Section 5

Provider Disputes and Grievances

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Provider Disputes

Introduction

If you have a dispute regarding a claim you submitted to HPSM, you may participate in HPSM's Provider Dispute Resolution (PDR). This process applies to all lines of business for contracted as well as non-contracted providers with one exception. This exception is for non-contracted providers who have a dispute regarding a claim for services provided an HPSM CareAdvantage member. In this case, the dispute must be resolved following federal guidelines that apply to Medicare managed care plans which are described at the end of this Section.

If a provider is dissatisfied with aspects of HPSM's operations or with another provider's or member's activities or behaviors, the provider may submit a Provider Grievance which is also described in this Section. To understand how to appeal a denial of a service authorization, please refer to the Member Grievance and Appeals Section of this Manual.

Provider Dispute Resolution

HPSM offers the Provider Dispute Resolution (PDR) for Providers to resolve claims issues. (The PDR replaces the Claims Inquiry Form or CIF process.) You can address any of the following concerns through HPSM's Provider Dispute Resolution Process:

- Claims believed to be inappropriately denied, adjusted, or contested.
- Resolution of a billing determination or other contract dispute.
- Disagreement with a request for reimbursement of an overpayment of a claim.

Examples of problems that can be resolved through the PDR:

- If a claim has been underpaid.
- A claim was overpaid due to a payment or billing error.
- A procedure was denied as inclusive to another procedure in error.
- Corrected claim where a previous payment was made.
- Utilization management decisions once a service has been provided

Providers should submit their dispute through submission of a Provider Dispute Resolution Request form. The form requests the following information:

- Provider name
- NPI
- Provider contact information
- Identification of the disputed item, including
  - the original HPSM claim number
  - date of service

- a clear description of the basis upon which the Provider believes the payment amount, request for additional information, request for the overpayment of a claim, denial, adjustment or other actions is incorrect.

A sample of the Provider Dispute Resolution form is included in the Forms Section of this chapter. In addition, the form is available on HPSM's website at www.hpsm.org. Provider disputes can be completed online and submitted through HPSM's web site. If you would like to submit PDRs via HPSM's website, please contact the Provider Dispute Resolution Assistant at 650-616-2817 for assistance. Forms submitted through the website go directly to the Provider Disputes Unit. If you want to print the form and send it via the mail or fax, please send your PDR to the address or fax number noted below. To expedite resolution be sure to mark your envelope to the attention of Provider Disputes. :

Health Plan of San Mateo
Attn: Provider Disputes
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Fax (650) 829-2051

Time Period for Submission

Provider disputes should be sent within 365 days of the last determination for timely consideration. HPSM will return any provider dispute that is lacking the information required (as previously noted) if it is not readily accessible to HPSM. In this case, HPSM will clearly identify in writing the missing information necessary to resolve the dispute. A provider may submit an amended provider dispute within 30 working days of the date of receipt of a returned provider dispute requesting additional information.

Time Frames for Resolution

HPSM will send an acknowledgement letter to the Provider within 15 working days of receipt of the dispute. If a Provider completes and submits the PDR form online, HPSM will send an acknowledgement letter within 2 working days of receipt.

HPSM will resolve a provider dispute or amended provider dispute and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute. If an investigation shows that a claim was originally denied or paid incorrectly due to HPSM error, any interest and penalty due for late payment will be included in the claim payment. Payment will be made within 5 working days from the issuance of HPSM's determination. If the dispute involves an issue of medical necessity or utilization management, the Provider may appeal this through HPSM's Appeal Process within 60 working days after issuance of the final determination. To understand

how to appeal, please refer to the Member Grievance and Appeals Section of this Manual.

Please refer to the flow chart at the end of this Section. The flow chart provides an overview of the PDR described.

