 All prospective parties to IDRP must register with the online IDRP portal in order to submit an IDRP Application or respond to an IDRP Application. Each provider and payor must create an Administrator account that will be responsible for approving the registrations of each user sub-account. Providers will be required to input a National Provider Identifier (NPI) number upon registration.

1.2.2 The prospective parties to IDRP include health plans, delegated entities, and noncontracting individual health professionals. Physician groups, independent practice associations, or other entities authorized to act on behalf of a noncontracting individual health professional may also initiate and participate in the IDRP.

1.3 IDRP Application

1.3.1 An Initiating Party must complete an IDRP Application online using the DMHC's external IDRP portal. The IDRP Application form is entirely web-based. IDRP Applications will not be accepted outside of the IDRP portal and there is no parallel paper process for the IDRP. The Application includes required data fields related to claims processing and billing. The information needed to complete these data fields should be readily available to the Initiating Party on the claim form(s), Explanation(s) of Benefits (EOBs), and Provider Dispute Resolution (PDR) determination letter(s) for the claim(s) that are in dispute.

1.4 Required Supporting Documents:

1.4.1 The following documents must be included with an IDRP Application in order for it to be processed by the DMHC:

- Claim Form(s)
- Provider Dispute Resolution (PDR) Determination Letter(s)
  - Note: If a provider attempted PDR, but did not receive an acknowledgment letter or determination letter from the Payor and at least 45 business days have passed since the date of receipt[2] of the provider dispute, the provider may submit dated proof of the PDR attempt in lieu of a PDR determination letter. In accordance with CCR §1300.71.38(d)(2), the 45 business day period shall be extended in situations where a provider dispute is returned and must be amended.
- Explanation(s) of Benefits or Remittance Advice

1.5 Narrative Summary Justification

1.5.1 In addition to the required supporting documents, a complete IDRP Application should include a narrative summary justification that addresses all information relevant to the Initiating Party's suggested appropriate reimbursement amount for the claim(s) at issue, including, but not limited to, the factors set forth in CCR §1300.71(a)(3)(B)(i)-(vi). These factors are listed here:

i. the provider's training, qualifications, and length of time in practice;
ii. the nature of the services provided;
iii. the fees usually charged by the provider;

[2] "Date of receipt" is defined at CCR §1300.71.38(a)(3).

iv. prevailing provider rates charged in the general geographic area in which the services were rendered;
v. other aspects of the economics of the medical provider's practice that are relevant; and
vi. any unusual circumstances in the case.

1.5.2 Although not required, this narrative summary justification is very important. It is the Initiating Party's chance to make its case and show that its suggested reimbursement amount is appropriate. The narrative summary justification should be well-organized and should cite or reference supporting documentation and evidence where applicable. All cited or referenced materials should be uploaded with the IDRP Application.

1.5.3 The DMHC will not impose a page-limit on the narrative summary justification.

1.6 Other Relevant Supporting Documents

1.6.1 The Initiating Party may also submit any other documents that it believes to be relevant to the suggested appropriate reimbursement amount for the claim(s) at issue and that it would like the independent review organization to consider when making an IDRP decision. It is the Initiating Party's responsibility to explain the relevance of this documentation in its narrative summary justification.

1.6.2 The independent organization conducting the IDRP will consider only the information and documents timely submitted to the DMHC by the parties to the dispute when rendering a decision. Therefore, it is the IDRP participant's responsibility to include all documents and information relevant to the appropriate reimbursement amount with the IDRP Application.

1.6.3 The DMHC will not impose a page limit on the supporting documents submitted with the IDRP Application.

1.7 General Guidelines

1.7.1 All claims in an IDRP Application must be for services rendered on or after July 1, 2017.

1.7.2 All claims in an IDRP Application must be for non-emergency services. If there is an unresolved dispute as to whether the health care services at issue are non-emergent, the claim(s) do not qualify for the IDRP.

1.7.3 All claims in an IDRP Application 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 noncontracting individual health professional.

