

COUNTY OF HUMBOLDT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH

POLICY NO. :	POLICY TITLE:	EFFECTIVE DATE:
0704.540	PROVIDER PROBLEM RESOLUTION PROCESS	05/01/2006
PROGRAM:	PERFORMANCE MANAGEMENT UNIT - QUALITY IMPROVEMENT	REVISION DATES: 6/29/15
AFFECTS:	QI AND ORGANIZATIONAL PROVIDERS	REVIEW DATES: 03/12/10; 07/16/10; 03/31/11; 9/30/13; 02/06/14; 11/1/16, 8/30/19

POLICY Good relations between the Humboldt County Department of Health and Human Services - Behavioral Health (DHHS-BH) and the Providers are essential to the effective delivery of specialty mental health services. The following outlines the mechanism by which Providers may address their concerns to DHHS-BH on any issue including payment for services, service authorization and processing delays.

DEFINITION(S) None

- PROCEDURE**
1. Grievances and Appeals must be in writing and submitted to:

Quality Improvement Coordinator
DHHS-BH
720 Wood Street
Eureka, CA 95501
Phone: (707) 268-2955 Option 1
Fax: (707) 476-4096
Email: BH-QI_QA@co.humboldt.ca.us
 2. Providers may use the QI-85 Provider Problem Resolution Request Form.
 3. The DHHS-BH Provider Problem Resolution Process provides for two types of problem resolution:
 - 3.1. Grievance - an expression of dissatisfaction with DHHS-BH regarding contract interpretation, policies, authorization process, timeliness of payment, or any situation believed to be unjust or inequitable in the relations between the provider and the DHHS-BH.
 - 3.2. Appeal – an appeal of denial or modification of an authorization request, or denial of payment for services by DHHS-BH.
 - 3.2.1. Recoupment – occurs when there has been an overpayment by DHHS-BH, or DHHS-BH has paid a Provider and later determines that the Provider should not have been paid for services claimed.
 4. GRIEVANCE PROCEDURE
 - 4.1. There shall be a sixty (60) calendar day resolution period during which time the responsible DHHS-BH staff shall review the grievance issue(s) and make a decision regarding resolution. The decision will be communicated in writing to the Provider within the sixty (60) calendar day timeframe.
 - 4.2. If no satisfactory resolution is proposed, the Provider may request review of the Grievance by the Behavioral Health Director, whose decision shall be final.
 5. APPEAL PROCEDURE
 - 5.1. A provider may appeal a denied or modified request for treatment authorization or a denial of payment of a claim or request for recoupment within ninety (90) calendar days of the

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- provider's receipt of the decision. The appeal must be in writing and include supporting documentation. Supporting documentation shall include, but is not limited to:
- 5.1.1. A copy of the original decision received from DHHS-BH.
 - 5.1.2. Any documentation supporting allegations related to timeliness, if at issue, including copies of fax records, phone records, or memos.
 - 5.1.3. Clinical records supporting the existence of medical necessity, if at issue.
 - 5.1.4. A summary of reasons why DHHS-BH should have approved treatment authorization or a more intensive level of treatment.
 - 5.1.5. A contact person(s) name, address and phone number.
- 5.2. There shall be a sixty (60) calendar day resolution period during which time DHHS-BH staff shall review the appeal and make a decision regarding resolution. The decision will be communicated in writing within the sixty (60) calendar day timeframe, and will address each issue raised by the provider, and any action required by the provider to implement the decision.
- 5.3. If the appeal concerns the denial or modification of a payment authorization request due to lack of medical necessity, DHHS-BH shall utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.
- 5.4. If the Appeal is granted, the Provider has thirty (30) calendar days from the date of receipt DHHS-BH's decision to submit a revised request for payment authorization.
- 5.5. If DHHS-BH does not respond within sixty (60) calendar days to the appeal, the appeal shall be considered denied.
- 5.6. Hospital Providers: If payment authorization for emergency services is denied for lack of timely notification or submission of the payment request or for lack of medical necessity, the Provider has the right to appeal through the State Department of Health Care Services (DHCS). If a provider chooses to do so, the appeal shall be submitted in writing, along with supporting documentation, within thirty (30) calendar days of the date of receipt of the non-approval of payment or within thirty (30) calendar days of DHHS DHHS-BH's failure to act on the request. Supporting documentation shall include, but not be limited to:
- 5.6.1. Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records, or memos.
 - 5.6.2. Clinical records supporting the existence of medical necessity if at issue.
 - 5.6.3. A summary of reasons why DHHS-BH should have approved the payment authorization.
 - 5.6.4. A contact person(s) name, address and phone number.
 - 5.6.5. Copies of the above will also be sent to DHHS-BH Health Quality Improvement Coordinator at the above address.
- 5.7. Exception to this appeals process: Providers who receive payment from the state's fiscal intermediary, currently Xerox State Healthcare, LLC (Xerox), may file appeals concerning the processing or payment of those claims directly to the fiscal intermediary.
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FORM(S)/
ATTACHMENTS

[QI-85 Provider Problem Resolution Request Form](#)

REFERENCE

[CCR Title 9, Div. 1, Chapter 11, Subchapter 5, Art. 3, Sections 1850.305, .310, .320, .325, and .350](#)
[CCR Title 28, Div. 1, Chapter 2, Art. 8, Section 1300.70](#)
[CCR Title 9 Section 1810.440 \(a\)\(5\)](#)
[CFR Title 42 Section 438.416](#)
