This information is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim practices and provider disputes for commercial HMO, POS, and PPO products where Anthem Blue Cross is delegated to perform claims payment and provider dispute resolution processes.

**Balance Billing Prohibition**

Except for applicable co-payments and deductibles, a physician shall not invoice or balance bill an Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company member for the difference between a physician’s billed charges and the reimbursement paid by Anthem Blue Cross for any covered benefit.

**Overpayment of Claims**

If Anthem Blue Cross determines that it has overpaid a claim; it will notify a physician in writing. If a physician contests Anthem Blue Cross notice of overpayment of the claim, the physician must notify Anthem Blue Cross within 30 working days of receipt of this notice of overpayment of the claim to explain the basis on which the physician believes the claim was not overpaid, and Anthem Blue Cross shall process such a contested notice of overpayment as a provider dispute, pursuant to the Claims and Dispute Regulations. If the physician does not contest Anthem Blue Cross notice of overpayment of the claim, the physician shall reimburse Anthem Blue Cross within 30 working days of receipt by the physician of Anthem Blue Cross notice. If the physician does not so reimburse Anthem Blue Cross, pursuant to the Prudent Buyer Plan Participating Physician Agreement, the physician authorizes Anthem Blue Cross to offset an uncontested notice of overpayment of a claim from the physician's current claim submission.

**Fee Schedule and Other Required Information Disclosure**

The disclosures required by the Claims and Dispute Regulations, including the fee schedule, detailed payment policies and rules, and nonstandard coding methodologies used by Anthem Blue Cross to adjudicate claims, shall be made available to physicians through Anthem Blue Cross ProviderAccess® Web site [https://provider2.anthem.com/wps/portal/ebpmybcc](https://provider2.anthem.com/wps/portal/ebpmybcc)

**Provider Dispute Mechanism**

**Contracted Provider Dispute**

A contracted provider dispute is a contracted provider’s or the plan’s capitated provider written notice to the plan, challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted, or contested; or seeking resolution of a billing determination, other contract dispute (or a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered), or disputing a request for reimbursement of an overpayment of a claim that contains, at a minimum, the following information:

- The provider’s name;
- The provider’s identification number;
- Contact information; and:
  - If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item; the date of service; and a clear explanation of the basis on which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment, or other action is incorrect;
  - If the dispute is not about a claim, a clear explanation of the issue and the provider’s position thereon; and
  - If the dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, and a clear explanation of the disputed item, including the date of service and the provider’s position thereon.
**Noncontracted Provider Dispute**

A noncontracted provider dispute is a noncontracted provider’s **written notice** to the plan, challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted, or contested; or disputing a request for reimbursement of an overpayment of a claim that contains, at a minimum, the following information:

- The provider’s name;
- The provider’s identification number;
- Contact information; and:
  - If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the date of service; and a clear explanation of the basis on which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement of an overpayment of a claim, or other action is incorrect;
  - If the dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees; and a clear explanation of the disputed item, including the date of service and the provider’s position thereon.

When contesting, adjusting, or denying a claim, Anthem Blue Cross, or its contracted PMG/IPA, must notify the provider of his or her right to file a formal dispute. To file a formal dispute, please send your request to:

**Anthem Blue Cross**
**P.O. Box 60007**
**Los Angeles, CA 90060-0007**

For your convenience, Anthem Blue Cross has developed the **Provider Dispute Resolution Request** form to expedite your request. This form is posted under the “Provider Forms” section on the ProviderAccess web site.

Once Anthem Blue Cross has received a provider dispute Anthem Blue Cross will send an acknowledgement letter to the provider. Upon completion of the review, Anthem Blue Cross will send a written notice to the provider notifying the provider of Anthem Blue Cross’ determination.

**Deadline for Submission**

The deadline for a provider dispute submission cannot be less than 365 days from the last date of action on the issue.

**Revision of Claim Follow-Up Form**

While the **Provider Dispute Resolution Request** form is the mechanism for filing a formal written dispute, the **Claim Follow-Up** form is the vehicle for submitting routine additional information, as requested by Anthem Blue Cross. The **Claim Follow-Up** form assists in properly identifying and routing documents for prompt claim adjudication. The **Claim Follow-Up** form has been revised and those items with dispute implications have been removed. The revised form is posted on the ProviderAccess Web site.