1.7.4 Prior to submitting an IDRP Application, the PDR process must be completed with either the health plan or the applicable delegated entity (*see* HSC §1371.30(a)(2)). An Initiating Party is not required to complete PDR with both the health plan and the delegated entity if each entity maintains a separate PDR process. Required proof of completed PDR is a final PDR determination letter.

- Note: If a provider attempted PDR, but did not receive an acknowledgment letter or determination letter from the Payor and at least 45 business days have passed since the PDR attempt, the provider may submit dated proof of the PDR attempt in lieu of a PDR determination letter. In accordance with CCR §1300.71.38(d)(2), the 45 business day period shall be extended in situations where a provider dispute is returned and must be amended.

1.7.5 Claims are eligible for the IDRP for 365-days from the final PDR date of determination.[3] If the provider attempted PDR, but the payor was non-responsive, the 365-day limit will run after 45 business days have passed since the date of receipt of the provider dispute.[4] In

[3] "Date of Determination" is defined at CCR §1300.71.38(a)(4).

the event that a claim is submitted to the IDRP, but disqualified due to a curable defect in the IDRP Application, the time during which the initial IDRP Application was pending with the DMHC is not included in the 365-day limit.

1.7.6 A dentist, licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code) is not a "noncontracting individual health professional" for purposes of the IDRP and cannot participate in the IDRP.

1.7.7 Medi-Cal managed health care service plans or any other entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code are excluded from the IDRP and cannot participate in the IDRP.

1.8 Bundle of Claims

1.8.1 An Initiating Party may "bundle" up to 50 claims in a single IDRP Application if the claims meet the following conditions (*see* HSC §1371.30(b)(3)):

- all claims must be for services provided by the same individual health professional;
- all claims must have the same payor (health plan or delegated entity);
- all claims must be for the same or similar services

1.8.2 A single claim within a bundle must contain Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes.

1.8.3 Required supporting documents (as described in Section 1.4) must be submitted for each claim within a bundle (e.g., PDR must be complete for each individual claim).

1.8.4 IDRP Applications that include improperly bundled claims will be rejected and closed. The DMHC will electronically send the Initiating Party a closing letter explaining why the IDRP Application was rejected through the IDRP portal. If the Initiating Party chooses to proceed with all or some of the claim(s), it must submit a new IDRP Application.

1.8.5 An IDRP Application is assigned a case ID# and each bundled claim receives a sub-ID # (*e.g.*, ID-1700001, ID-1700001-1). The IDRP Application requires documents and other information for bundled claims to be inputted at both the case level and the claim level. The IDRP portal includes functionality to identify which documents are relevant to specific claim(s) within a bundle. All documents uploaded within the IDRP portal should be identified by claim where possible. Documents uploaded to the IDRP Application will be sent to the independent organization without reformatting or other changes.

1.8.6 An IDRP Application with bundled claims will be allowed only a single narrative summary justification document. However, the parties to the IDRP are free to organize the narrative by claim, if applicable.

1.8.7 Any bundles exceeding 50 claims must be submitted in separate IDRP Applications. For example, 100 similar claims meeting the conditions in HSC §1371.30(b)(3) must be submitted in at least two (2) separate IDRP Applications that contain up to 50 bundled claims.

1.9 Confidentiality of IDRP Application

1.9.1 IDRP Application information identifying the claim(s) at issue will be shared with the applicable opposing party for purposes of determining (i) whether the DMHC has jurisdiction over the claim(s), and, if relevant, (ii) whether the Health Plan will be participating in the IDRP or delegating participation to a delegated entity. The information that will be shared for these purposes includes, for each claim, the:

- Subscriber name
- Patient name
- Patient ID#
- Patient date of birth (DOB)
- Dates of Service (DOS)
- Provider name
- Facility name[5]
- Claim Number

1.9.2 Following identification of the opposing party participating in the IDRP, the Initiating Party's complete IDRP Application will be viewable by both parties and the independent organization reviewing the dispute.

