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Perlman Medical Group

Provider Dispute Resolution Process

Definitions

CMS Provider Dispute Resolution (PDR) – A written dispute submitted to Perlman Medical Group by a non-contracted provider contending that the amount paid for a covered service is less than the amount that would have been paid under Original Medicare.

Appeal – A formal grievance process whereby a member or provider exercises their right to contest and request a reversal of an authorization or claim decision to deny or partially deny a benefit or service. All disputes from a non-contracted provider, except in the case of fee schedule disputes, are classified as an appeal.

All appeals and second level PDRs must be submitted to the Member's Health Plan directly.

PDR Submission

Non-Contracted Providers must submit all first level disputes in writing to Perlman Medical Group within one hundred and twenty (120) days from the date of the initial payment determination. Five additional days may be allowed for mail delivery. Non-Contracted Providers should either fax their first-level Payment Dispute Requests to (866) 680-3587 or mail them to:

Perlman Medical Group

Attn: Provider Dispute Department

3900 5th Avenue, Suite 200

San Diego, CA 92103

PDR Process

Perlman Medical Group may accept a PDR request filed after one hundred and twenty days if the non-contracted provider of service submits a written request for an extension of the timeframe for good cause.

Written disputes submitted to Perlman Medical Group must include the following:

1. The claim number and the member's identification number.
2. Specific service(s) and/or items(s) for which reconsideration is being requested, including date(s) of service.

3. The Provider's contact information, including name, NPI, phone number, fax number, email address, and mailing address.
4. A clear explanation of why the party disagrees with Perlman Medical Group's initial determination and should include any supporting documentation the appealing party wants to be considered with the dispute.

If a PDR is filed without the appropriate supporting documentation or enough information to make a determination on the PDR, Perlman Medical Group may send a request for additional information to the Provider of Service. If the Provider of service fails to provide the requested information within fourteen (14) days of the request, Perlman Medical Group shall make a determination with the information available.

Perlman Medical Group shall send written notice of the resolution, including pertinent facts and an explanation of the reason of the determination, within thirty (30) days of the receipt of the PDR. If the written determination results in payment, payment will be mailed concurrently with the written determination. Interest will be paid on the additional amount of the payment due, from the date of the original claim, until the date the claim was reprocessed. Interest would be calculated in the same manner as interest on all claims, which is outlined in Section 80 of the Medicare Claims Processing Manual.

Second-Level PDR

The Non-Contracted Provider may submit a second level written appeal request to the applicable Health Plan by email, fax, or mail within 180 calendar days of written notice from Perlman Medical Group of its payment review determination, if any of the following are true:

- After Perlman Medical Group makes its payment review determination, a non-contracted provider still disagrees with the pricing decision, or
- Thirty (30) calendar days have elapsed from the date Perlman Medical Group has received the payment dispute, and Perlman Medical Group has not responded.