	Provider Dispute Resolution			
	Chapter:	Financial Management	**Policy #**	3-4-4
	Section:	Purchasing	**Revision #**	6

I. **PURPOSE:** To establish policy and procedures to ensure potential providers and current paneled/contracted providers with West Michigan Community Mental Health (WMCMH) have access to timely dispute resolution on decisions for non-service-related issues including:

a. Denial or suspension of provider panel status with cause
b. Request for Proposal (RFP) awards/denials
c. Claims payments and authorizations
d. Reduction, suspension or adjustments of payments to providers
e. Results from provider monitoring activities and/or results reported on the Provider Quality Report
f. A sanction or decision to place provider(s) on provisional status
g. Credentialing or re-credentialing decisions
h. Other non-clinical issues

II. **APPLICATION:** All contracted providers who have applied for or have active status and/or active contract on the WMCMH Provider Panel.

III. **REQUIRED BY:** Michigan Department of Health and Human Services (MDHHS) and Lakeshore Regional Entity (LRE) Contract (*LRE Policy 4.7 – Network Provider Appeals and Grievances*) and accrediting bodies.

IV. **DEFINITIONS:**

Dispute Resolution: The process for resolving differences between two or more parties or groups. This process could be informal or formal. The resolution seeks to achieve fairness for all participants.

Grievance: An expression of dissatisfaction by a provider regarding a perceived inequitable issue, aspects of interpersonal relation or other related issues.

Appeal: A formal process established so that providers may request reconsideration of an action or decision that has been made by WMCMH.

Adverse Notification: A written notice, that documents a denial of authorization or claim by any means; a reduction, suspension or adjustment to a claim; or the denial of participation as a panel provider.

Active Status: A provider that has submitted their Provider Application and meets the requirements/accepted to the WMCMH Provider Panel.

Active Contract: A contract that has been signed between the provider and WMCMH for services.

Adverse Action: An action taken by WMCMH which may include a denial of authorization or claim; a reduction, suspension, or adjustment to a claim; or the denial of participation as a panel provider. A determination could be made based upon Medicare/ Medicaid sanctions, state sanctions or limitation licensure, registration or certification or beneficiary concerns.

V. **POLICY**: West Michigan Community Mental Health will provide for a fair and efficient process for resolving provider complaints (i.e., grievances and appeals) that is compliant with State, Federal and Balanced Budget Act regulations as indicated in the Michigan Department of Health and Human Services (MDHHS) Contracts and Prepaid Inpatient Health Plan (PIHP) Contract.

VI. **PROCEDURES**:

A. Provider Grievance and Appeals will be coordinated through the Provider Network Coordinator.

B. Right to Dispute – Providers will be notified of their right to request dispute resolution any time an adverse action takes place.

C. Informal Dispute Resolution – Providers are encouraged to resolve problems and disagreements with the appropriate WMCMH staff person prior to making a formal request for dispute resolution. WMCMH staff can be contacted regarding these disputes:

Type of Dispute	Administrative Office (231) 845-6294
Denial or suspension of provider panel status with cause	Director of Network, QI, and Compliance and/or Chief Executive Officer
Request for Proposal (RFP) awards/denials	Provider Network Coordinator
Claims payment and authorizations	Finance & Reimbursement Departments
Reduction, suspension or adjustments of payments to providers	Finance & Reimbursement Departments
Results from provider monitoring activities and/or results reported on the Provider Summary Report	Provider Network Coordinator
A sanction or decision to place provider on provisional status	Director of Network, QI, and Compliance and/or Clinical Oversight Committee
Credentialing or re-credentialing decisions	Provider Network Coordinator

D. Formal Dispute Resolution

1. When a dispute cannot be resolved informally, the provider has the option of filing a formal written request for dispute resolution. Written request for dispute resolution should be directed to the WMCMH Provider Network Coordinator.

2. WMCMH reserves the right to use on-site claims, utilization, provider monitoring reviews and interviews with involved parties when reviewing dispute to make a decision.

3. Grievance

3.1 A grievance can be submitted in writing or verbally to the WMCMH Provider Network Coordinator

3.2 WMCMH must notify the provider in writing of a decision regarding a grievance within 30 calendar days of receipt of the request, and offer an appeal request if applicable.

4. Appeals

Appeals of decisions made by WMCMH through the dispute resolution process must be filed in writing within 30 calendar days after receiving adverse notification from WMCMH. Written request for appeal can be made to the WMCMH Provider Network Coordinator. All claims are permanently denied after one year (365 days) from the date of service.

4.1 Level 1 Appeal – The Appeal shall be reviewed by the Provider Network Coordinator, in coordination with applicable WMCMH department overseeing the area the appeal addresses. A written decision will be issued within 30 calendar days to the provider by the department making the decision. Appeals involving more than $5,000 will automatically be moved to a Level 2 Appeal.

4.2 Level 2 Appeal – The provider has the option of filing a Level 2 Appeal, if dissatisfied with the decision of a Level 1 Appeal. A level 2 Appeal must be filed in writing within 20 calendar days to the Chief Executive Officer. A written decision will be issued by the Chief Executive Officer to the provider within 30 calendar days.

4.3 Level 3 Appeal – The provider has the option of filing a Level 3 Appeal, if dissatisfied with the decision of a Level 2 Appeal. A level 3 Appeal must be filed in writing within 20 calendar days to the WMCMH governing board. A written decision will be issued by the governing board to the provider within 30 calendar days.

If the provider fails to submit a request for appeal of the dispute resolution decision within 20 calendar days, the provider will be deemed to have accepted WMCMH's determination and will have waived all further internal and external processes regarding the issues.

The provider must exhaust all WMCMH appeals processes before pursuing an appeal with the LRE. Disputes that cannot be resolved between WMCMH and the Provider shall be reviewed by the LRE consistent with LRE Policy 4.7 Network Provider Dispute Resolution.

E. Monitoring **–** Data will be collected and reviewed at least quarterly on the type, frequency, and resolution of appeals to affect changes within WMCMH, if necessary. Additional reporting requirements of this data may be necessary.

VII. **SUPPORTING DOCUMENTS**:

LRE Policy 4.7 – Network Provider Dispute Resolution
WMCMH Policy – 4-2-1 Code of Ethics
WMCMH Policy – 2-1-2 Credentialing

VIII. **POLICY/PROCEDURE REVIEW:**

REV#	APPROVED BY	Policy/Procedure	DATE
			10/2019
2	Admin Policy Comm	Procedure	07/2021
3	Admin Policy Comm	Procedure	07/2022
4	Admin Policy Comm	Procedure	06/2023
5	Admin Policy Comm	Procedure	06/2023
6	Admin Policy Comm	Procedure	06/2024
***Board Approval Date**: 11/21/2017*			

IX. **CHIEF EXECUTIVE OFFICER ENDORSEMENT:**

I have reviewed and approved policy # 3-4-4 Revision # 6.

CEO: Lisa A. Williams Approval Signature:_____