1.9.3 It is each IDRP participant's responsibility to redact all proprietary, confidential, or protected health information that should not be viewed by the DMHC, the independent organization, or parties to the IDRP. Additionally, it is each IDRP participant's responsibility to redact all identifying information relating to patient claims that are not the subject of the IDRP from documents uploaded to the IDRP portal.

1.9.4 If a party wishes to submit evidence of its contracted rates with entities not a party to the IDRP, the party may provide a de-identified list of these rates and attest to their veracity.

2 RECEIPT

2.1 Intake - IDRP Application Review

2.1.1 After an Initiating Party submits the IDRP Application, a dated Acknowledgment of IDRP Application Submission will be electronically forwarded to the Initiating Party using the e-mail address listed in the registration process.

2.1.2 DMHC Intake Staff will do an initial review of the complete IDRP Application to confirm that the Initiating Party has identified the applicable health plan for all claim(s) contained in the IDRP Application.

2.1.3 Once an Initiating Party has submitted an IDRP Application, an Opposing Party (either the noncontracting individual health professional or the health plan/delegated entity) is required to participate in the IDRP by law (*see* HSC §1371.30(a)(3)).

2.2 Request for Opposing Party Response I (ROPR I)

2.2.1 If the Initiating Party is a noncontracting individual health professional, the DMHC will send a ROPR I communication to the health plan through the IDRP portal. The ROPR I is entirely web-based. ROPR I responses will not be accepted outside of the IDRP portal and there is no parallel paper process for the ROPR I. The ROPR I requires the health plan to confirm or deny DMHC jurisdiction over the claim(s) at issue. If the health plan confirms DMHC jurisdiction, it must also indicate whether it is the responsible payor for purposes of participating in the IDRP or if it has delegated payment function to a delegated entity that will be participating in the IDRP. Even if the health plan names a delegated entity in its response to ROPR I, the health plan is ultimately responsible for implementing the IDRP decision (*see* HSC §1371.30(d)).

2.2.2 The ROPR I communication contains the following data fields collected from the IDRP Application that will allow the health plan to identify the claim(s) and accurately respond:

- Subscriber name
- Patient name
- Patient ID#

[5] For purposes of DMHC IDRP, "facility" means (i) the contracting health facility where the service(s) at issue were provided, or (ii) the contracting health facility where the provision of covered services resulted in the service(s) at issue.

- Patient date of birth (DOB)
- Dates of Service (DOS)
- Provider name
- Facility name[6]
- Claim Number

2.2.3 If the health plan indicates that it is not the responsible payor for purposes of participating in the IDRP, the health plan will not have access to the IDRP Application or any documents uploaded as part of the IDRP Application going forward. However, the health plan will have access to selected case status information in order to monitor whether the delegated entity has fulfilled its obligation to participate in the IDRP.

2.2.4 If the health plan names a delegated entity as the responsible payor for purposes of the IDRP, the health plan will be required to select the delegated entity from a list of pre-registered entities, or provide accurate and current contact information for the delegated entity if the name does not appear on the list of pre-registered entities.

2.2.5 If the health plan names a delegated entity as the responsible payor for purposes of the IDRP, then the delegated entity is required to participate in the IDRP (*see* HSC §1371.30(f)).

2.3 Closing Non-Jurisdictional Claims

2.3.1 If the health plan indicates in its ROPR I response that the claim(s) at issue are not within the DMHC's jurisdiction, the DMHC will close the IDRP Application using the "Non-Jurisdictional" close reason and will electronically issue a closing letter to the parties.

2.3.2 If the health plan states that the DMHC does not have jurisdiction, it should specify in its ROPR I response the specific regulatory body that does have jurisdiction over the claim(s) at issue (*i.e.* California Department of Insurance, etc.), DMHC Intake Staff will include this information in the closing letter.

2.4 Request for Opposing Party Response II (ROPR II)

2.4.1 After the DMHC receives a ROPR I response and confirms jurisdiction and the contact information for the Opposing Party, the DMHC will electronically send a ROPR II notification to the Opposing Party through the IDRP portal.

