Provider Notice – Commercial Patient Services

The services that you gave to our HMO Commercial member and the payment adjudication for those services qualify under the auspices of AB 1455 and the rules at 28 CAC, Division 1, Chapter 2, Article 8.

In compliance with the above cited references, PCA is required to advise you of the claim dispute option available to providers.

- Providers have 180-days from the date of service(s) in which to file a claim and 365-days from the date PCA issued payment in which to file a dispute.
- Upon receipt of a provider dispute, PCA's Principle Provider Dispute Officer shall, within 15-working days, determine whether the provider's statement of dispute is complete, clear, and contains those elements which serve to qualify the dispute under the requirements at 28 CAC.
    - A written dispute must meet the criteria stated at 28 CAC. PCA will review the dispute and respond in writing to the provider stating the review findings.
- A provider dispute which qualifies under the requirements at 28 CAC shall be fully resolved within forty-five (45) working days from the date the dispute was received.
    - If additional information is needed from the provider, a finding on the stated issue being disputed shall be finalized forty-five working days from the date the additional information is received by PCA.

Providers are advised that the dispute must be in writing. PCA is not allowed to assume or add information not supplied by the provider through the dispute processes.

Disputes are to be mailed to: Principle Provider Dispute Officer
Primary Care Associates Medical Group, Inc.
450 S Melrose Ave., Suite 220
Vista, CA 92081-6664

The Department of Managed Health Care regulatory requirements may be found at www.ca.gov.

PCA's usual and customary fee schedule used to adjudicate non-contracted provider claim(s) is based on research which incorporates historical geographic provider performance criteria. Additional information about PCA may be found at www.pcamg.com.

As provided in the Knox-Keene Act of 1985, HMO members are protected against receiving provider billings. This includes the billing of a surcharge where a payment determination has been made in accordance with applicable statutory and regulatory requirements.

Note: The statutory provisions of AB 1455 are not applicable to services given to Senior (Medicare eligible HMO) members.