Participating Provider Disputes

Partners Health Management

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POLICY

It is the policy of Partners Health Management (Partners) to respect participating providers' rights while also holding them accountable, fulfilling Partners' obligations, ensuring an adequate and quality provider network and protecting members, other stakeholders and public funds (Medicaid and non-Medicaid). To this end, and consistent with controlling authorities including applicable contracts, laws, regulations and accreditation requirements, Partners maintains a robust, formal process consistent with its written agreements to address and reconsider certain actions or decisions by Partners against participating providers before becoming final. [NM-13] The goal is not to create another layer of litigation, but to provide a user-friendly, streamlined avenue by which Partners can reconsider and be certain of its position before issuing a final decision on behalf of the organization regarding participating providers. As defined in formal procedures, not all disputes are subject to this process. [NM-14(a

A participating provider has the right to dispute certain actions taken by Partners. Dispute rights shall be available to network providers for the following reasons:

a. Program Integrity related findings and activities.
b. Finding of fraud, waste or abuse by Partners.
c. Finding of or recovery of an overpayment related to fraud, waste or abuse concerns.
d. Withholding or suspension of a payment related to fraud, waste or abuse concerns.
e. Termination of or determination not to renew an existing contract.
f. Violation of terms between Partners and the provider professional competence or conduct that results in a change in provider status. [NM-15]
g. Select administrative matters.

PROCEDURE

Unless otherwise clearly indicated, all terms and abbreviations used in this policy and procedure are to be construed consistent with the glossary and definitions provided in the last section of this document.

I. Initiation of the Dispute Resolution Process [NM-14(b)(c) & (d)]

A. A participating provider can submit a request in writing using the Dispute Resolution Form, which can be found on the Partners' website, no later than 21 calendar days from the receipt or attempted delivery of the Local Management Entity/Managed Care Organization (LME/MCO) decision resulting in the request. If the provider fails to meet the timeframes to request initiation of the Dispute Process, the decision of the LME/MCO becomes final and the provider may not further exercise the Dispute Process. [NM-14(b) & (d)]

B. The provider will receive a copy of the Dispute Resolution Form, along with the notification of action or decision taken by the LME/MCO. A provider may also contact Partners by telephone or in person, and the

appropriate staff person will assist the provider with obtaining a copy of the Dispute Resolution Form. [NM-14(d) & (g)]

C. The Dispute Resolution Form collects the following information, at a minimum: [NM-14(c)]
   1. The nature of the problem.
   2. Previous attempts, if any, to resolve it.
   3. Any other pertinent information that the provider feels is important.

D. In addition, the provider may submit additional information in writing either by electronic mail, surface mail, special delivery, hand delivery or other source of written communication. [NM-14(c)] The provider will not submit originals unless requested to do so. Partners is under no obligation to return documents submitted by a provider in support of its dispute unless expressly agreed upon in advance in writing.

II. Nature or Type of Dispute [NM-14(d)]

A. As soon as Partners receives the completed Dispute Resolution Form from the provider, the Partners' Provider Network Dispute Specialist will perform an analysis of the nature or type of the dispute and assign it to the appropriate track described below. The provider network dispute specialist may confer with other departments as appropriate, to assist with making this determination, if needed.

   1. Type I: Disputes of an *administrative* or *non-clinical* nature are those pertaining to matters such as, but not limited to, the following:
      a. Claims and billing, including timely filing of claims and demands for payback of an overpayment.
      b. Adequacy of facility and staffing.
      c. Compliance with state and Partners' policy.
      d. Compliance with contractual requirements not excluded below.
      e. Compliance with state regulatory requirements (e.g., Core Rules, Client Rights Rules, etc.).
      f. Network accessibility issues.
      g. Not submitting requested medical records.
   2. Type II: Disputes of a *clinical* nature are those that involve the provider's professional competency or conduct and/or the participating provider's status within the network. They include, but are not limited to, the following:
      a. The appropriateness or quality of professional services including assessment, treatment, consultation and referral.
      b. The appropriateness of interactions between a provider treatment staff and a member.
      c. Conduct by a professional that may adversely affect treatment outcomes—e.g., failure to exercise professional judgment in disclosing client information:
         (i) Termination, suspension and/or other sanction or action directed by Partners at a specific participating provider that directly results in a substantial change in that provider's status in Partners' network.
   3. Exclusions: Not all parties and issues are subject to this participating provider dispute process.
      a. Parties: This process is limited to participating providers under an existing contract with Partners. Excluded include applicants, credentialed but not contracted providers, employees of providers (including Relatives of Direct Support Employees (RDSE) and others not defined as participating providers below.
         (i) If a participating provider has been issued a notice of dismissal or termination from the network, then the provider is considered participating for purposes of this dispute process up to and through the last day of participation as indicated on the notice, unless the notice is received on or after the last participation day, in which case the provider must be given

