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 Administration, Customer Care, Network Development, Provider Contracts and Regulatory Affairs	
Owner (Title): Manager of Claims Administration	
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:** 01/01/2018

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. Issue Tracker: A Issue Tracker is generated for each entry in HealthRules Manager. The Issue Tracker is used to track customer and provider 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.

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 PDRs that is linked into the Issue Tracker.

IV. PROCEDURE:

A. **Receipt of a PDR**: Upon receipt of a written PDR by Claims Research, 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 it is verified 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 an Issue Number:** After the PDR has been validated, the Claims Research Specialist logs the PDR into the HealthRules 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 Issue 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 HealthRules 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, 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.

    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 Research 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. **Overturned Initial Decision:** If the dispute was resolved in favor of the provider, then the claim must be sent to the Claims Processing team for reprocessing through an email and the Issue Tracker.

    a) Claims Processing informs the Claims Research Specialist through an email and the Issue Tracker of the completion of the adjusted claim.

    b) The Claims Research Specialist works with the Claims Lead or Claims Auditor 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 Research 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 Research Specialist issues a determination letter to the provider.

3. **Request for Further Information:** If no determination can be made, then the Claims Research 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 the ICE template letters 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 Research Specialist 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 Contracts Manager
b) **Utilization Management –** SHP Medical Director
c) **Claim Check Issues –** SHP Manager of Claims Administration
d) **U&C or Negotiated –** SHP Manager of Claims Administration 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 and Issue Tracker.

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)
01/01/2018	Revised Document
12/31/2015	Reviewed Document
12/31/2014	Reviewed Document
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