**Enhancements to the Electronic Overpayment and Recovery Process**

Anthem Blue Cross is currently revising the electronic notice of overpayment and recovery process. We have collaborated with our provider partners to develop a process that improves the provider’s ability to reconcile. The notice of overpayment will be sent to the provider in a separate paper communication; then, the provider has 30 working days to either dispute the overpayment in writing or provide reimbursement. If the provider fails to respond within this time frame and has authorized Anthem Blue Cross to offset overpayments, the amount will be electronically debited.
Anthem Blue Cross Billing Dispute External Review Process

As of May 4, 2006, the Billing Dispute External Review Process is available to physicians who are class members of the Shane-Thomas Managed Care Settlement Agreement (“the Settlement Agreement”) and physician groups comprised of such physicians. The process is intended to resolve:

1) Disputes over the application of Anthem Blue Cross’s coding, payment rules and methodologies for fee-for-service claims to patient specific factual situations.

2) Disputes relating to whether Anthem Blue Cross has complied with the provisions of the Settlement Agreement, requiring a physician to submit records in connection with a claim for payment (either prior to or after payment).

Please note that physicians and physicians’ groups must exhaust Anthem Blue Cross’s internal appeal/review process for billing disputes before submitting a dispute to the Billing Dispute External Review Board (BDERB). This requirement will be deemed to have been satisfied if Anthem Blue Cross has responded to your appeal, and their response indicates internal review has been exhausted or if there is no notice of Anthem Blue Cross decision within 30 calendar days after you have supplied all documentation reasonably needed to complete the internal appeal/review. Physicians and physicians’ groups must submit their Billing Dispute request directly to the BDERB. It must be post-marked no later than 90 calendar days after exhausting Anthem Blue Cross’s internal appeals/review process.

In order to initiate the external Billing Dispute External Review Process, certain criteria must be met, and a fee is required. The requirements are:

- Disputes may be submitted only by a physician who is a member of the Shane-Thomas settlement class or a physician group comprised of such physicians.
- Anthem Blue Cross’s internal appeals/review process must be exhausted.
- The amount in dispute (for either a single claim for covered services or multiple claims involving similar issues) must be greater than $500*.
- The dispute must be filed in writing within 90 calendar days after the exhaustion of Anthem Blue Cross’s Internal Appeals/review Process.
- The physician or physician group must submit the proper filing fee as shown below.

*A physician or physician group may submit a dispute with a disputed amount less than $500 to the BDERB if the physician or group intends to submit additional disputes involving similar issues within one year such that the aggregate amount in dispute will exceed $500. The BDERB will defer consideration of the dispute until and unless such additional disputes are submitted.

Filing fees are as follows:
- If the amount in dispute is less than or equal to $1,000, the fee is $50.
- If the amount in dispute is more than $1,000, the fee is $50 plus 5% of the amount by which the amount exceeds $1,000, but in no event more than 50% of the cost of the review.

If the Physician prevails, the filing fee will be refunded.

**Instructions:**

Please be sure that your submission meets the requirements set forth below. You must be able to answer “Yes” to these questions. (Note, if this is a dispute regarding a “Records Requirement”, please download and complete a copy of the “Request for Dispute of Records Requirement” at www.hmosettlements.com)

A. Are you a class member of the Shane-Thomas Managed Care Settlement Agreement?
B. Date of Service - Is the date of service after July 11, 2005?

C. Exhaustion of the Plan’s Internal Appeals/review.
   
   1. Have you filed an internal appeal with Anthem Blue Cross and been notified of the outcome?
      
      OR

   2. Have you filed an internal appeal about which Anthem Blue Cross has failed to communicate a notice of its decision within 30 calendar days after receiving all documentation reasonably needed to complete the appeal/review?

D. Amount in Dispute - The amount in dispute (the additional amount you believe Anthem Blue Cross should have paid) for the single or multiple claims must be more than $500.

   1. Is the disputed amount of the single or multiple claim(s) submitted at this time more than $500?
      
      Or

      Have you previously filed and deferred consideration of billing disputes involving similar issues within one (1) year, and if so, does the filing of this claim result in an aggregate disputed amount greater than $500?

      Or

      If this request is less than $500, but you would like this request to be deferred so that you may submit additional billing disputes later? (Note: The filing fee is payable with your first submission.)

