Quarterly Claims Settlement Practices Report

Step 1	Step 2	Step 3	Step 4

Health Plan

Created By

Period

Status

Date Created

Principal Officer

Name

Phone

Email

Identify and complete Step 1 of this report if the Plan has failed to timely reimburse at least 95% (including the activity of all of its claims processing organizations) of complete claims with the correct payment including interest and penalties due and owing, that became due and payable in the reporting period. (FN2)
(Note: If you do not have any information to report, please go to Disclosure of Emerging Claims Payment Deficiencies.)

	Month Ending October, 2005	Month Ending November, 2005	Month Ending December, 2005
Total number of Commercial and Healthy Families (HMO) claims paid, denied, adjusted or contested during the reporting period (FN3)			
Total number of Commercial and Health Families (HMO) claims paid, denied, adjusted or contested within 45 working days			
Total Number of PPO/POS/Specialized claims paid, denied, adjusted or contested during the reporting period			
Total number of PPO/POS/Specialized claims paid, denied, adjusted or contested within 30 working days			
Total number of Medi-Cal claims paid, denied, adjusted or contested during the reporting period			
Total number of Medi-Cal claims paid, denied, adjusted or contested within 30 calendar days			
Total number of Medi-Cal claims paid, denied, adjusted or contested within 45 working days			
Total number of claims that were PAID or ADJUSTED during the reporting period	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of claims PAID or ADJUSTED within 45 working days (Commercial, Healthy Families and Medi-	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006

Cal) and/or 30 working days (PPO, POS and Specialized) during the reporting period			
Total number of claims PAID or ADJUSTED beyond 45 working days (Commercial, Healthy Families and Medi-Cal) and/or 30 working days (PPO, POS and Specialized) that included the payment of applicable interest and/or penalty during the reporting period	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of emergency service claims (FN4) paid, denied, adjusted or contested during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of those emergency service claims PAID or ADJUSTED within 45 working days (Commercial, Healthy Families and Medi-Cal) or 30 working days (PPO, POS, Specialized and Medi-Cal) during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of claims received during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006

Disclosure of Emerging Claims Payment Deficiencies

Please identify any of the following deficiencies that were identified relating to Plan activity (including the activity of all of its claims processing organizations) if the Plan failed to meet any of the standards during the reporting period. **(Note: If you do not have any information to report, please go directly to Step 2.)**

Please check all that apply.

☐ Failed to forward at least 95% of misdirected claims consistent with sections 1300.71 (b) (2) (A) and (B) during the reporting period.

☐ Failed to accept a late claim consistent with sections 1300.71 (b) (4) at least 95% of the time during the reporting period.

☐ Failed to provide an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section 1300.71 (d) (1) at least 95% of the time for the affected claims during the reporting period.

☐ Failed to contest or deny a claim, or portion thereof, within the timeframes of section 1300.71 (h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims during the reporting period.

☐ Failed to provide the required Notice to Provider of Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b) at least 95% of the time for the affected claims during the reporting period.

☐ Requested reimbursement of an overpayment of a claim inconsistent with the provisions of 1300.71 (b) (5) and (d) (3), (4), (5) and (6) more than 5% of the time for affected claims during the reporting period.

☐ Rescinded or modified an authorization for health care services, consistent with section 1300.71(a)(8)(T), on three (3) or more occasions during the reporting period.

☐ Imposed a deadline for the receipt of claims that was less than 90 days after the date of service for contracted providers consistent with section 1300.71(b)(1).

☐ Imposed a deadline for the receipt of claims that was less than 180 days after the date of service for non-contracted providers consistent with section 1300.71(b)(1).

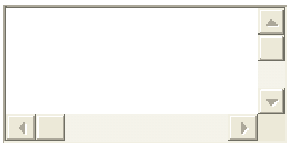
☐ Failed to establish that the requests for medical records were required to determine payor liability consistent with section 1300.71(a)(8)(H) over any 12-month period.

☐ Failed to establish that the requests for medical records were required to determine payor liability for

emergency room services consistent with section 1300.71(a)(8)(I) over any 12-month period.

Deleted: ¶

Indicate below any corrective action the plan has instituted.



Save

(FN1) The compliance determination shall be made by averaging the organization's claims payment timeliness over the entire reporting period. If an organization is deficient in an individual month but compliant for the overall reporting period, the plan does not need to report that organization.

