4.26 Provider Problem Resolution Process

I. PURPOSE

To describe provider informal problem resolution process and formal appeal process

II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will implement problem resolution and appeal processes that enable each provider to resolve problems or concerns about any issue related to SLOBHD's performance of its duties, including payment authorization. SLOBHD will not subject a provider to discrimination or any other penalty for using the provider problem resolution and appeal processes.

SLOBHD will give providers written information about the problem resolution and appeal processes at the time a contract is established and again if SLOBHD makes an adverse authorization decision.

III. REFERENCE

- California Code of Regulations, Title, 9, §§ 1850.305 - 1850.320, 1850.350
- Code of Federal Regulations, Title 9, §§ 438.400 – 438.424
- Department of Health Care Services (DHCS) – Mental Health Plan (MHP) Contract, Exhibit A, Attachment I, section 15
- SLOBHD Policy 3.30, Notices of Action
- SLOBHD Policy 4.07, Beneficiary Grievances, Appeals and Expedited Appeals
- SLOBHD Policy 10.21 Contracting and Monitoring of Services
- SLOBHD Policy 10.14, Monitoring and Authorizing Network Provider Services
- SLOBHD Network Provider Handbook

IV. PROCEDURE

A. Provider Problem Resolution Process (informal)

1. Network Providers will contact Managed Care staff during regular business hours to discuss concerns.

2. Other Contracted Providers will contact the SLOBHD Fiscal contract manager during regular business hours to discuss concerns.

3. Every effort will be made to resolve the issue at this level.

4. The Provider Appeal Process may be initiated by the provider at any time before, during, or after the Informal Provider Problem Resolution process.

B. Provider Appeals Process (formal)

1. SLOBHD will provide an appeals process for Network Providers and Contract Providers to use only when the appeals issue involves a payment or authorization denial or modification.

2. SLOBHD will notify the provider in writing when a decision is made to modify, reduce, deny or terminate an authorization before or after the service was provided (this may be a Notice of Adverse Benefit Determination NOABD or other written response to the provider from SLOBHD).

3. The provider will submit a written appeal to the Managed Care Program Supervisor (Network Providers) or to the Fiscal contract manager (other providers) within 90 calendar days of the receipt of non-approval of payment. This appeal is often called a "first level appeal".

4. A copy of the appeal will be forwarded to the Patient's Rights Advocate for logging and tracking purposes.

5. When the appeal concerns the denial or modification of a payment authorization request, SLOBHD will utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.

   a) QST staff will review appeals from Network Provider staff.
   b) Managed Care staff will review appeals for other contract provider staff.

6. Within 60 calendar days from the receipt of the appeal, SLOBHD will:

   a) Inform the provider in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider.
   b) Inform the provider of any action required by the provider to implement the decision.
   c) If the appeal is not granted in full the provider will be notified of any right to submit an appeal to DHCS.

7. If a provider chooses to appeal further, the provider will submit an appeal to the DHCS, in writing, within 30 calendar days of receipt of SLOBHD's appeal letter. This appeal is often called a "second level appeal".

8. DHCS will request documentation from SLOBHD, and will render a decision within 60 calendar days of receipt of documentation.

C. Client Record Review Findings Appeal Process

1. When the appeal is related to disallowances of paid claims resulting from client record review findings, the provider may request an informal appeal by DHCS.
    a) The appeal must be filed, in writing, within 60 calendar days of the denial.
    b) The appeal must include written documentation supporting the rationale for the informal appeal for each disallowance in dispute.

2. The provider may request a formal appeal if DHCS does not resolve the matter in the provider's favor.

V. DEFINITIONS

1. Action:

a) A determination that medical necessity criteria have not been met and the beneficiary is not entitled to any Specialty Mental Health Service (SMHS)
b) A denial, modification or reduction of a provider's request for authorization prior to the delivery of the service
c) A denial, modification, reduction or termination of a provider's request for payment authorization after the service after the service was provided
d) A failure to act within the timeframes for resolution of grievances, appeals, or expedited appeals
e) A failure to provide a specialty mental health service within the timeframe established by the MHP.

2. Appeal:

a) A request by a beneficiary or representative for review of an Action
b) A request by a beneficiary or representative for review of SLOBHD's determination to deny or modify a beneficiary's request for a covered SMHS
c) A request by a beneficiary or representative for review of the timeliness of the delivery of SMHS
d) A request by a provider for review of client record review findings that resulted in the disallowance of paid claims

3. MHP Payment Authorization

The written, electronic or verbal authorization given by an MHP to a provider for reimbursement of specialty mental health services provided to a beneficiary.

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VI. DOCUMENT HISTORY

Revision Date:	Section Revised:	Details of Revision:
11/18/2015	All	Added purpose, reformatted, added F
08/17/2017	All	Reformatted, New CRF Language
01/25/2018	All	Reformatted
Prior Approval dates:		
Prior Approval dates: 5/30/2009, 6/5/2010, 10/12/2012		

Signature on file		*08/24/2017*
Approved by:	Anne Robin, LMFT, Behavioral Health Administrator	Date