reasonable time to initiate the dispute mechanism. The time frame is generally stated in the dismissal/termination notice.

b. Medical Necessity and Other Enrollee Appeals: Medical necessity appeals, including disputes regarding resource allocation and SIS scores, are not included within the scope of this provider dispute process, but are addressed as adverse benefit determinations by the Utilization Management department under separate policies and procedures for enrollees and beneficiaries.
   (i) This provider dispute process does not include disputes primarily or exclusively belonging to the member, beneficiary, enrollee or his/her legally responsible person (LRP).

c. Clear For-Cause Contract Violations: If the provider contract is explicit and breached, this provider dispute process is not required. For example, if a providers' clinical license is revoked, if the provider is convicted of claims fraud or if the provider receives a failing fidelity score (TMACT), the provider loses its facility license, etc.
   (i) For those violations described in the Integrated Payment and Reporting System (IPRS) (aka non-Medicaid) contract (the contract with providers who deliver state-funded services), Article IV, Term and Termination, the dispute resolution process is not available. Those violations include but are not limited to:
      (i) Repeated non-performance of obligations without corrective action.
      (ii) Violations of professional standards.
      (iii) The commission of unlawful acts.

d. Grievances: Disputes by individuals and entities not covered by this process may be eligible for the grievance/complaint process provided in separate policies and procedures by Partners.

e. Untimely or Previously Adjudicated Disputes: Each dispute must be brought timely and cannot be brought again by the same participating provider regarding the same action or decision by Partners.

III. Panel Reviews by Type of Dispute

Partners' provider dispute process involves an internal panel review for Type I (administrative) disputes and a two-level panel review process for Type II (clinical/network status) disputes. With only a few exceptions, the panels follow the same process as described here.

A. All Panel Reviews

1. Unless otherwise specified, the provider network dispute specialist will consult with the dispute coordinator to perform the duties associated with this provider dispute resolution process.
2. A participating provider initiates the provider dispute resolution process by submitting a Dispute Resolution Form generally included with the action or decision being disputed and also available on Partners' website. A provider may also contact Partners by telephone or in person, and the appropriate staff person will assist the provider with obtaining a copy of the Dispute Resolution Form and answer relevant questions on how to complete it. While the form is the preferred method for initiating this dispute process, other writings covering substantially the same information will be accepted.
3. The provider network dispute specialist will send an acknowledgement letter to the provider via certified or registered mail as soon as reasonable based on the urgency of the situation, but no later than five calendar days of receipt of the Dispute Resolution Form. The acknowledgement letter will include the following information, satisfied by enclosing a copy of this policy and procedure, if not already provided:
   a. An explanation of the dispute resolution process and provider rights, including for Type II disputes the right to request a second-level panel review if dissatisfied with the first-level panel resolution.

b. That at any time during the process, the provider may submit to Partners for consideration any supporting documentation and any additional written information.
c. An invitation for the provider to present provider's arguments to the panel in person or by telephone.

