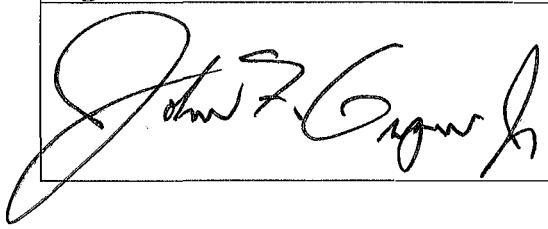
SAN FRANCISCO HEALTH PLAN

CL-07: Provider Dispute Resolution Mechanism

APPROVAL/REVIEW/REVISION HISTORY			
Signature	**Title**	**Date**	**Action**
	CEO	10/10/19	Biennial Review

SFHP POLICY AND PROCEDURE

Provider Dispute Resolution Mechanism

Policy and Procedure Number:	CL-07
Department Owner:	Claims
Lines of Business Affected:	Medi-Cal, Healthy Workers HMO, Healthy Kids HMO

POLICY STATEMENT

San Francisco Health Plan (SFHP) maintains a fast, fair, and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes.

This policy and procedure workflow addresses the full scope of contracted and non-contracted provider disputes including claims and other types of billing and contract disputes in compliance with relevant sections of the Health and Safety Code and Title 28.

PROCEDURE

I. Informing Providers

A. SFHP ensures providers (contracted and non-contracted) are informed of the Provider Dispute Resolution (PDR) Mechanism whenever the plan contests, adjusts, or denies a claim.
B. This information informs the provider of the availability of the Provider Dispute Resolution Mechanism and the procedures for obtaining forms and instructions for submission, including the mailing address and phone number for inquiries. This information is provided via the following channels:
    1. Message on Remittance Advice
    2. Provider section of San Francisco Health Plan (SFHP) website:
    3. http://www.sfhp.org/providers/
    4. Provider contract language (contracted providers only)SFHP Network
    5. Operations Manual
    6. SFHP Claims Operations Manual

C. A provider dispute is handled and resolved without charge to the provider. Notwithstanding the foregoing, SFHP has no obligation to reimburse a provider for any costs incurred in connection with utilizing the Provider Dispute Resolution Mechanism.
D. SFHP does not discriminate or retaliate against a provider (including, but not limited to, the cancellation of the provider's contract) because the provider filed a contracted provider dispute or a non-contracted provider dispute.

II. Timeframes for Dispute Resolution

SFHP follows Title 28, Section 1300.71 guidelines governing timeframes for completing each step within the PDR process:

Step	Timeframe for Completion
Provider submits provider dispute	Within 365 days of the plan's or the plan's capitated provider's action or inaction
Acknowledge receipt of provider dispute	Electronically filed disputes- within 2 working days of receipt Paper disputes- within 15 working days of receipt
Resolve dispute and issue a written determination	Within 45 working days of receipt of a dispute
Pay any outstanding monies determined to be due, together with all interest and penalties	Within 5 working days of date of resolution or Written Determination

III. Submission

A. The provider completes the Provider Dispute Resolution Request form ("the form") or creates a letter which must include the pertinent details of the disputed claim, including the same number assigned to the original claim, if applicable, and an explanation of the dispute. The Provider Dispute Resolution Request Form can be found at: https://www.sfhp.org/files/providers/Provider_Dispute_Form.pdf.
B. The provider may send the dispute to San Francisco Health Plan (SFHP), via mail at: San Francisco Health Plan, Attention PDR Unit, PO Box 194247, San Francisco, CA 94119. The provider may also fax the dispute to SFHP at 415-547-7827.
C. The provider must submit the provider dispute for an individual claim, billing, dispute, other contractual dispute, or unfair payment pattern by SFHP, no later than 365 days after SFHP's action or, in the case of inaction, no later than 365 days after the Time for Contesting or Denying Claims has expired.