You must submit Anthem Blue Cross’s final appeal letter with your dispute. You must also attach to the Billing Dispute External Review Form and all supporting documentation that you would like to be considered by the Billing Dispute External Review Board. Examples of supporting documentation include Remittance Advice(s) and clinical information.

The Billing Dispute External Review Board may request additional documentation from you. Any such additional documentation must be submitted within 30 calendar days of the request.
Anthem Blue Cross Billing Dispute External Review Form

Please send this completed form, and the filing fee to the Billing Dispute External Review Board, IMEDECS (formerly known as HAYES Plus, Inc.). Attach the final appeal denial letter and supporting documentation: Explanation of Benefits (EOB) and additional clinical information, etc.

IMEDECS
157 S. Broad Street
Lansdale, PA 19446
Phone: (215) 855-4633 Fax: (215) 855-5318

Physician Information:

<table>
<thead>
<tr>
<th>Treating Physician Name (as submitted on claim):</th>
<th>National Provider Identifier (NPI) (as submitted on claim):</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Telephone Number:</th>
<th>Fax Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office (      ) ext.</td>
<td>Office (     )</td>
</tr>
</tbody>
</table>

Contact Name: Contact Phone Number: Contact E-Mail:

If Codes/Modifiers are Disputed:
A specific code set must be identified; a minimum of two codes must be entered below.

Note: To see examples of the types of disputes eligible for review, please refer to the attached Example Billing Dispute Category List.

<table>
<thead>
<tr>
<th>CPT® Code (Primary)</th>
<th>CPT Code® (secondary)</th>
<th>(and/or) Modifier</th>
</tr>
</thead>
</table>

Claim Information:
If your billing dispute contains multiple claims for the same code set, please attach a separate sheet noting the physician’s name, member’s name, member’s ID, date of service, and claim number.

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>Member ID Number:</th>
<th>Member Group Number (Optional)</th>
</tr>
</thead>
</table>

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

Request for Physician Billing Dispute External Review:

<table>
<thead>
<tr>
<th>Date of Service:</th>
<th>Claim Number(Indicated on Explanation of Payment):</th>
</tr>
</thead>
</table>

Amount in dispute (the additional amount you believe you are entitled to receive in this dispute):

$ Filing fee: (Please check one.)

____$50.00 Disputed amount greater than $500 and less than or equal to $1000.00

____$50.00 + 5% of amount of dispute which exceeds $1000.00. The fee may not exceed 50% of the cost of the review.

No amount is enclosed because this claim is an aggregate of a deferred claim for which a filing fee has previously been paid.
Amount enclosed: 
Please Make check payable to IMEDECS.

The decision of IMEDECS is final and binding on Anthem Blue Cross and the physician or physician group only with respect to the specific case under review by IMEDECS. Physicians may access the Anthem Blue Cross website (https://provider2.anthem.com/wps/portal/ebpmybcc) or the IMEDECS website (www.IMEDECS.com) for further information.

Comments:

I hereby acknowledge the terms of the Billing Dispute External Review Process, further certify that I am a member of the class, and further certify the accuracy of the material and information submitted with the request.

Signature of Physician:  
Date:
DISPUTE CATEGORY EXAMPLE LIST

The following list contains examples of the types of billing disputes that are eligible for submission to the Billing Dispute External Review Process. It is not an exhaustive list of every eligible dispute, but is provided to assist you in submitting eligible disputes for External Review. Disputes that are not eligible for this process may still be referred to Anthem Blue Cross’s resolution through the internal appeal process. For example, disputes about the reimbursement rates set by Anthem Blue Cross through its fee schedules or about allowable fee determinations for out of network physicians may be referred to Anthem Blue Cross.

IMEDECS will determine whether your dispute is eligible for review. To assist IMEDECS with the determination, please indicate the type of issue that you are raising.

