Claim Submission

All claims must be submitted within 90 calendar days from the date of service for contracted providers unless otherwise stated in the provider service agreement.

Please submit claims and encounters electronically via Office Ally at www.officeally.com.

- For Claims, use payer ID **PPM01**
- For Encounters, use payer ID **PPM02**

Complete Claim Definition

Complete claims are defined as containing the following information:

- **Complete Member Eligibility**
- **Date of Service**
- **Valid Diagnosis Codes (ICD-9) – submit with highest level of specificity**
- **Valid CPT, HCPCS, Revenue Codes**
- **National Drug Code (NDC) for physician-administered drugs**
- **Billed Amount**
- **Days and Units**
- **Place of Service Code**
- **Anesthesia start and stop time**
- **Itemization of Services**
- **Rendering Facility**
- **Referring Provider Name and NPI**
- **Rendering Provider Name and NPI**
- **Provider Demographic Information (including Tax ID#)**

Acknowledgement of Claims

Providers are responsible for verifying that electronic claim submissions transmit successfully via Office Ally at www.officeally.com. If the claim transmitted successfully via Office Ally, the Status of the claim will display as "Passed". If the claim did not transmit successfully via Office Ally, the Status of the claim will display as "Failed". It is also the provider's responsibility to correct any errors preventing successful transmission. Please allow 2 business days from the date of electronic submission to verify receipt of claim. Providers may verify claim status utilizing our online web portal, "Connect" or may fax the claim status inquiry to (951) 280-8223. Faxed claim status inquiries will be responded to within 5 business days.

Reimbursement of Claims

Complete claims will be processed within 45 business days for contracted HMO managed care claims upon receipt of claim. Claims requiring additional information in order to render claim determination will be contested. The provider will be notified of the additional information necessary to render claim determination. Upon receipt of the additional information, the claim will be processed within 45 business days upon receipt of the necessary information.

In the event a complete claim is not reimbursed within this timeframe, interest will automatically be reimbursed as follows:

Commercial, Healthy Families, Healthy Kids and Medi-Cal:

- Emergency Claims will be reimbursed at the greater amount of $15.00 per annum or 15% interest per annum
- All other claims will include 15% interest per annum

Failure to automatically pay the interest reimbursement for a late claim within 5 days from the payment date of the claim will result in an additional reimbursement of $10.00 to the provider.

Fee Schedule Reimbursement

Please refer to your provider service agreement contract for fee schedule reimbursement rates. A link to the Medi-Cal and Medicare fee schedules is available at www.ppmcinc.com.

Claims Processing Standards

Vantage Medical Group utilizes claims processing standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies and major credentialing organizations.

CPT/HCPCS Modifiers

Vantage Medical Group recognizes both the CPT (Current Procedural Terminology) and Medi-Cal guidelines for modifiers. The addition of a modifier will be reviewed to determine the proper reimbursement for the procedure.

Anesthesia

Anesthesia claims must be submitted with the anesthesia start and stop times. For obstetrical regional anesthesia (CPT code 01967), the anesthesia report certifying "actual time in attendance" with patient must be submitted with the claim. Claims submitted without required documentation will be contested. Only time in attendance may be billed.

Assistant Surgeon Reimbursement

Assistant surgeons are only payable if the surgery warrants an assistant surgeon. Payable services for an assistant surgeon are payable as follows unless otherwise stated in the provider service agreement:

- If the reimbursement is based on Medicare rates, the assistant surgeon will be paid 16% of the primary surgeon's allowable reimbursement
- If the reimbursement is based on Medi-Cal rates, the assistant surgeon will be reimbursed based on the Medi-Cal fee schedule rates listed for Procedure Type "O" for assistant surgeons

Bi-Lateral Procedure Reimbursement

Bi-lateral procedures will be reimbursed at 150% of the procedure reimbursement.

Global Reimbursement and Case Rates

Services that are contracted at a global reimbursement or case rate will be paid according to the service agreement rate. All other services will be denied as inclusive of the global reimbursement or case rate unless otherwise stated in the provider service agreement.