IV. Receipt

A. Upon receipt of the form or letter by the Plan, the dispute document is date stamped. The date of receipt is considered the first working day of the dispute and is used to calculate the timeline in which SFHP must resolve the dispute.
B. SFHP assigns a tracking number to each dispute or bundled dispute. For claims disputes, the tracking number(s) will reference a specific, individual claim number. For disputes containing multiple, like, claims, a tracking number will be assigned to each individual claim contained within the dispute. For annual reporting purposes, these will be reported as individual disputes.
C. SFHP sends a letter of acknowledgment indicating receipt of the dispute and the tracking number assigned to the dispute claim. Acknowledgment letters are sent

within 15 working days of receipt for written submissions, or within 2 working days of receipt for electronic submissions.

V. Processing and Resolution

A. Responsibility for triaging and resolving the provider disputes is delegated to the Provider Dispute Resolution Unit (PDR Unit), which resides in SFHP's Claims Department.
B. The SFHP PDR Unit responds to provider disputes with a determination letter within 45 working days from the date of receipt.
C. The PDR unit processes provider disputes in the order that they are received.
D. If the dispute is lacking information required to make a determination, the PDR Unit opens a PDR case, assigns the tracking number and then closes the case with a determination letter that notifies the Provider to resubmit the PDR with the additional information. The provider is notified, clearly stated in writing, of the missing information necessary to resolve the dispute.
    1. Upon receipt of the additional information a new case is opened and a new tracking number assigned for full processing of the PDR.

VI. Provider Dispute Scenarios

A. Contracted Providers

1. If the dispute is related to a claim payment issue or the payment the provider received is other than expected:
    a. The PDR Unit confirms, whether or not, the claim was processed correctly and the payment sent to the provider was correct.
    b. For contracted providers, if payment was issued accurately pursuant to contract terms, the dispute is upheld.
    c. No Clinical Operations (CO) review is necessary.
    d. The PDR Unit forwards a copy of the dispute to the CO department if the payment is related to UM edits.

2. If the dispute pertains to a claim that was denied for duplicate, non-covered benefit, benefit/charges, additional information needed, contract disputes, or invalid billing, the following steps are taken:
    a. The PDR Unit reviews the submitted documentation and determines whether the documentation substantiates the denied claim(s).
    b. The PDR Unit may forward the request to the appropriate department for review if a determination cannot be made by individuals within the PDR Unit.
    c. The PDR Unit ensures impacted claim(s) are (re)processed for payment and send a determination letter notifying the provider of the dispute outcome within 45 working days of the receipt of the dispute.
    d. If related to a non-covered benefit, PDR Unit will identify the exclusion in the Medi-Cal Provider Manual, Medi-Cal FFS schedule, or SFHP EOC and/or consult with Compliance staff. For HW HMO and HK HMO, the sources will include the SFHP EOC and DMHC statutes and regulations.

i. If exclusion is found, then no CO review is necessary.
ii. If exclusion is not found, then see scenario #C4.

B. Non-Contracted Providers

1. If the dispute is related to a claim payment issue or the payment the provider received is other than expected:
   a. The PDR Unit confirms whether or not the claim was processed correctly and the payment sent to the provider was correct.
   b. For non-contracted providers, payments are reviewed for accuracy in accordance with the CT-02 Policy and its pricing tiers. The PDR Unit ensures impacted claim(s) are (re)processed for payment and send a determination letter notifying the provider of the dispute outcome within 45 working days of the receipt of the dispute.
   c. The PDR Unit forwards a copy of the dispute to the CO department if the payment is related to UM edits.
2. If the dispute is regarding a retro-authorization review and there is no denied claim, and the submitting provider is not contracted with SFHP:
   a. Non-contracted provider dispute submissions for reasons other than outlined (see definitions) are considered closed upon receipt.
   b. The PDR Unit sends a letter to the submitting provider indicating that their dispute is closed without determination and provides information regarding alternative appeal mechanisms.
   c. PDR Unit will forward retro-authorization request to Clinical Operations for authorization processing, as this is not considered a PDR.