4. The provider network dispute specialist shall ensure all pertinent information is gathered and organized in an orderly, confidential fashion, including:
   a. Information collected from the provider, e.g.:
      (i) Provider demographic information.
      (ii) Summary of problem/issue.
      (iii) Documents furnished by the provider during the dispute.
      (iv) Provider's view of the issue(s), including how to resolve it.
   b. All relevant information and documents from the appropriate Partners' staff making or supporting the decision or action, e.g., correspondence, research, contract(s), findings and summaries, as applicable.
   c. If necessary, Partners' staff person will investigate the matter further, which may involve a visit to the provider's office location.
5. If reasonably feasible, the provider network dispute specialist or dispute coordinator may work closely with the provider to mediate and negotiate with the provider an amicable resolution in lieu of a panel review. The participating provider should submit in writing any decision or election to withdraw or stop the provider dispute process.
6. The provider network dispute specialist will convene a panel composed as required herein. None of the voting panelists may have a conflict of interest nor have been involved in the initial decision or action that is the subject of the dispute or a prior panel in the dispute. To the extent possible, panelists should be selected who are familiar with the issues,, services and subjects raised by the provider or expected to arise in the panel review.
7. Each panel meets as soon as reasonable, preferably prior to the effective date of the action or decision being disputed. First-level panels will meet no later than 30 calendar days following receipt by Partners of the completed Provider Dispute Resolution Form. Second-level panels shall meet no later than 30 calendar days following receipt of the provider's request for a second-level panel review. The action or decision being disputed shall not pend or be extended during this dispute process unless expressly agreed in advance in writing by Partners.
8. While providers are invited to present to the panel, it is an accommodation and not a right; a provider's availability should not be permitted to delay the prompt and timely scheduling and holding of a panel review. If the provider has elected to present to the panel, the provider will be notified of the date and place of the panel review as far in advance as is feasible and prudent. This notification need not be in formal writing if time does not permit.
9. Panel reviews shall be held at one of Partners' office locations or via electronic in person platform such as Zoom, if meeting in person is not feasible. Panelists must attend in person or via electronic platform such as Zoom. The meeting location is at the sole discretion of Partners, but will take into consideration, to the extent feasible, the availability and location of all panelists and participants, including any provider confirming an intent to present in person to the panel.
10. Other than minimal information needed to check for conflicts, all panelists and participants in a panel review shall sign a confidentiality agreement prior to seeing the documents and hearing the information gathered for the panel. Each panel will have the opportunity to carefully and thoroughly review and consider all information surrounding the case, including documents, information and presentation, if any, by the provider.

11. No formal chair of a panel is required. All procedures shall be facilitated by the Provider Network Dispute Specialist, Dispute Coordinator or other designated and qualified Partners' staff. A disputed decision or action by Partners is upheld unless a simple majority or more of a panel votes otherwise.
12. Providers electing to present to the panel may do so for no more than 15 minutes. This time is intended to be a presentation and not a question-and-answer period. The provider is invited to use the time largely as it sees fit to persuade the panel to reconsider Partners' action or decision being disputed. The provider may not remain present for any other portion of the confidential panel review and reconsideration. A provider seeking to present must give Partners advance notice of who will be attending and speaking for the provider.
13. Subject matter experts at Partners may be invited to attend the review to counsel and inform the panel, including appropriate Partners' clinicians as needed, regarding clinical matters or issues that are anticipated or raised. While Partners' Chief Legal Officer or other attorney for Partners may attend and also counsel and inform the panel, he or she will not attend during the presentation by the provider nor engage and ask questions of the provider, to the extent required by attorney codes of ethics and conduct. Partners may have an attorney present if the participating provider elects to have an attorney present. This provider dispute process is intended to be informal reconsideration by Partners of its decision or action; as such, participation by attorneys is not encouraged but is also not prohibited.
14. As necessary, the provider network dispute specialist will consult with relevant Partners' personnel, including the dispute coordinator, the provider network director, the chief medical officer, the chief legal officer, chief operations officer (COO), or the chief executive officer (CEO).
15. Following presentation and review of all materials and information, panelists will deliberate among themselves with or without Partners' staff present to counsel and inform, as determined by the panel.
16. Panels must limit their decisions to the facts, information, and controlling authorities before them. Panels may not reverse decisions made by the chief medical officer, or a committee chaired or membered by the chief medical officer , without the express consent of the chief medical officer. Any decision that reasonably contradicts controlling authorities must first be approved by the CEO in consult with the Chief Legal Officer.
17. Once the panel decision has been made, a written notification is sent within five calendar days, by trackable mail, to the provider regarding the outcome of the panel review.
18. Any notes, minutes or other materials and information regarding the proceedings are kept and held in strictest confidence. This does not prohibit a provider from sharing the information with legal counsel or Partners' staff from sharing as reasonably appropriate internally.

