Provider Dispute Resolution Mechanism

Whenever a provider claim is denied, contested or adjusted (claim not paid at 100% of billed charges), Western Health Advantage (WHA), or one of its Contracted Medical Groups/IPAs (CMGs), will inform the provider in writing of the availability of the provider dispute resolution (PDR) mechanism and the procedures for obtaining forms and instructions for filing a provider dispute. This process is available for use by both contracted and non-contracted providers who disagree with the plan's or CMG's decision.

Plan Level Disputes

Provider disputes for denied, contested or adjusted claims issued by WHA should be filed with WHA and not with the CMG. For PDR inquiries or filing instructions, you can call WHA at 916.563.2250, 888.563.2250 toll-free or 888.877.5378 TTY/TDD. Or you can mail a written request, along with your denial notice, a brief description of your issue and any other relevant information, to: Western Health Advantage, Attn: Provider Dispute Resolution
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833

For your convenience, you can download and complete the attached standardized Provider Dispute Resolution Request form.

Provider disputes for claims must be received within 365 days from the most recent action on the issue. In cases of inaction, disputes must be received within 365 days after the time for contesting or denying the claim has expired. Disputes received after this deadline will be rejected and returned to the provider.

WHA will acknowledge a written dispute within 15 working days of receipt and make a final determination within 45 working days. If a dispute is returned for additional information, you have 30 working days to provide the information to WHA. If the information is received timely, the dispute will be processed within 45 working days from date of receipt of the additional information. If the additional information is not received or not received timely, the dispute will be closed.

Multiple claims that are substantially similar can be filed in batches as a single provider dispute in a bundled notice with individual claims numbered and identified by the original claim number. The attached Provider Dispute Resolution Request for Multiple "Like" Claims form is provided for your use.

If a dispute is submitted by a provider on behalf of an enrollee, it will be handled through WHA's grievance process, rather than the provider dispute process.

continued

Contracted Medical Group/IPA (CMG) Level Disputes

Provider disputes involving denied, contested or adjusted claims issued by a CMG should be filed with the CMG rather than with WHA. Contact the CMG directly for information about their PDR process or for a copy of their Provider Dispute Resolution Request forms, or visit their website. Provider disputes involving issues of medical necessity or utilization management can be appealed to WHA within 60 working days after issuance of final determination by the CMG.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-888-563-2250 (TTY/TDD 1-888-877-5378)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function) or if your grievance involves and/or is related to cancellation, rescission, or renewal of your plan enrollment, subscription, or contract, you can contact the California Department of Managed Health Care directly at any time without first filing a grievance with us.

Provider Dispute Resolution Request

Western Health Advantage

Mail to: 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Attention: Provider Dispute Resolution

Questions: 916.563.2250 or 888.563.2250 toll-free or 888.877.5378 TTY

Please complete the below form. 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. Do not include a copy of a claim that was previously processed. Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.

Provider Information

*Provider NPI #_____ Provider Tax ID # _____

*Provider Name _____

Address _____ Suite # _____

City, State, Zip _____

Phone _____

Provider Type ❑ MD ❑ Mental Health Professional ❑ Mental Health Institutional ❑ Hospital ❑ ASC ❑ SNF ❑ DME
❑ Rehab ❑ Home Health ❑ Ambulance ❑ Other (please specify)_____

Claim Information

❑ Single ❑ Multiple "LIKE" Claims (complete attached spreadsheet) Number of Claims _____

*Patient Full Name (First Middle Initial Last) _____

Date of Birth _____ *Health Plan ID# _____

Patient Account # _____ Original Claim ID# _____
(If multiple, use spreadsheet)

Service "From/To" Date: (*Required for Claim, Billing and Reimbursement of Overpayment Disputes) _____

Original Claim Amount Billed $_____ Original Claim Amount Paid $_____

Dispute Type ❑ Claim ❑ Appeal of Medical Necessity/Utilization Management Decision

❑ Seeking Resolution of a Billing Determination ❑ Contract Dispute

❑ Disputing Request for Reimbursement or Overpayment ❑ Other_____

*Description of Dispute _____

_____

_____

Expected Outcome _____

_____

_____

Print Name _____ Title _____

Signature _____ Date _____

Phone _____ Fax _____

❑ Check here if additional information is attached (please do not staple)

OFFICE USE ONLY Tracking # _____ Prov. ID#_____ Contracted ❑ Yes ❑ No

Provider Dispute Resolution Tracker

Western Health Advantage

INSTRUCTIONS

This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution. The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

Tracking # _____ Provider ID or NPI # _____

a. Provider Name _____ b. Contracted Provider ❑ Yes ❑ No

c. Date Dispute Received (Date Stamped) _____

d. Date of Initial Payment or Action _____

e. Was Dispute Received Within Time Frame? (c–d) ❑ Yes ❑ No (If No, should be returned to provider without action)

f.1. Dispute Type ❑ Claim ❑ Appeal of Medical Necessity/UM Decision ❑ Billing Determination

❑ Overpayment Dispute ❑ Contract Dispute ❑ Other (Please specify)_____

f.2. Provider Type ❑ Professional ❑ Institutional ❑ Other _____

g. Date Dispute Acknowledged _____ h. Turnaround Time (g–c)_____

TYPE OF LETTER SENT List the various ICE letters as applicable

If no additional information requested:

j. Date of Action _____ k. Action Turnaround Time (j–c) _____

l. Type of Action ❑ Upheld ❑ Overturned ❑ Other _____

If additional information requested:

m. Date Additional Info Requested _____ n. Turnaround Time (m–c) _____

o. Date Addition Info Received _____ p. Receipt Turnaround Time (o–c) _____

q. Date of Action _____ r. Action Turnaround Time (q–o) _____

s. Type of Action ❑ Upheld ❑ Overturned ❑ Other _____

Complete description of determination rationale _____

_____

_____

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_____

_____

_____

Provider Dispute Resolution Request

FOR USE WITH MULTIPLE "LIKE" CLAIMS (Claims disputed for the same reason)

Western Health Advantage

	*Patient Last Name	*Patient First Name	Date of Birth	*Health Plan ID#	Original Claim ID#	*Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

❑ Check here if additional information is attached (please do not staple)

Page _____ of _____