   If the dispute is regarding a retro-authorization review and there is a denied claim:
   - *See scenario C#1 for outpatient and elective inpatient services.*
   - *See scenario C#5 for inpatient admissions.*

3. If the dispute is regarding an authorization decision and there are no denied claims, and the submitting provider is not contracted with SFHP:
   a. Non-contracted provider dispute submissions for disputes other than denied, adjusted or contested claims or overpayment disputes are considered closed upon receipt.
   b. The PDR Unit sends a letter to the submitting provider indicating that their dispute is closed without determination and provides information regarding alternative appeal mechanisms.

   If the dispute is regarding an authorization denial and there is a denied claim:
   - *See scenario C#6 for outpatient and elective inpatient services.*
   - *See scenario C#5 for inpatient admissions.*

C. Contracted and Non-Contracted Providers

1. If the dispute is regarding a request for a retro-authorization review for outpatient services or elective inpatient services requiring prior authorization (i.e., no auth had been requested and provider is now asking for a retro-auth):
    a. The PDR Unit forwards a copy of the dispute to the CO department to be reviewed.
    b. CO determines if the dispute meets CO-22 conditions for a retro-authorization review.
    c. If conditions are met, the CO department reviews for medical necessity, as stated in CO-22.
        i. If medical necessity criteria are met, Nurse Reviewer will overturn denial.
        ii. If medical necessity criteria are not met, Nurse Reviewer forwards case to the SFHP Medical Director for review and decision.
    d. The CO department provides the PDR Unit with a determination and an explanation for the determination to be included in the Determination Letter.
    e. The PDR Unit ensures impacted authorization(s) and/or claim(s) are (re)processed for payment, if needed.
    f. The PDR Unit sends a determination letter notifying the provider of the dispute outcome within 45 working days of the receipt of the dispute.

2. If the dispute is regarding an outpatient service for which the provider obtained an approved authorization, but is billing mismatched service codes and/or service dates, or additional units than originally authorized:
    a. The PDR Unit forwards a copy of the dispute to the CO department.
    b. The CO department reviews claim denial reason against approved authorization.
    c. If denial was due to administrative mismatch, CO department will review and overturn, as appropriate.
    d. If denial was due to additional billed units or service codes and requires additional medical necessity review, case is reviewed for medical necessity:
        i. If medical necessity criteria are met, Nurse Reviewer will overturn denial.
        ii. If medical necessity criteria are not met, Nurse Reviewer forwards case to the SFHP Medical Director for review and decision.
    e. The CO department provides the PDR Unit with a determination and an explanation for the determination. For cases involving medical necessity review, the contact information of the reviewing licensed health care provider is to be included in the determination letter.
    f. The PDR Unit ensures impacted authorization(s) and or claim(s) are (re)processed for payment, if needed.
    g. The PDR Unit sends a determination letter notifying the provider of the dispute outcome within 45 working days of the receipt of the dispute.

3. If the disputing provider indicates the billed service was denied, but was urgent or emergent:
    a. The PDR Unit forwards a copy of the dispute to the CO department.

i. The CO department verifies urgency (e.g. rendered in Emergency Department or Urgent Care) and overturns denial.
ii. If either the CO department or Nurse Reviewer cannot confirm urgency, the dispute is forwarded to the SFHP Medical Director for review and decision.

b. The CO department provides the PDR Unit with a determination and an explanation for the determination. For cases involving medical necessity review, the contact information of the reviewing licensed health care provider is to be included in the determination letter.
c. The PDR Unit ensures impacted authorization(s) and or claim(s) are (re)processed for payment, if needed.
d. The PDR Unit sends a determination letter notifying the provider of the dispute outcome within 45 working days of the receipt of the dispute.