B. First-Level Type 1 (administrative) or Type II (clinical/network status) Panel Review

<u>First Level Panel Review:</u>

1. The appeals first level committee consists of at least three qualified individuals who were not involved in the original decision, action or inaction giving rise to the appeal; and at least one clinical peer who is not an employee of Partners or a Partners' committee member.
2. These individuals review and make decisions on each appeal.
3. The committee participants include those representing a variety of functional areas with expertise related to the appealed decision, action or inaction.
4. The designated Partners' staff member compiles available information, including summaries of his/her own research, if applicable.
5. The committee meets as soon as possible, but no later than 15 business days following receipt of the appeal.

Written Notice regarding First Level Panel Review (Type I and II):
Once the decision has been made, a written notification is sent to the provider within five business days regarding the outcome of the committee review, but no later than 30 calendar days of receipt of the appeal request or from the date final evidence was received if an extension was granted, along with the notification of action or decision. The notice includes appeal rights. [NM-14(g)]

C. Second Level Panel Review (Type I and II):
   1. If the provider is dissatisfied with the first level committee's resolution and requests a second review, Partners will convene a second level committee with at least three qualified individuals that did not participate on the first level committee.
   2. This committee must include at least one clinical peer who is not an employee of Partners or a Partners' committee member.
   3. The provider being reviewed may submit additional information that he/she deems important to support his/her case.
   4. The designated Partners' staff member compiles all available information, including any summaries of his/her own research, if applicable.
   5. The committee meets as soon as possible, but no later than 15 business days from receipt of the appeal to review the appeal, with special review and consideration of any additional information presented by the provider to support his/her case.

Written Notice Regarding Second Level Panel Review:
Once the decision has been made, a written notification is sent to the provider within five business days regarding the outcome of the committee review, but no later than 30 calendar days of receipt of the appeal request or from the date final evidence was received if an extension was granted, along with the notification of action or decision.

IV. Appeals to State
   A. Final Decision: The participating provider must exhaust the full provider dispute process afforded by Partners to appeal Partner's final decision to the state. The potential for appealing and how to do so will be included in any final decision issued by Partners under this provider dispute process.
   B. Medicaid: Partners provider dispute decisions involving Medicaid funds or contracts, if appealable, are to the North Carolina Office of Administrative Hearings to the extent required by law.
   C. Non-Medicaid: Partners' provider dispute decisions involving non-Medicaid funds or contracts, if appealable, are to a North Carolina DMH/DD/SAS hearing officer, to the extent required by law.

Member Safety Mechanism
Partners' first priority is the well-being of its members. If the Partners' Chief Medical Officer or Chief Clinical Officer is of the opinion that the provider who is the subject of any dispute poses a significant risk to the health, welfare or safety of members, the provider may be immediately suspended pending the results of an investigation. [NM-17(a)]

A. A suspended participating provider will not receive funding to receive new referrals from Partners. Any suspension must be by Partners Network Management Committee pursuant to LME/MCO Issued Sanctions Policy..

B. Written notification of the intent to suspend the provider pending investigation is sent to the provider as soon as possible based on the urgency of the situation, but no later than five calendar days of becoming aware of the

issues. The notification includes the availability of the Dispute Resolution Process including the Dispute Resolution Form and the mechanism for initiation, and a Dispute Resolution Form. [NM-17(c)]

C. In addition, Partners provides written notification to the appropriate entities, such as:

1. Division of Health Service Regulation (DHSR)
2. The Department of Social Services (DSS)
3. The Division of Mental Health/Developmental Disability /Substance Abuse Services (DMH/DD/SAS) Program Integrity Unit

D. As with any dispute, the provider may contact Partners' Provider Network Management department to share any information that they believe may bring about a favorable outcome.