2.4.2 The ROPR II is the Opposing Party's opportunity to fully respond to the Initiating Party's IDRP Application. When the Opposing Party receives the ROPR II, the Opposing Party will have access to the IDRP Application, including every document uploaded by the Initiating Party as part of the IDRP Application. This includes the Initiating Party's narrative summary justification document. It is the DMHC's expectation that an Opposing Party will address any inaccurate information contained in the IDRP Application and/or any arguments raised in the narrative summary justification.

2.4.3 The Opposing Party must complete the ROPR II online, through the IDRP portal. The ROPR II is entirely web-based. ROPR II responses, including communications or documentation of any kind, will not be accepted outside of the portal and there is no parallel paper process for providing a ROPR II response. The ROPR II includes data fields related to claims processing and claims payment. The information needed to complete these data fields should be readily available to the Opposing Party within the documents associated with the previously completed PDR process.

2.4.4 The ROPR II response does not require certain document uploads to be deemed complete. However, it is the Opposing Party's responsibility to provide any information

[6] For purposes of DMHC IDRP, "facility" means (i) the contracting health facility where the service(s) at issue were provided, or (ii) the contracting health facility where the provision of covered services resulted in the service(s) at issue.

and documents it believes to be relevant to its suggested appropriate reimbursement amount for the claim(s) at issue as part of the ROPR II response.

2.4.5 In addition to optional supporting documents, a complete ROPR II response should include the Opposing Party's narrative summary justification that addresses all information relevant to its suggested appropriate reimbursement amount for the claim(s) at issue. The narrative summary justification should address any evidence offered by the Initiating Party concerning the factors set forth in CCR §1300.71(a)(3)(B)(i)-(vi), listed here:

i. the provider's training, qualifications, and length of time in practice;
ii. the nature of the services provided;
iii. the fees usually charged by the provider;
iv. prevailing provider rates charged in the general geographic area in which the services were rendered;
v. other aspects of the economics of the medical provider's practice that are relevant; and
vi. any unusual circumstances in the case.

2.4.6 The Opposing Party's narrative summary justification should be well-organized and should cite or reference supporting documentation and evidence where applicable. All cited or referenced materials should be uploaded with the ROPR II response.

2.4.7 The DMHC will not impose a page-limit on the Opposing Party's narrative summary justification.

2.4.8 The Opposing Party may also submit any other documents that it believes to be relevant to the appropriate reimbursement amount for the claim(s) at issue and that it would like the independent organization to consider when making an IDRP decision.

2.4.9 The independent organization conducting the IDRP will consider only the information and documents timely submitted through the IDRP portal by the parties to the dispute when rendering a decision. Therefore, it is the IDRP participant's responsibility to include all documents and information relevant to its suggested appropriate reimbursement amount with the ROPR II response.

2.4.10 The DMHC will not impose a page limit on the supporting documents submitted with the ROPR II response.

2.5 Failure to Respond to ROPR I or ROPR II

2.5.1 If a health plan fails to timely respond to ROPR I, the DMHC's Provider Complaint Unit will refer the matter to the DMHC' Office of Enforcement for the possible imposition of administrative or civil penalties (Enforcement Action).

2.5.2 If an Opposing Party fails to timely respond to ROPR II, the case will proceed to the independent organization to commence billing. If both the Initiating Party and Opposing Party remit IDRP review fees, the independent organization will consider only the information and documents timely submitted through the IDRP portal by the Initiating Party when reaching an IDRP decision.

2.5.3 If an Opposing Party fails to timely respond to ROPR II, the case will proceed to the independent organization. If the Initiating Party remits its share of the IDRP review fee, but the Opposing Party does not, the independent organization will issue a Default Decision awarding the Initiating Party its full requested reimbursement amount.

2.5.4 If a delegated entity fails to respond to any communications from the DMHC during the IDRP, the health plan that has delegated payment function to that delegated entity may be subject to an Enforcement Action.