4. If the dispute is regarding a claim that was denied as not a covered benefit, but the disputing provider's position is that the service is medically necessary:
   a. The PDR Unit forwards a copy of the dispute to the CO department.
   b. The CO department reviews authorization history to confirm if service was requested for coverage.
      i. If the non-covered service was requested and approved for medical necessity via exception handling, CO department will overturn.
      ii. If the non-covered service was not requested and does not meet CO-22 conditions for a retro-authorization review, the CO department will deny for no prior authorization and untimely retrospective request.
   c. The CO department provides the PDR Unit with a determination and an explanation for the determination. For cases involving medical necessity review, the contact information of the reviewing licensed health care provider is to be included in the determination letter.
   d. The PDR Unit ensures impacted authorization(s) and or claim(s) are (re)processed for payment, if needed.
   e. The PDR Unit sends a determination letter notifying the provider of the dispute outcome within 45 working days of the receipt of the dispute.

5. If the dispute is regarding an inpatient admission and the member entered through the Emergency Department,:
   a. The PDR Unit forwards a copy of the dispute to the CO department for medical necessity review.
      i. If medical necessity criteria are met, Nurse Reviewer will overturn denial.
      ii. If medical necessity criteria are not met, Nurse Reviewer forwards case to the SFHP Medical Director, who was not involved in the initial decision, for review and decision.
   b. The CO department provides the PDR Unit with a determination and an explanation for the determination. For cases involving medical necessity review, the contact information of the reviewing licensed health care provider is to be included in the determination letter.

c. The PDR Unit ensures impacted authorization(s) and or claim(s) are (re)processed for payment, if needed.
d. The PDR Unit sends a determination letter notifying the provider of the dispute outcome within 45 working days of the receipt of the dispute.

6. If the dispute is regarding an authorization denial for an outpatient service or elective inpatient service, and the service has been rendered:
   a. The PDR Unit forwards a copy of the dispute to the CO department.
   b. The CO department reviews authorization denial against PDR submission and claim.
      i. If the authorization was denied for an administrative reason (e.g., untimely retrospective request or insufficient clinical documentation) the administrative denial will be upheld.
      ii. If the authorization was denied for lack of medical necessity, the PDR will be forwarded to an SFHP Medical Director, who was not involved in the initial decision, for review and decision
   c. The CO department provides the PDR Unit with a determination and an explanation for the determination. For cases involving medical necessity review, the contact information of the reviewing licensed health care provider is to be included in the determination letter.
   d. The PDR Unit ensures impacted authorization(s) and or claim(s) are (re)processed for payment, if needed.
   e. The PDR Unit sends a determination letter notifying the provider of the dispute outcome within 45 working days of the receipt of the dispute.

7. If the dispute is regarding an authorization denial for administrative days due to no evidence of or untimely submission of SNF call logs:
   a. The PDR Unit forwards a copy of the dispute to the CO department.
   b. Nurse Reviewer confirms whether or not the facility attempted to submit timely SNF call logs.
      i. If the Nurse Review determines SNF call logs were attempted timely, Nurse Reviewer will overturn the denial.
      ii. If the Nurse Review determines SNF call logs were not attempted or not submitted timely, original denial is upheld.
   c. The CO department provides the PDR Unit with a determination and an explanation for the determination. For cases involving medical necessity review, the contact information of the reviewing licensed health care provider is to be included in the determination letter.
   d. The PDR Unit ensures impacted authorization(s) and or claim(s) are (re)processed for payment, if needed.
   e. The PDR Unit sends a determination letter notifying the provider of the dispute outcome within 45 working days of the receipt of the dispute.

8. If the dispute is regarding an authorization denial for administrative days due to lack of medical necessity:
   a. The PDR Unit forwards a copy of the dispute to the CO department.

i. If administrative day medical necessity criteria are met, Nurse Reviewer will overturn denial.
ii. If administrative day medical necessity criteria are not met, Nurse Reviewer forwards case to the SFHP Medical Director, who was not involved in the initial decision, for review and decision.

b. The CO department provides the PDR Unit with a determination and an explanation for the determination. For cases involving medical necessity review, the contact information of the reviewing licensed health care provider is to be included in the determination letter.
c. The PDR Unit ensures impacted authorization(s) and or claim(s) are (re)processed for payment, if needed.
d. The PDR Unit sends a determination letter notifying the provider of the dispute outcome within 45 working days of the receipt of the dispute.