(FN2) The compliance determination shall be made by averaging the plan's claims payment timeliness over the entire reporting period. If a plan is deficient in an individual month but compliant for the overall reporting period, the plan does not need to report.

(FN3) For reporting purposes, an adjusted claim is a claim that the payor reimburses at a different rate than the provider's billed charges. Post-payment adjustments, which result from the reconsideration of the original claim payment after the claimant's inquiry or submission of a dispute are not included here, but should be included in the Annual Dispute Resolution Mechanism Report.

(FN4) For purposes of this report, emergency service claims are defined as "Services with a 'Place of Service Code' of ER (emergency room) on the CMS 1500 or the UB92 claim form".

AAA TEST RBO

Return to Step 2 Organization Listing

	Month Ending 10/31/05	Month Ending 11/30/05	Month Ending 12/31/05

Total number of Commercial and Healthy Families (HMO) claims paid, denied, adjusted or contested during the reporting period (FN3)			
Total number of Commercial and Health Families (HMO) claims paid, denied, adjusted or contested within 45 working days			
Total Number of PPO/POS/Specialized claims paid, denied, adjusted or contested during the reporting period			
Total number of PPO/POS/Specialized claims paid, denied, adjusted or contested within 30 working days			
Total number of Medi-Cal claims paid, denied, adjusted or contested during the reporting period			
Total number of Medi-Cal claims paid, denied, adjusted or contested within 30 calendar days or less			
Total number of Medi-Cal claims paid, denied, adjusted or contested within 45 working days			
Total number of claims that were PAID or ADJUSTED during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of those claims PAID or ADJUSTED within 45 working days (Commercial, Healthy Families, and Medi-Cal) or 30 working days (PPO, POS and Specialized) that included the payment of applicable interest and/or penalty during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of those claims PAID or ADJUSTED beyond 45 working days (Commercial, Healthy Families, and Medi-Cal) or 30 working days (PPO, POS and Specialized) during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of emergency service (FN4) claims paid, denied, adjusted or contested during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of those emergency service claims PAID or ADJUSTED within 45 working days (Commercial, Healthy Families and Medi-Cal) or 30 working days (PPO, POS, and Specialized) during the reporting period.	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006
Total number of claims received during the reporting period	Required as of Q4 2006	Required as of Q4 2006	Required as of Q4 2006

Indicate below any corrective action the plan has instituted.

- ☐ Bi-weekly reporting
- ☐ Breach notice
- ☐ Contracted with additional payors
- ☐ Plan monitor placed
- ☐ Plan performed more frequent monitoring
- ☐ Plan terminated contract

- [ ] Corrective action plan requested
- [ ] Provider notice to terminate contract
- [ ] De-delegated claims processing
- [ ] Required additional staffing
- [ ] Enrollment freeze
- [ ] Required additional training
- [ ] No action taken
- [ ] Weekly reporting
- [ ] Other (Specify)

If "Other" is indicated as a corrective action above please specify the details in the text box below.

Save

(FN1) The compliance determination shall be made by averaging the organization's claims payment timeliness over the entire reporting period. If an organization is deficient in an individual month but compliant for the overall reporting period, the plan does not need to report that organization.

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AAA TEST RBO

Return to Step 3 Organization Listing

Disclosure of Emerging Claims Payment Deficiencies

Please check all that apply.

- [ ] Failed to forward at least 95% of misdirected claims consistent with sections 1300.71 (b) (2) (A) and (B) during the reporting period.

☐ Failed to accept a late claim consistent with sections 1300.71 (b) (4) at least 95% of the time during the reporting period.

☐ Failed to provide an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section 1300.71 (d) (1) at least 95% of the time for the affected claims during the reporting period.

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Indicate below any corrective action the plan has instituted.

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☐ Breach notice
☐ Contracted with additional payors
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☐ De-delegated claims processing
☐ Enrollment freeze
☐ No action taken
☐ Other (Specify)
☐ Plan monitor placed
☐ Plan performed more frequent monitoring
☐ Plan terminated contract
☐ Provider notice to terminate contract
☐ Required additional staffing
☐ Required additional training
☐ Weekly reporting

If "Other" is indicated as a corrective action above please specify the details in the text box below.

Save