3 PROCESSING

3.1 IDRP Application and ROPR II Review

3.1.1 The DMHC will conduct a first-look review of the complete IDRP Application and ROPR II response to determine whether any uploaded documents are illegible, missing pages, or contain inapplicable protected health information, and cannot be sent to the independent organization conducting the IDRP.

3.1.2 If the DMHC determines that certain documents need to be redacted or re-uploaded due to illegibility or other technical errors, the DMHC will contact the appropriate party to the IDRP to resolve the issue electronically through the IDRP portal using a Request for Information (RFI) communication.

3.1.3 If a party does not timely respond to the RFI communication, any affected document(s) will undergo review by the DMHC and independent organization in its present condition.

3.1.4 Once the DMHC has resolved any technical issues with the IDRP Application and ROPR II response, the DMHC will begin evaluating the case to determine whether it qualifies for the IDRP.

3.2 Qualifying a Case for the IDRP

3.2.1 It is the DMHC's responsibility to qualify cases for the IDRP prior to billing and review by the independent organization conducting the IDRP.

3.2.2 The DMHC must confirm the following information in a case before qualifying the case for the IDRP:

- All claims in the case must be for services rendered on or after July 1, 2017.
- All claims in the case must be for non-emergency services. If there is an unresolved dispute as to whether the health care services at issue are non-emergent, the claim(s) do not qualify for the IDRP.
- All claims in the case 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 noncontracting individual health professional.
- If the case contains bundled claims, all claims in the case must be for the same or similar services
- All claims in the case must be accompanied by valid proof of completed PDR with either the health plan or the applicable delegated entity (see HSC §1371.30(a)(2)). Valid proof of completed PDR is a final PDR determination letter. The only exception to this requirement is in circumstances where a provider attempted PDR, but did not receive an acknowledgment letter or determination letter from the Payor and at least 45 business days have passed since the date of receipt[7] of the provider dispute. In this limited circumstance, dated proof of the provider's PDR attempt is valid proof of PDR. In accordance with CCR §1300.71.38(d)(2), the 45 business day period shall be extended in situations where a provider dispute is returned and must be amended.
- All claims in the case must be submitted to the IDRP within 365-days from the final PDR date of determination.[8] If the provider attempted PDR, but the payor was non-responsive, the 365-day limit will run after 45 business days have passed since the date of receipt of the provider dispute.[9] In the event that a claim is submitted to the IDRP, but disqualified due to a curable defect in the

[7] "Date of receipt" is defined at CCR §1300.71.38(a)(3).

[8] "Date of Determination" is defined at CCR §1300.71.38(a)(4).

[9] "Date of receipt" is defined at CCR §1300.71.38(a)(3).

IDRP Application, the time during which the initial IDRP Application was pending with the DMHC is not included in the 365-day limit.

- The noncontracting individual health professional cannot be a dentist, licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code).
- The health plan cannot be 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 pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code..

3.2.3 If a case qualifies for the IDRP, the DMHC will draft a qualification memorandum (in a format to be determined by DMHC) for the independent organization conducting the IDRP.

3.2.4 The qualification memorandum will ask the independent organization conducting the IDRP to respond to the same question in every case: Based solely on all relevant information submitted by the parties, what is the appropriate reimbursement amount for each CPT and/or HCPCS code billed by the provider?

3.2.5 If an Initiating Party indicates in its Application, or an Opposing Party indicates in its ROPR II response, that a dispute exists as to whether the claims at issue are properly coded (i.e. upcoding, downcoding, etc.), the qualification memorandum will include an additional question: Based solely on all relevant information submitted by the parties, are the claims at issue appropriately coded for the purpose of calculating the reimbursement amount, and if the claims are not properly coded, what is the appropriate reimbursement amount for each of the claims, as appropriately coded? When a qualification memorandum contains this additional question, the parties will be charged the higher "Standard rate including coding review" rate as stated in Section 4.2.5, below.

3.2.6 The qualification memorandum will be electronically sent to the independent organization to commence billing and resolution.