9. If the dispute is submitted on behalf of an enrollee or a group of enrollees treated by the provider, the dispute is handled within Member Grievance process, QI-06 - Member Grievances and Appeals, and not in the plan's or the plan's capitated provider's dispute resolution mechanism.
   a. The PDR Unit forwards the case to the Grievance Unit and considers the dispute closed.
   b. The Member Grievance Unit is responsible to send an acknowledgment letter to the submitting provider notifying the provider that the submission has been identified as a member grievance and will be resolved through the Member Grievance process.

10. If the dispute is regarding a claim that is the responsibility of a delegated medical group:
    a. The PDR Unit considers the dispute closed.
    b. The PDR unit informs the delegated medical group of the submission and forwards any submitted documents.
    c. The PDR unit sends a notification letter to the submitting provider stating the dispute is closed and has been forwarded to the delegated medical group.
    d. If the provider is disputing the determination of the delegated medical group that they believe to be unfair, SFHP obtains relevant claim and medical records from the delegated medical group to review the dispute.
    e. If SFHP determination is in favor of the provider, SFHP ensures that the medical group issues the correct payment, plus applicable interest.

VII. Documentation

A. PDR cases are created in SFHP's care management software application, except for
   1. Disputes received by SFHP for non-SFHP members. These documents will be destroyed and the submitting provider will be notified.
   2. Paper and electronic dispute documentation is stored securely, either in a locked cabinet or secure network folder, by the plan for a minimum of 10 years.

VIII. Payment

1. Past Due Payments.
    1. The PDR Unit considers any additional information that the provider submits which could result in additional payment being made.
    2. If the provider dispute involves a claim and is determined in whole or in part, in favor of the provider, SFHP pays any outstanding monies determined to be due, and all interest and penalties required by policy, CL-02, Interest Calculation for Late Payment of Claims, within five (5) working days of the issuance of the Determination letter.
    3. The additional payment includes all interest and penalties required. Accrual of interest and penalties for the payment of these resolved provider disputes commences on the day following the expiration of "Time for Reimbursement" as set forth in section 1300.71(g) of Title 28. If the claim was not processed correctly and the payment was incorrect, the original decision is overturned and additional payment is made to the provider for the service.
    4. The Operations Manager of Claims may approve timely submission penalties to be waived under certain circumstances. In these instances, the provider is issued a payment for the full eligible payment amount without penalties.

MONITORING

1. SFHP maintains a claims quality assurance program consistent with SFHP Policy and Procedure PPI-01.

2. SFHP provides oversight of its delegated claim adjudication responsibilities consistent with SFHP Policy and Procedure DO-05.

3. Provider disputes are reported in the following ways:
    a. Quarterly summary of disputes for non-delegated medical groups is reported to the SFHP management team by the Claims Department.
    b. Annual Plan Claims Payment and Dispute Resolution Mechanism Report are submitted to the Department of Management Health Care (DMHC) no later than15 days after the close of the calendar year as part of the yearly DMHC reporting process.
    c. Claims Department provides an annual PDR report for non-delegated medical groups to the Compliance & Regulatory Affairs Department.
    d. Delegated medical groups submit annual PDR reports to the Compliance & Regulatory Affairs Department.
    e. Disputes contained in a bundled submission must be reported to DMHC separately as individual disputes.
    f. Information may be submitted in an aggregate format if all data entries are appropriately footnoted to provide full and fair disclosure.
    g. Compliance and Regulatory Affairs will remind delegated medical groups to report bundled PDRs as individual disputes in the quarterly report.
    h. The Compliance & Regulatory Affairs department compiles all PDR reports for SFHP and delegated medical groups and submits the annual report (part

of the Title 28, Section 1300.71, Timeliness of Claims Filing Report) to DMHC via the DMHC web portal.

i. The Compliance and Regulatory Affairs Specialist and Compliance Officer review the annual report and consult with the Claims Manager to ensure bundled PDRs have been reported separately.

4. Operations Manager of Claims conducts a monthly audit of a sample of disputes to ensure the accuracy and compliance of SFHP's dispute mechanism.