Non-Contracted Provider Dispute Resolution—CareAdvantage Only

Non-Contracted providers who want to submit a CareAdvantage Dispute have 60 calendar days from the date they receive notification of HPSM's action (EOP) to submit their dispute. However, unlike other lines of business, providers must sign a waiver of liability statement attesting that they waive any right to collect payment from the member in order for HPSM to process the dispute. If the waiver is received timely, HPSM will process the dispute within 60 calendar days from the date the waiver was received. If a waiver is not submitted, HPSM must send the dispute to the Medicare-contracted Independent Review Entity (IRE), which will issue the final dispute decision..

To facilitate this process, HPSM's Dispute Resolution Form includes the necessary waiver on the second page.

Provider Grievances

If a provider is dissatisfied with other aspects of HPSM's operations or with another provider's or member's activities or behaviors, the provider may submit a Provider Grievance:

> A **Provider Grievance** is a formal oral or written expression of dissatisfaction by a provider with any aspect of HPSM's operations, or another provider's or member's activities or behaviors – with the exception of HPSM's decisions regarding claims or service authorizations – regardless of whether any remedial action is requested or can be taken.

Filing a Provider Grievance

Provider Grievances can be submitted through the following routes:

- Verbally, by visiting HPSM in person or calling (650) 616-2850
- In writing via mail or facsimile at:

Health Plan of San Mateo
Attn: Grievance and Appeals
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Fax (650) 616-8235

Provider Grievances may be received by HPSM's Provider Services Department or by the Grievance and Appeals Coordinator.

A Provider Grievance must be filed within 365 calendar days from the date of an incident or action that is dissatisfactory.

Processing the Grievance

Once a Grievance is filed, a Grievance and Appeals Coordinator will send an acknowledgment letter within 5 calendar days. He or she may follow up with you to clarify the problem and identify your preferred course of action.

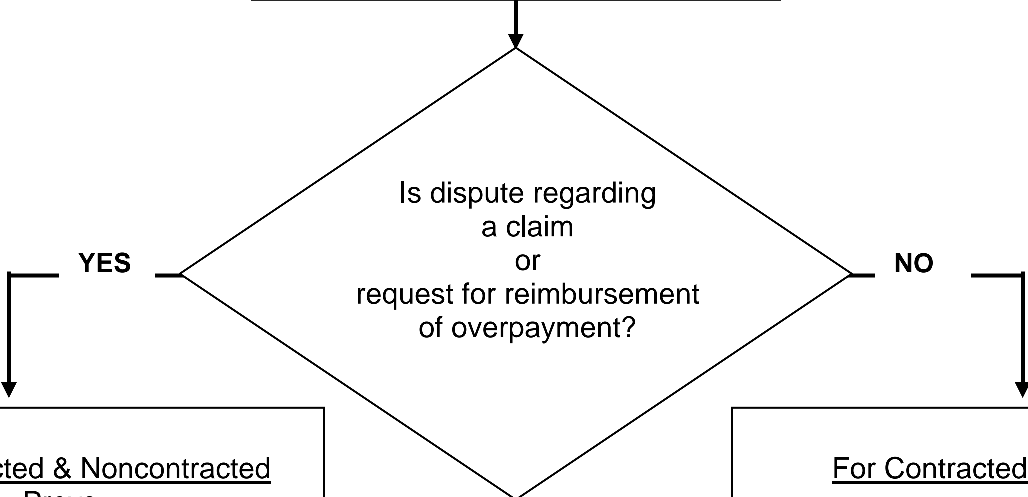
Making a Determination

A Grievance and Appeals Coordinator will issue a resolution letter within 30 calendar days of receipt of the Provider Grievance. Appropriate administrative review and follow-up will continue until all actions stated in the resolution have been completed. We will notify you of the decision in writing.