Examples of Billing Disputes eligible for review if all requirements indicated above are satisfied include:

___ Assistant Surgeons (includes modifier 82) – Eligible/Non Eligible
___ Consultation on X-ray Examination, Written Report (CPT® code 76140)
___ Modifier 22 – Unusual Procedural Services
___ Modifier 23 – Unusual Anesthesia
___ Modifier 24 – Unrelated Evaluation & Management Service by the Same Physician during a Postoperative Period
___ Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
___ Modifier 51 – Multiple Procedures
___ Modifier 59 – Distinct Procedural Service
___ Modifier 62 – Two Surgeons
___ Modifier 66 – Surgical Team
___ Therapies – Modalities per Date of Service
___ Reduction of the intensity of an E&M code(s).
___ Reduction of the intensity of a service (other than an E&M code)
___ Other “bundling” edits
Frequently Asked Questions:

Q: When I file a dispute, how quickly will I have a resolution?
A: Once the Billing Dispute External Review Board (BDERB) receives your billing dispute, it will evaluate your submission to determine if you have met the requirements. The BDERB will then request verification and documentation from Anthem Blue Cross. Anthem Blue Cross has 30 days to submit documentation to the BDERB. After the BDERB receives all necessary documentation, the BDERB has 30 days to review the billing dispute.

Q: If my billing dispute is decided in my favor, what is the resolution time for Anthem Blue Cross to process the claim for reimbursement?
A: If the billing dispute is decided in the physician's favor, the plan will reprocess the claim and send payment to you within 15 days after receipt of notification of the BDERB'S decision.

Q: What is a retained claim?
A: Retained claims are claims that were “in process” as of July 11, 2005. Specifically, a retained claim can be:
   • a claim that had been filed with Anthem Blue Cross, but had not been finally adjudicated as of July 11, 2005; or
   • a claim that has not yet been filed with Anthem Blue Cross, but for which the contractual period allowed for filing has not expired.
A claim is considered finally adjudicated when Anthem Blue Cross's internal appeals/review process has been completed.

Q: Can I submit a dispute about a retained claim to the BDERB?
A: Billing disputes about retained claims can be submitted to the BDERB provided they are submitted before the later of: (1) May 4, 2006; or (2) 90 days after you exhaust Anthem Blue Cross's internal appeals process.

Q: What do I do if I want to challenge a request for records?
A: If the dispute relates to Anthem Blue Cross's requirement that records be submitted (either prior to or after payment), the physician or physician group may elect not to utilize Anthem Blue Cross's internal appeals process and request that the BDERB grant an expedited review, but must demonstrate that Anthem Blue Cross's requirement has a “significant adverse economic effect” on the physician. If the BDERB determines that this has not been demonstrated, it will dismiss the claim pending exhaustion of Anthem Blue Cross's internal appeals process. A copy of the “Request for Dispute of Records Requirement” can be downloaded at www.hmosettlements.com.

Q: Are there further appeal rights after the BDERB decision? Is the decision binding?
A: The decision made by the BDERB is final and is binding on both Anthem Blue Cross and the physician or physician group.

Q: What if I have multiple claims for the same situation?
A: A physician or physician group with multiple claims for similar situations may submit those disputes to the BDERB together, so long as the total of disputes add up to more than $500. Note: The filing fee is payable with your first submission.

Q: What if I have disputed amounts of $500 or less?

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A: If physician’s billing dispute amounts are $500 or less, additional, similar billing disputes may be submitted within one year of the original billing dispute submission date to accumulate an amount in excess of $500. **Note:** The filing fee is payable with your first submission.

Q: **Do I have to pay the filing fee?**
A: Yes, the filing fee is required.

Q: **Where do I send my payment for the filing fee?**
A: The filing fee must be submitted to the BDERB at the same time the billing dispute is submitted.

Q: **How will I know that I have exhausted the Internal Appeals/Review Process?**
A: Please refer to the internal appeals/review policies and procedures on the Anthem Blue Cross website to be sure that the proper procedures have been followed. If you have followed the proper procedures and received Anthem Blue Cross’s decision, the related notification will state that the internal appeal/review process is exhausted. Also, if you have followed the proper procedures but Anthem Blue Cross has failed to notify you of its decision within 30 calendar days after receiving all documentation reasonably needed to complete the internal appeal/review, the internal appeal/review process is deemed to be exhausted.

Q: **Who may submit disputes to the BDERB**
A: Physicians who have participated as class members of the Shane-Thomas Managed Care Settlement Agreement and physician groups comprised of such physicians. If you are uncertain whether you are part of the Settlement Class, please contact Anthem Blue Cross’s provider services at 1-800-677-6669.

Q: **Who should I contact to check the status of my billing dispute submitted to the BDERB?**
A: Please contact the BDERB, IMEDECS at 215-855-4633.

Q: **Can I fax my request to the BDERB? If so, what is the fax number?**
A: Yes, physicians may fax the billing dispute to IMEDECS at 215-855-5318.