5. Operations Manager of Claims ensures acknowledgement and determination letters are prepared and sent to providers within regulated timeframes listed above.

6. If there appear to be PDRs that have not been sent a Determination Letter within 45-working days, Operations Manager of Claims implements appropriate corrective action, including staff training, as needed.

7. Operations Manager of Claims submits corrective action plan to the Compliance Officer for review and monitoring.

8. SFHP's Chief Operations Officer has primary responsibility for the oversight of the Provider Dispute Resolution Mechanism, including review of its operations and for noting any emerging patterns of provider disputes to improve administrative capacity, plan provider relations, claims payment procedures and patient care.

9. The Officer, Compliance and Regulatory Affairs is responsible for the oversight of the preparation of reports and disclosures as specified in sections 1300.71(e) (3) and (q) and 1300.71.38(k) of Title 28.

DEFINITIONS

Contracted Provider Dispute: A contracted provider's written notice to the plan or the plan's capitated provider 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 or 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:

(A) 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 upon 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;

(B) If the dispute is not about a claim, a clear explanation of the issue and the provider's position regarding the issue; and

(C) If the dispute involves an enrollee or group of enrollees: the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider's position regarding the item.

Disputes submitted on behalf of an enrollee or a group of enrollees are resolved using the Member Grievance process, QI-06: Member Grievances and Appeals. SFHP reserves the right to verify the member's permission to proceed with the grievance.

Non-Contracted Provider Dispute: A non-contracted provider's written notice to the plan or the plan's capitated provider 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:

(A) 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 upon 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.

(B) If the dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider's position regarding the item.

Date of receipt: The working day when the provider dispute, by physical or electronic means, is first delivered to the plan's or the plan's capitated provider's designated dispute resolution office or post office box.

Date of Determination: The date of postmark or electronic mark on the written provider dispute determination that is delivered, by physical or electronic means, to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the Date of Determination, the DMHC may consider, when auditing the plan's or the plan's capitated provider's provider dispute mechanism, the date the check is printed for any monies determined to be due and owing the provider and date the check is presented for payment.

Determination Letter: The written determination provided to the submitting provider by the provider dispute resolution unit within 45 working days after the date of receipt of the provider dispute. The Written Determination will state the pertinent facts and explain the reasons for its determination. The Written Determination will communicate the details back

to the provider in a Determination Letter and will include the action taken, whether the claim payment is upheld and no additional payment is due or the claim is overturned and additional payment will be made on the claim. If the claim is overturned and the provider dispute is determined in favor of the provider, and additional payment is to be made, the determination letter will also include the amount of the adjusted claims payment, including any interest and penalties as required.

Provider Dispute Resolution Unit: The department responsible to coordinate, document and resolve provider disputes. The unit consists of two members, a Provider Dispute Resolution Specialist and a Provider Dispute Resolution Coordinator.

AFFECTED DEPARTMENTS/PARTIES

Claims
Clinical Operations
Compliance & Regulatory Affairs
Customer Service
Performance and Process Improvement
Provider Network Operations

RELATED POLICIES AND PROCEDURES, DESKTOP PROCESS and PROCESS MAPS

CL-02:	Interest Calculation for Late Payment of Claims
CT-02:	Pricing of Claims for Extra-Contractual and Non-Contracted Providers
QI-06:	Clinical Member-Grievances
QI-17:	Member Appeals
CS-13:	Member Grievances and Appeals Rights Intake and Case Creation
CS-14:	Non-Clinical Grievances and Non-Clinical Decline-to-file
UM-01:	Utilization Management of Authorization Requests and Notice of Action
UM-22:	Authorization Requests
DTP:	Claims Desktop Process for PDRs

REVISION HISTORY

Effective Date: 8/1/2018
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REFERENCES

1. Health and Safety Code, Sections, 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.37, 1371.4 and 1371.8
2. California Code of Regulations, Title 28, Sections1300.71, 1300.71.38, 1300.71.4 and 1300.77.4