Global Surgery Days

AMA guidelines will be applied to determine the surgical follow-up period for all surgeries. Office and hospital visits related to a surgery and billed during the surgical follow-up period of the surgery, are not separately reimbursable if billed by the surgeon or assistant surgeon. The initial consult is only payable to the surgeon on an emergency basis to determine the need for surgery.

Immunizations and Injectables

Immunizations and injectables must be submitted with the 11 digit NDC (National Drug Code) in conjunction with the customary CPT or HCPCS code. Failure to submit the 11 digit NDC code will result in claim rejection and delay the processing of your claim. Please refer to the following website for complete instructions on how to submit the correct NDC #: http://files.medi-cal.ca.gov/pubsdoco/ndc/articles/ndc_9630.asp. Immunizations and injectables are reimbursable according to the provider service agreement unless covered by the VFC (Vaccines for Children) program for Medi-Cal recipients or by another entity. In the event an administration fee is billed on the same date as an office visit, the administration charge will be considered inclusive of the office visit charge. If an office visit is not billed in conjunction with the administration charge, the administration charge will be allowed separately from the immunization.

Multiple Surgical Procedures Reimbursement

Multiple surgical procedures performed during the same operative session will be reimbursed as follows unless otherwise stated in the provider service agreement:

- The major procedure will be reimbursed at 100% of the allowable amount
- Each subsequent or minor procedure will be reimbursed at 50% of the allowable amount unless the procedure is excluded from the multiple procedure reduction or is inclusive of another procedure performed during the same operative session

Per Diem Rates

Services that are contracted at a per diem rate will be paid at the contracted rate for each day billed. All other services will be denied as inclusive of the per diem rate unless otherwise stated in the provider service agreement.

Unlisted Procedures

For services that do not have a listed reimbursement rate and are considered unlisted procedures, Vantage Medical Group will evaluate reimbursement for each procedure code unless otherwise defined in the provider's service agreement.

Provider Dispute Resolution Process

A provider dispute is a written notice from the contracting provider that:

- Challenges, appeals or requests reconsideration of a claim (including a bundled group of similar multiple claims) that has been denied, adjusted or contested
- Challenges a request for reimbursement for an overpayment of a claim
- Seeks resolution of a billing determination or a contractual dispute

Effective January 1, 2004, provider disputes must be submitted within 365 calendar days from the date of Vantage Medical Group's claim determination. Please mail or fax Provider Dispute Resolution (PDR) forms to the following address:

Vantage Medical Group
2115 Compton Avenue, Dept. 300
Corona, CA 92881
Fax: (951) 280-8206

The Provider Dispute (PDR) form is available at www.ppmcinc.com.

The provider dispute must include provider's name, identification number, contact information, including telephone number, and:

- If the dispute is regarding a claim or a request for reimbursement of an overpayment, a clear identification of the disputed item, the date of service, a clear explanation of the payment amount, and any additional pertinent information
- If the dispute is not about a claim, a clear explanation of the issue
- If the dispute involves a member, the member's name, identification number, and a clear explanation of the disputed item, including the date of service
- If the dispute is regarding a denial for timeliness, written proof of previous billings must be included

Provider disputes must be submitted on the *Provider Dispute Resolution Request Form*. The provider dispute must be submitted using the same number assigned to the original claim. If the provider dispute does not include the required submission elements as discussed above, the dispute will be returned to the provider along with a written statement requesting the missing information necessary to resolve the dispute. The provider must resubmit the dispute along with the missing information within 30 business days from the receipt of the request for additional information.

A provider dispute that is submitted on behalf of a member will be processed through the member dispute appeal process. When a provider submits a dispute on behalf of a member, the provider is assisting the member with his or her member dispute appeal process.

Vantage Medical Group will acknowledge receipt of a provider dispute in writing within 15 business days upon receipt. Providers may also verify receipt of a provider dispute utilizing our online web portal, "Connect" or may fax a status request to (951) 280-8206.

Vantage Medical Group will resolve each provider dispute within 45 business days upon receipt of the provider dispute. A written determination will be mailed to the provider notifying them of the outcome of the provider dispute. Provider disputes that are resolved in the favor of a provider will be reimbursed within 5 calendar days from the date the determination is rendered.