Health Net

Health Net Billing Dispute External Review Board Request Form

The Billing Dispute External Review Board (BDERB) Resolution Process is available after the exhaustion of the internal appeal process * to physicians and physician groups covered by the Physician Settlement who seek resolution of the following matters:
BDERB Appeal Subject Matters:

a) Application of coding and payment rules and methodologies (including without limitation any bundling, down-coding, application of CPT® modifier, and/or other reassignment of a code by Health Net) to patient-specific factual situations, including without limitation the appropriate payment when two or more CPT® codes are billed together, or whether a payment-enhancing modifier is appropriate,

b) Concerns regarding requirements that a physician submit clinical information / records, either prior to or after payment, in connection with an adjudication of the claim for payment, or

c) Concerns regarding retained claims, so long as the retained claims are submitted to the BDERB prior to the later to occur of i. 90 days after the implementation date or ii submits such retained claims. 30 days after exhaustion of the Health Net internal appeal process.

Please note that you must include the appropriate filing fee with this form.

Instructions - Make Sure the Submission Meets the Requirements Set Forth Below

A. Exhaustion of Internal Appeals: You must be able to answer "Yes" to <u>one</u> of the two questions listed below.

(1) Were you notified by Health Net that the internal appeal process was exhausted?

Yes___ No___

OR

(2) Has Health Net failed to communicate a notice of decision within forty-five (45) calendar days from Health Net's receipt of all documentation needed to complete your internal appeal?

Yes___ No___

B. Deadline for Filing: You must be able to answer "Yes" to this question.

Will this request be received within ninety (90) days of Health Nets notification?

Yes___ No___

* You may be deemed by to have satisfied this requirement if Health Net does not communicate notice of a decision within forty-five (45) days from the receipt of all documentation reasonably needed to decide the internal appeal. Physicians and PPG's must submit this request within ninety (90) days of receipt of Health Net's internal appeal notice of decision.

C. Amount in Dispute: The amount in dispute (the additional amount you believe Health Net should have paid) of the single or multiple claims must be more than $500.

(1) Is the amount of the single or multiple claim(s) in dispute more than $500?

Yes___ No___

(2) If you answered "No" to "C (1)", have you previously filed and deferred consideration of similar claims within one (1) year and if so does the filing of this claim result in an aggregate amount of greater than $500?

Yes___ No___

(3) If you answered "No" to "C (2)" would you like this request to be deferred?

Yes___ No___

D. **Have you included your filing fee and supporting documentation?** All supporting documentation must be attached to this form. Examples include Explanation of Payment(s), the final appeal denial letter and additional clinical information. The Billing Dispute Administrator may request additional documentation from you. Any such additional documentation must be submitted within 30 calendar days of the Billing Dispute Administrator's request.

SEND THIS COMPLETED FORM, ALL SUPPORTING DOCUMENTATION AND THE FILING FEE TO:

Independent Medical Expert Consulting Services, Inc. (IMEDECS)
157 S. Broad Street
Suite 400
Lansdale, PA 19446
Phone: 215.855-4633
Fax: 215.855.5318

PHYSICIAN INFORMATION

Treating Physician Name (as submitted on claim) **Tax Identification Number** (as submitted on claim)

Billing Address (Street, City, State, ZIP)

Telephone Number **Fax Number**

Contact Name **Contact Phone Number** **Contact E-mail**

CLAIM INFORMATION

Member Name **Member ID Number** **Member Group Number**

Member Address (Street, City, State, ZIP)

Health Net

REQUEST FOR PHYSICIAN BILLING DISPUTE

Date of Service

Case Number (indicated on Health Net's resolution letter)

Amount in Dispute

The additional amount that you believe Health Net should have paid on the claim(s) in dispute:

$_____

Filing Fee: (Please check one)

___ $25.00 - Claim amount between $500.00 - $1,000.00
___ $25.00 +5% of amount of dispute which exceeds $1000.00[1]
___ No amount is enclosed because this claim is an aggregate of a deferred claim.

Amount Enclosed:
Make check payable to **IMEDECS**

The decision of Hayes Plus, Inc. is **final and binding** on the parties only with respect to the specific case being reviewed by Hayes Plus, Inc. Providers may refer to Health Net's physician website (www.healthnet.com) or Hayes Plus, Inc. (www.imedecs.com) for further information.

Comments

I hereby agree to the terms of the Billing Dispute External Review Board and further certify the accuracy and completeness of the material and information submitted with the request:

Signature of the Physician:_____ Date:_____

[1] In no event will the fee be greater than 50% of the cost of the review.

Health Net

Request for Dispute of Medical Records Submission

Health Net does not routinely require submission of clinical information before or after payment of claims, except: (i) as to certain categories of claims, set forth on Health Net, Inc's website at www..healthnet.com; and (ii) for the purpose of investigating fraudulent, abusive, or other inappropriate billing, provided that Health Net has a reasonable basis for believing that such an investigation is warranted.

If you believe Health Net request for clinical information was inappropriate (whether the request was made before or after the claim was processed), you may contest the request by completing this form. An external, independent Clinical Information Officer will then review Health Net request for clinical information and render a determination according to the terms of the Settlement Agreement Among Health Net and Physicians. This process does not apply to requests for clinical information for pre-certification purposes.

"Clinical information" means clinical, operative, or other medical records; other records kept in the ordinary course of a physician's practice; and requested statements of medical necessity.

Each "" request must include the following:

1. Completion of "Request for Dispute of Medical Records" form below;
2. A copy of the documentation you received (typically an Explanation of Payment or a letter) indicating that clinical information was required by Health Net, Inc;
3. A check in the amount of $25.00 made payable to:

Independent Medical Expert Consulting Services, Inc. (IMEDECS).

157 S. Broad Street
Suite 400
Lansdale, PA 19446
Phone: 215.855.0615
Fax: 215.855.5318

Please note: The authority of the Clinical Information Officer in this dispute process does not extend to issues of payment.

Treating Physician Name (as submitted on claim) :

Tax Identification Number (as submitted on claim) :

Billing Address (Street, City, State, ZIP) :

Telephone Number :
Office ( ) ext.

Fax Number :
Office ( )

Contact Name :

Contact Phone Number :

Patient ID	Date of Service (Must be from May 10, 2005 to present)	CPT ® Code Disputed	Associated Diagnosis Code	Explanation of Payments Claim Denial Code (if any)

Please describe why you believe the request for clinical information should be denied:

Submitted by (Printed Name) _____ Signature Date _

Title _____

PLEASE ENSURE THAT YOU ATTACH RELEVANT DOCUMENTATION, INCLUDING THE DOCUMENTATION YOU RECEIVED INDICATING THAT CLINICAL INFORMATION WAS REQUIRED BY HEALTH NET, Inc.

Revised 051706