3.3 Disqualifying a Case for the IDRP

3.3.1 If a case is not qualified for the IDRP, the DMHC will draft a disqualification memorandum (in a format to be determined by DMHC) that provides a detailed explanation as to why the case is not qualified and which documents and/or other information the DMHC relied on in reaching its conclusion.

3.3.2 The DMHC will electronically send the applicable closing letter to both parties to the IDRP through the IDRP portal. The closing letter will include the close reason.

3.3.3 The DMHC will close the case in the IDRP portal.

4 RESOLUTION

4.1 Independent Organization Intake

4.1.1 The DMHC is contracted with an independent organization (Maximus, Inc.) that conducts IDRP proceedings. The independent organization is independent of either party to the IDRP (*see* HSC §1371.30(c)(1)).

4.1.2 Upon receipt of the qualification memorandum from the DMHC, the independent organization will commence intake, billing, assignment, and review of a case.

4.1.3 The independent organization will ensure that the decision in each case is made by a reviewer with training and experience in health care billing, reimbursement, and usual and customary charges.

4.1.4 For cases involving services provided by a physician, the independent organization will ensure that the decision in each case is made by a reviewer with training and experience in health care billing, reimbursement, and usual and customary charges in consultation with a practicing California-licensed physician of the same or similar specialty as the physician whose services are the subject of the proceeding. The consulting California-licensed physician shall provide input, consistent with 4.3.1-4.3.11, as to the appropriate reimbursement amount for the services subject to the proceeding.

4.2 Pre-Payment/Billing

4.2.1 Reasonable and necessary fees for the purpose of administering the IDRP will be split equally between the parties (*see* HSC §1371.30(b)(2))

4.2.2 Payment of IDRP fees is billed and collected solely by the independent organization conducting the IDRP.

4.2.3 All IDRP fees will be paid electronically through the IDRP portal.

4.2.4 All IDRP fees will be collected before the independent organization commences review of the IDRP and prior to the issuance of a Decision Letter.

4.2.5 IDRP fees increase based on the number of claims bundled within a case. A list of current IDRP fees is as follows:

Standard rate (no dispute over correct coding of claims)

$315 per review
$315 per review of 2-10 substantially similar claims
$340 per review of 11-25 substantially similar claims
$395 per review of 26-50 substantially similar claims

Standard rate including coding review

$330 per review
$330 per review of 2-10 substantially similar claims
$355 per review of 11-25 substantially similar claims
$415 per review of 26-50 substantially similar claims

4.2.6 Once a case is qualified for the IDRP by the DMHC, and the independent organization collects payment from the Initiating Party, the case cannot be withdrawn and any funds remitted by the parties will not be refunded.

4.2.7 The Initiating Party is billed for IDRP first. After the Initiating Party timely remits its IDRP fee, the Opposing Party is billed.

4.2.8 If an Initiating Party fails to timely remit payment for the IDRP, the independent organization will notify the DMHC. The DMHC will close the case and electronically send a closing letter to both parties to the IDRP.

4.2.9 If an Initiating Party timely remits its share of the IDRP review fee, but the Opposing Party does not, the independent organization will issue a Default Decision awarding the Initiating Party its full requested reimbursement amount.

4.3 Review Guidance

4.3.1 The independent organization will have a maximum of thirty (30) calendar days following receipt of payment to complete its review of a case and provide the DMHC with an IDRP Decision Letter.

4.3.2 The reviewer shall conduct a de novo review to determine the appropriate amount of reimbursement.

4.3.3 The burden of proving the appropriate amount of reimbursement shall be equal on both parties.

4.3.4 While a payor's average contracted rate may be considered by the reviewer in determining the appropriate reimbursement amount if submitted as evidence, it shall not be afforded deference and shall be given evidentiary weight equal to any other evidence submitted by either party.

4.3.5 A payor's average contracted rate may only be considered if it is the average contracted rate for the same geographic region in which the services subject to the proceeding were provided.

4.3.6 The review organization's IDRP Decision regarding the appropriate reimbursement amount for the claim(s) at issue shall be based solely on all relevant information as

submitted by the parties to the IDRP (*see* HSC §1371.30(b)(5)). No other information shall be considered by the reviewer, except as provided in 4.3.11.