E. Partners makes every effort to achieve final resolution to these kinds of cases ahead of the designated deadlines, given the provider has been suspended. However, Partners does not compromise outcome to complete the case quickly. [NM-17(b)]

F. When the information-gathering and investigation is complete, a first-level panel convenes.

G. All other steps to the panel review process are the same as outlined above, including the written notification and the right to a second-level panel review.

VI. **Disputes Related to Provider Payment Withhold or Suspension:**

A. Partners notifies the Department within 10 business days of a suspension or withhold of provider payment and provide information regarding provider appeals to the Department upon request.
B. Partners notifies the Department within five business days of an appeal regarding the suspension or withhold of provider payment, finding or recovery of an overpayment or any action related to a finding of fraud, waste or abuse, as well as any administrative or general court of justice for actions related to Medicaid managed care.
C. Partners schedules a committee hearing with the provider to review the appeal of a payment withhold or suspension of a payment.
D. Within 15 business days of appeal receipt, the committee issues a decision as to whether there was compelling cause to suspend or withhold the provider's payment.
E. Upon a finding that Partners did not have good cause, any withheld or suspended payment is reinstated within five business days and interest is paid in accordance with the contract.

VII. Documentation

A. Information pertaining to all disputes, administrative or panel, is documented in the designated database. This information is also filed in the provider files maintained in the Provider Network Management department.
B. Quarterly reports are created for presentation to the Quality Improvement Committee (QIC) and other appropriate committees for tracking and trending.
C. When patterns emerge, the QIC will request an action plan to bring about improvements.

Glossary & Definitions

Unless otherwise defined, the terminology in this Policy and Procedure (P&P) is based on the definitions in URAC Health Network Accreditation Guide, Network Management Standards N-NM 13-17 and the current contract with DHB, including the following from Attachment F:

1. Applicant: A provider who is seeking to participate in the Closed Network of PIHP, as set forth at N.C.G.S. §108D-1(1).
2. Closed Provider Network (also referred to as Network, Closed Network, Provider Network, and PIHP Closed Provider Network): The group of providers that have contracted with PIHP to furnish covered mental health, intellectual or developmental disabilities, and substance abuse services to enrollees, as set forth at N.C.G.S. § 108D-1(2).
3. Credentialing: The pre-contract screening and decision process, including primary source verification (PSV), conducted by PIHP to verify that the applicant is qualified to deliver services to enrollees and eligible to participate and be enrolled and contracted in PIHP's Closed Provider Network. The process includes obtaining a provider enrollment application, verifying the information received from the applicant, and assessing the required qualifications, certifications, endorsements and licensure of the applicant, as well as additional credentialing elements required by PIHP's accrediting body. In addition, this also includes criminal background and federal and state database checks. PIHP is not required to enroll or contract with a credentialed provider. Enrollment in the PIHP Closed Network is distinct from enrollment in the NC Medicaid Program.
4. DHHS or Department: The North Carolina Department of Health and Human Services, which is the designated single state Medicaid agency for the state of North Carolina.
5. Days: Except as otherwise noted, refers to calendar days. The terms *working day* and *business day* shall each mean a day on which DHB and PIHP are officially open to conduct their affairs.
6. DHB: The Division of Health Benefits also known as NC Medicaid, which is overseen by DHHS.
7. DMH/DD/SAS: The Division of Mental Health, Developmental Disabilities and Substance Abuse Services
8. Enrollment: When referring to enrollees, this means an action taken by DHB to add a Medicaid beneficiary's name to the monthly Enrollment Report following the receipt and approval by DHB of Medicaid Eligibility for a person living in the defined catchment area. When referring to providers, this means the process of submitting a credentialing application for consideration to become a provider in the PIHP Closed Network, unless the context is referring to the process of submitting an online enrollment application via NCTracks for consideration to become a provider in the NC Medicaid or Health Choice programs.
9. Medical Assistance Program (Medicaid): DHB's program to provide medical assistance to eligible citizens of the state of North Carolina, established pursuant to Chapter 58, Articles 67 and 68 of the North Carolina General Statutes and Title XIX of the Social Security Act, 42 U.S.C. 1396 et. seq.
10. NC Medicaid Program: The fee-for-service program operated by DHHS for the provision of health care services to Medicaid beneficiaries based on the payment methods set forth in the State-funded Benefits plan and the applicable policies and procedures of DHB. Enrollment into the PIHP Closed Network is distinct from enrollment into the NC Medicaid Program.
11. NCTracks: The multi-payer Medicaid Management Information System for the NC Department of Health and Human Services.
12. Network Provider: Means as defined in 42 CFR 438.2 [“Network provider means any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, or PAHP, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement.”][Per URAC N-NM13 – 17, “participating provider” applies only to contracted providers in Partners’ network.][Per NCGS § 108D-1(13), network

provider is “An appropriately credentialed provider of mental health, intellectual or developmental disabilities, and substance abuse services that has entered into a contract for participation in the closed network of one or more local management entity/managed care organizations.”]

13. OAH: North Carolina Office of Administrative Hearings.
14. Out-of-Network Provider: Any person or entity providing covered services who is not a member of the PIHP Provider Network.
15. PIHP (Prepaid Inpatient Health Plan): An entity that: (1) Provides medical services to enrollees under contract with the state agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract.
16. Provider: Any person or entity providing mental health (MH), individuals with developmental disabilities (I/DD) and/or substance use (SU) services.
17. PSV: Primary Source Verification
18. State: The state of North Carolina.
19. State Plan: The North Carolina State Plan for Medical Assistance submitted under Title XIX of the Social Security Act and N.C.G.S. §108A-54 and approved by CMS.
20. Subcontract: An agreement which is entered into by PIHP in accordance with Section 11- Subcontracts.
21. Subcontractor: Any person or entity which has entered into a subcontract with PIHP. [Per 42 C.F.R. 438.2, a network provider is not a subcontractor merely by virtue of its provider agreement with Partners.]
    a. Distinctions:
        i. Provider enrollment, credentialing and contracting are distinct. DMA screens and determines provider enrollment into and disenrollment from the North Carolina Medicaid and medical assistance plan or program and from that pool of enrolled Providers, Partners has full authority to create and manage its Closed Provider Network, including credentialing, contracting and termination.
        ii. Participating providers and network providers are providers *contracted* with Partners, so excludes applicants and non-contracted providers, even if enrolled by state or credentialed by state or an LME-MCO.

14.2.7 Identification of over/under payments: PIHP shall identify all overpayments and underpayments to Providers and shall offer providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.

DMH Contract:

6.7 Provider Disputes

The LME/MCO shall establish written procedures for dispute resolution with providers in accordance with the LME/MCO accrediting body requirements.

6.4.2 Contracting with Providers

The LME/MCO may choose not to contract with providers based upon its available funding resources, and on the LME/MCO's determination of provider qualification or need for the type of service offered by the provider. If the LME/MCO declines to contract with individual providers or provider agencies to deliver non-Medicaid funded services; it is not required to offer appeal rights. If the LME/MCO has determined that it has sufficient numbers of providers to meet the needs of its non-Medicaid members, it is not obligated to conduct credentialing reviews of

providers requesting to contract with the LME/MCO. The LME/MCO is not required to contract with providers beyond the number necessary to meet the needs of non-Medicaid members.

The Disputes policy and procedure will be reviewed annually by the Provider Council for input or suggestions and through the annual policy review process.

Regulatory References include but are not limited to-

- Rules/Regulations:
- URAC: HNM v7.1, Standards 13-17
- NC DMH/DD/SAS Contract:
- DHB Contract:
- NCQA:
- MCO P, P &Ps:

REVISION CHRONOLOGY SECTION

Revision Approval Date	*Reason for Revision*
Click here to enter a date.	Click here to enter text.
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