

SHARP HEALTH PLAN POLICY AND PROCEDURE



Title:
Provider Dispute Resolution Overview

Product Line (check all that apply):

- Group HMO
- Individual HMO
- PPO
- POS
- N/A

Division(s): Administration, Finance and Operations

Department(s): Claims Research, Customer Care, Network Development, Provider Contracts and Regulatory Affairs

Owner (Title): Claims Research Supervisor

Relevant Regulatory/Accrediting Agencies/Citations (specify):

- CMS: _____
- DMHC: Title 28, California Code of Regulations (CCR), Sections 1300.71 and 1300.71.38 (AB 1455)
- NCQA-HP: _____
- NCQA-WHP: _____
- OTHER: _____

Approved by: (Signature of VP, Compliance Officer, or CEO)
 Signature on File

Approval date:
 12/06/12

- I. PURPOSE:** This Policy and Procedure establishes Sharp Health Plan’s (Plan) guidelines for the processing all provider claims disputes.
- II. POLICY:** It is the policy of Sharp Health Plan (Plan) to adhere to requirements of the regulations in Title 28, California Code of Regulations (CCR), Sections 1300.71 and 1300.71.38 (AB 1455), when processing Provider Disputes.
- III. DEFINITIONS:**
 - A. Customer Service Record (CSR): A Customer Service Record (CSR) is generated for each entry in the GE Customer Service Module. CSRs are used to track customer inquiries and requests for assistance.
 - B. Provider Dispute Resolution (PDR): A 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 or other contract dispute or disputing a request for reimbursement of an overpayment of a claim.

- C. Date of Receipt: The working day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the Plan (including the Plan's contracted Sharp HealthCare Claim Shop) or the Plan's capitated provider's designated dispute resolution office or post office box.
- D. Date of Service (DOS): The date on which the service was provided.
- E. PDR Sweep: Any Provider Dispute Resolution that is overturned by Utilization Management (UM) or had an error in the contract set-up will trigger a review of all related claims.
- F. OnBase: The imaging software database used to store all claims and PDRs.

IV. PROCEDURE:

- A. **Receipt of a PDR**: Upon receipt of a written PDR by the Claims Research Department, each dispute page is date stamped to indicate the date the PDR was received.
- B. **Validate the PDR**: Once received by the Claims Research Specialists they verify that the PDR is valid and meets all the necessary criteria.
 - 1. **Criteria for a valid PDR**: In order to be considered valid, each PDR must meet the following criteria:
 - a) The receipt of a provider dispute for an individual claim, billing dispute or other contractual dispute must be less than three hundred and sixty five (365) days of last plan's action.
 - b) It must include the provider's name and the provider's identification number.
 - c) The provider contact information.
 - d) 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, contest, denial, adjustment or other action is incorrect.
- C. **Assign a CSR Tracking Number**: After the PDR has been validated, the Claims Research Specialist logs the PDR into the GE system to assign an electronic tracking number to each PDR. Each PDR has its own individual tracking number. This must be completed on the same day as the PDR is received and validated.
 - 1. The CSR creation date must be the same as the date the PDR was received by the Claims Research Department.
- D. **Create a PDR Tracking Form**: Once a PDR is assigned a tracking number through the GE system, the Claims Research Specialist begins an ICE approved PDR tracking form to monitor the progress and turn-around-time of each PDR.
- E. **PDR Acknowledgement Letter**: Once a valid PDR is received, the Claims Specialists must acknowledge receipt to the provider.

1. If the dispute was received electronically (via e-mail), then an acknowledgement must be issued within two (2) working days and is handled using an Auto-Reply system.
2. If the dispute was received in written format (including fax), then an acknowledgement letter must be issued within fifteen (15) working days. The acknowledgement letter is generated using the template letters in the Global Works system.
 - a) A copy of the acknowledgement letter is then be attached to the existing PDR form.

F. **PDR Determination Timeframe:** Within forty-five (45) working days of receipt of the PDR or the amended PDR, the Claims Specialist must make a determination and issue a written determination stating the pertinent facts and explaining the reasons for the determination on the disputed claims.