PROVIDER DISPUTE MECHANISM – Page 1

Written Provider Dispute Rec'd

- provider name
- provider ID#
- provider contact info



YES:

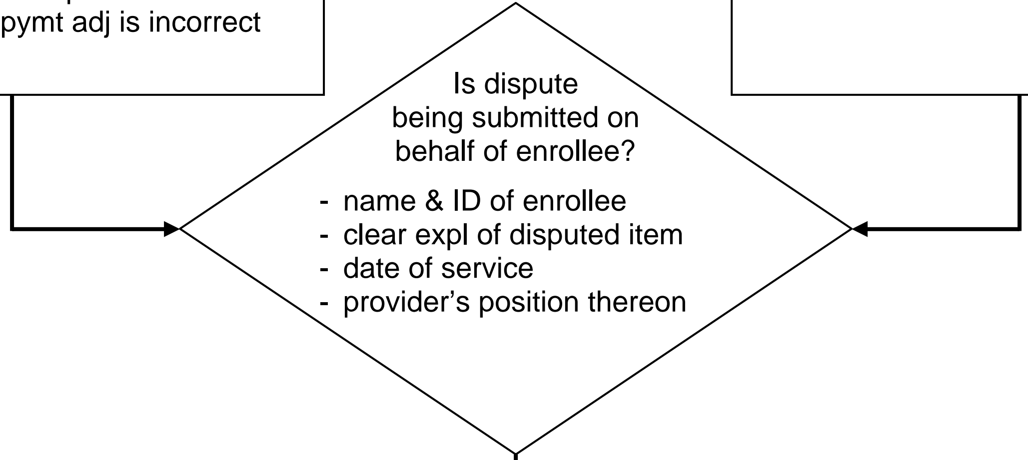
For Contracted & Noncontracted Provs

- clear ID of the disputed item
- date of service
- clear expl. of basis for provider's feeling pymt request denial contest or pymt adj is incorrect

NO:

For Contracted Providers

- clear explanation of issue and provider's position thereon



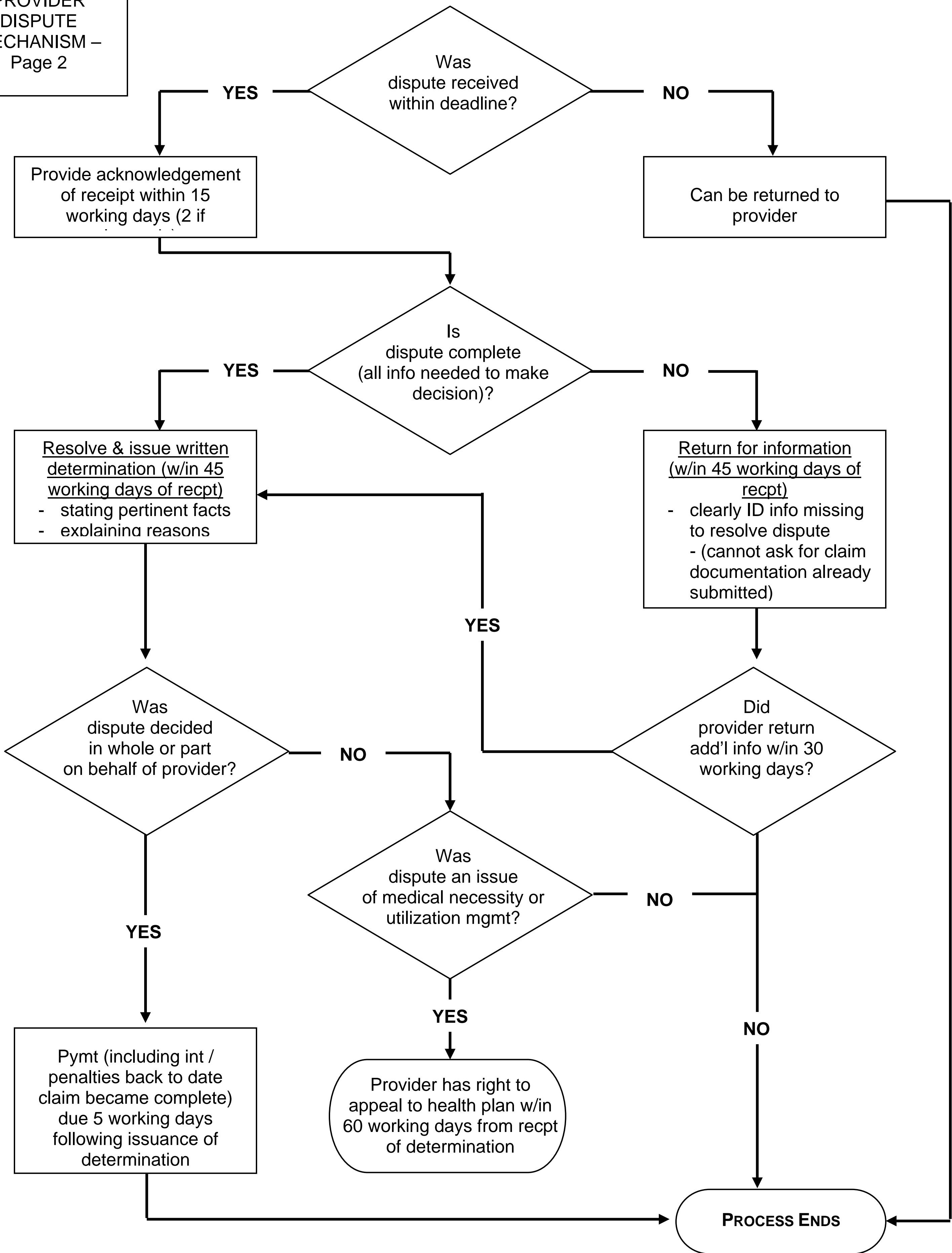
YES

Refer Dispute to HPSM's Grievance Process

- HPSM may verify the member's authorization to proceed with the grievance

NO

Date Stamp the dispute when received and process as a Provider Dispute (**SEE PAGE 2**).


PROVIDER DISPUTE MECHANISM – Page 2
Was dispute received within deadline?
YES
NO
Provide acknowledgement of receipt within 15 working days (2 if
Can be returned to provider
Is dispute complete (all info needed to make decision)?
YES
NO
Resolve & issue written determination (w/in 45 working days of recpt)
- stating pertinent facts
- explaining reasons
Return for information (w/in 45 working days of recpt)
- clearly ID info missing to resolve dispute
- (cannot ask for claim documentation already submitted)
YES
Was dispute decided in whole or part on behalf of provider?
NO
Did provider return add'l info w/in 30 working days?
Was dispute an issue of medical necessity or utilization mgmt?
NO
YES
YES
NO
Pymt (including int / penalties back to date claim became complete) due 5 working days following issuance of determination
Provider has right to appeal to health plan w/in 60 working days from recpt of determination
PROCESS ENDS

PROVIDER DISPUTE RESOLUTION REQUEST

By submitting this form, I agree not to bill the member(s) named on it.

***Initial here and sign at bottom of form*: __________**

INSTRUCTIONS

- **For routine follow-up,** please contact Health Plan of San Mateo's Claims Department at (650) 616-2056.
- **To request dispute resolution**, please complete the form below. **Fields with an asterisk (*) are required.**
- Be specific when completing the *Description of Dispute* and *Expected Outcome.*
- Provide additional information to support the description of the dispute. You do not need to include a copy of a claim that was previously processed.
- **Fax** the front and the back of the completed form to **(650) 829-2051** or **mail** it to:

  Attn: Provider Disputes
  Health Plan of San Mateo
  701 Gateway Boulevard, Suite 400
  South San Francisco, CA 94080

*Provider Name:	*NPI #:
Provider Address:	
Provider Type: ☐ PCP ☐ Specialist ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other (please specify):	
Line of Business: ☐ Medi-Cal ☐ CareAdvantage ☐ Healthy Families ☐ HealthWorx ☐ ACE ☐ Healthy Kids	☐ Contracted ☐ Non-Contracted ***(see back of form, for CareAdvantage only)***