4.3.7 The relevant information considered by the independent organization includes, but is not limited to, information submitted by the parties regarding the factors set forth in CCR §1300.71(a)(3)(B)(i)-(vi), listed here:

i. the provider's training, qualifications, and length of time in practice;
ii. the nature of the services provided;
iii. the fees usually charged by the provider;
iv. prevailing provider rates charged in the general geographic area in which the services were rendered;
v. other aspects of the economics of the medical provider's practice that are relevant; and
vi. any unusual circumstances in the case.

4.3.8 The reviewer's objective is not to determine whether the payor provided reimbursement consistent with HSC §1371.31(a)(1).

4.3.9 Evidence that a payor's network is insufficient to provide access to the services subject to the review is relevant to the determination of whether the amount reimbursed by the payor reflects the economics of the market and is therefore appropriate.

4.3.10 Evidence of good faith attempts by a noncontracting individual health professional to contract with the payor is relevant to the determination of whether the amount reimbursed by the payor reflects the fair market value for services and is therefore appropriate.

4.3.11 Notwithstanding 3.2.4 and 3.2.5, the review organization may consult the FAIR Health database for information regarding provider rates and allowed amounts for the same services provided in the same geographic region.

4.3.12 The IDRP Decision drafted by the independent organization will provide a written explanation of the appropriate reimbursement amount decision, and will include a list of appropriate reimbursement amounts by relevant CPT and/or HCPCS code.

4.3.13 The independent organization will electronically communicate all IDRP Decisions to the DMHC for final approval and distribution to the IDRP parties through the IDRP portal.

4.4 IDRP Decision

4.4.1 IDRP Decision Letters, including IDRP Default Decision Letters, will not be distributed to the parties before final approval (to confirm application of IDRP guidelines, professional drafting, and formatting) by the DMHC.

4.4.2 Once an IDRP Decision Letter (or Default Decision Letter) is approved, the DMHC will electronically send the IDRP Decision Letter and DMHC cover letter to both parties to the IDRP through the IDRP portal.

4.4.3 The decision obtained through the IDRP is binding on both parties. The health plan and delegated entity, if applicable, shall implement the decision obtained through the IDRP. If dissatisfied, either party to the IDRP may pursue any right, remedy, or penalty established under any other applicable law (see HSC §1371.30(d)).

5 TIME PERIOD TO RESPOND TO IDRP COMMUNICATIONS

5.1 Paperless IDRP

5.1.1 The IDRP is entirely electronic and is conducted through the IDRP portal. There is no parallel paper process for the IDRP, and documents will not be accepted or considered outside of the IDRP portal. To ensure maximum security, all documents uploaded to the IDRP portal must be in Portable Document Format (.PDF).

5.2 Response Deadlines

5.2.1 The following response deadlines apply for each communication type within the IDRP portal. Deadlines begin to run on the business day following electronic transmittal of the communication through the IDRP portal. [Example: RFI communication sent by DMHC on Friday, September 15th. The 5-day deadline begins to run on Monday, September 18th. Assuming no intervening State holidays, the response is due by 11:59 p.m. on Friday, September 22nd.]:

Time to Respond to RFI:	5 business days
Time to Respond to ROPR I:	5 business days
Time to Respond to ROPR II:	20 business days
Time for Initiating Party to remit fee:	30 calendar days
Time for Opposing Party to remit fee:	30 calendar day

ACRONYMS

AB 72:	Assembly Bill 72 (Bonta 2016)
CPT:	Current Procedural Terminology
DMHC:	California Department of Managed Health Care
EOB:	Explanation of Benefits
HCPCS:	Healthcare Common Procedure Coding System
IDRP:	Independent Dispute Resolution Process
NPI:	National Provider Identifier
PDF:	Portable Document Format
PDR:	Provider Dispute Resolution
RFI:	Request for Information
ROPR I:	Request for Opposing Party Response I
ROPR II:	Request for Opposing Party Response II