1. **Overtured Initial Decision:** If the dispute was resolved in favor of the provider, then the claim must be sent to the Claims Processing Department for reprocessing through a CSR.
 - a) Claims Processing informs the Claims Specialist through a CSR of the completion of the adjusted claim.
 - b) The Claims Research Specialist works with the Accounts Payable Department to coordinate the payment of the adjusted claim with the issuing of the Determination Letter.
 - c) The Claims Research Specialist mails the written determination within five (5) working days of the issuance of the check.
 - d) For any claims that were overturned as a result of a contract or utilization review, the Claims Specialist conducts a PDR Sweep to identify any other possibly affected claims.
2. **Upheld Initial Decision:** If the dispute was resolved in favor of the Plan, then the Claims Specialist issues a determination letter to the provider.
3. **Request for Further Information:** If no determination can be made, then the Claims Specialist must make a request for additional information from the provider so that a determination can be made. A request for additional information can only be issued once per dispute. If the information is not received, the Plan will not make any other additional requests.
 - a) A provider may submit an amended provider dispute within thirty (30) working days of the date of receipt of a returned provider dispute setting forth the missing information.
 - b) A failure to respond constitutes cause to determine the dispute in favor of the Plan.

- c) The request for additional information letters are generated using template letters in the Global Works System and must specifically address the information requested to make a determination.
 - i) A copy of the request for additional information letter is then be attached to the existing PDR form.

G. **Determination Letters:** Once a determination on a PDR has been reached then the Claims Specialists must issue a written determination to the provider which states the pertinent facts as well as explaining reason for the determination.

- 1. **In Favor of the Provider:** In those cases were the determination is in favor of the Provider, the written determination is sent to the provider within forty-five (45) working days of the PDR or amended PDR.
 - a) The determination letter must indicate the additional amount owed to the provider as a result of the favorable determination.
 - b) Any outstanding moneys determined to be due and all interest and penalties must be paid to the provider within five (5) working days of the issuance of the written determination.
 - c) A copy of the determination letter and a copy of the check to the provider is then be attached to the existing PDR form.
- 2. **In Favor of the Plan:** In those cases were the determination is in favor of the Plan, the written determination is issued on the same day as the PDR is closed.
 - a) A copy of the determination letter is then be attached to the existing PDR form.
- 3. **Refund is required:** In those cases were a refund is required, but not received within thirty (30) working days from the dispute request, the dispute will be closed and the refund request will continue as outlined in the Claims Overpayments and Retractions Policy and Procedure.

H. **Second Level Appeals**

- 1. In the event that the provider appeals the original Provider Dispute determination from a Claims Research Specialist (a second level appeal) then the Provider Dispute and all relevant information is turned over to the to the appropriate department for a higher level review.
 - a) **Contracts** – SHP Senior Contracts Consultant
 - b) **Utilization Management** – SHP Medical Director
 - c) **Claim Check Issues** – SHP Claims Research Supervisor
 - d) **U&C or Negotiated** – SHP Claims Research Supervisor and repricing agency

I. **PDR Filing and Record Keeping:**

- 1. All PDR forms and attachments are maintained by Sharp Health Plan for a period of 5 years.

- a) The most current 2 calendar years is maintained at Sharp Health Plan.
- b) All records 3 years and older are scanned in OnBase.

V. ATTACHMENTS: N/A

VI. REFERENCES: Title 28, California Code of Regulations (CCR), Sections 1300.71 and 1300.71.38 (AB 1455)

VII. TAGS: Provider Dispute, Claims, Second Level Appeals, PDR, AB 1455

VIII. REVISION HISTORY:

Date	Modification (Reviewed and/or Revised)
08/29/2013	Revised Document
11/12/2012	Reviewed Document
12/23/2011	Reviewed Document
02/22/2011	Revised Document
01/31/2011	Revised Document
06/01/2010	Revised Document
08/27/2009	Revised Document
01/02/2007	Revised Document
10/01/2006	Revised Document
01/01/2006	Revised Document
09/01/2005	Revised Document
12/01/2003	Revised Document
09/01/2003	Original Document