*Claim Information ☐ Single ☐ Multiple "like" claims (complete a Supplemental Form) *Total number of claims:* ______

*Member Name		Date of Birth:
*Member ID Number:	Original Claim ID Number (if multiple claims, use attached spreadsheet):	
Service "From/To" Dates **Required for Claim, Billing, and Reimbursement of Overpayment Disputes*	Original Claim Amount Billed:	Original Claim Amount Paid:

Dispute Type ☐ Denied Claim ☐ Underpayment of a Claim ☐ Request for Reimbursement of Overpayment ☐ Appeal of Medical Necessity / Utilization Management Decision ☐ Contract Dispute ☐ Other (please specify):

* Description of Dispute (continue on back if needed):
Expected Outcome:

		( )
Contact Name (please print)	Title	Phone Number
		( )
Signature	Date	Fax Number

☐ Check here if additional information is attached. *(Please do not staple additional information.)*

For Health Plan Use Only: Tracking #:	Provider ID #:

HEALTH PLAN OF SAN MATEO PROVIDER DISPUTE RESOLUTION REQUEST (SIDE 2)

☐ **I am NOT a CareAdvantage Contracted Provider.** ***(Please complete and sign the waiver below.)***

☐ **I am a Contracted Provider.** ***(Please disregard the waiver.)***

HEALTH PLAN OF SAN MATEO
WAIVER OF LIABILITY STATEMENT

Member Name	Member ID / Member HIC Number
Provider Name	Dates of Service
Health Plan of San Mateo	
Health Plan	

As a provider of the mentioned member(s) , I hereby waive any right to collect payment from the mentioned member(s) for the mentioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature	Date

H5428_CA_3070_08 (approved 02/08/2008)

Description of Dispute (continued)

For Health Plan Use Only: Tracking #: Provider ID #:

PROVIDER DISPUTE RESOLUTION REQUEST

Supplemental Form for Use with Multiple "Like" Claims

By submitting this form, I agree not to bill the member(s) named on it.

Initials of signatory on main form*: ________ *For CareAdvantage only, also see back of form.

This form provides additional information for the following dispute resolution request:

Provider Name	**To cross-reference this supplemental form with the main form, please give member's name from main form:**	**Date**

#	Member Last Name - - - - - - - - - - - - Member First Name	DOB	Health Plan ID #	Original Claim ID #	Service "From/To" Dates	Original Claim Amount Billed - - - - - - - - - - - Original Claim Amount Paid	Expected Outcome
1							
2							
3							
4							

☐ Check here if additional information is attached. *(Please do not staple additional information.)*
This is Supplemental Form # _____of _____ supplemental forms for this request.

For Health Plan Use Only
Tracking #:
Provider ID #:

HEALTH PLAN OF SAN MATEO
PROVIDER DISPUTE RESOLUTION REQUEST
SUPPLEMENTAL FORM (SIDE 2)

☐ **I am NOT a CareAdvantage Contracted Provider.** ***(Please complete and sign the waiver below.)***

☐ **I am a Contracted Provider.** ***(Please disregard the waiver.)***

HEALTH PLAN OF SAN MATEO
WAIVER OF LIABILITY STATEMENT

Member Name #1 from reverse side	Member ID / Member HIC Number
Member Name #2 from reverse side	Member ID / Member HIC Number
Member Name #3 from reverse side	Member ID / Member HIC Number
Member Name #4 from reverse side	Member ID / Member HIC Number
Member Name #5 from reverse side	Member ID / Member HIC Number
Provider Name	Dates of Service

Health Plan of San Mateo

Health Plan

As a provider of the mentioned member(s) , I hereby waive any right to collect payment from the mentioned member(s) for the mentioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature	Date

H5428_CA_3070_08 (approved 02/08/2008)

For Health Plan Use Only: Tracking #:	Provider ID #: