PDR-001	Provider Appeals and Provider Dispute Resolution Policy	
Effective Date: January 1, 2021	POLICY AND PROCEDURE	
Committee Approval: 04/12/2021 Previous Versions: See revision history on last page		
CCR title 28, §1300.71, CA AB 1455 Medicare Advantage: See HMO Act §§1852(a)(2)(A)		

Provider Appeals and Provider Claims Dispute Resolution Policy

This Provider Dispute Resolution (PDR) policy applies to claims payment responsibility delegated to Canopy Health and not retained by Canopy Health's upstream health plans, per the Division of Financial Responsibility (DOFR) document for each plan. It applies to all disputes between Canopy Health or its delegated medical groups/IPAs and contracted providers and all claims payment disputes between Canopy Health or its delegated medical groups/IPAs with non-contracted providers.

Commercial Disputes

A "Provider Dispute" is a provider's written notice challenging, appealing or requesting reconsideration of a claim (or a bundled group of similar multiple claims that are individually numbered) that has been paid, denied or adjusted and is seeking resolution of a billing determination or other contract dispute, or is disputing a request for reimbursement of an overpayment of a claim. Notice of the appeal

process and certain specified information must be included in all notices to providers regarding payment or denial of a claim.

A Provider Dispute must be submitted in writing via mail. Submission of a letter or any PDR dispute form (including ICE, UHC, or HN form) fits the "in-writing" requirement. If the dispute involves a claim, the original claim number must be included. The initial dispute must be submitted to the entity with whom the provider has the dispute. The provider should be notified of the provider dispute process describing the right to file a formal dispute in writing, including information on where to send the dispute (physical address, email, and/or Fax) and where to obtain a copy of the Provider Dispute Resolution form on the EOB.

Provider Disputes must be submitted 365 calendar days from the date of the last action on the claim, billing or contractual issue. Incomplete disputes will be returned to the provider for completion within 30 working days.

The Provider Dispute will be acknowledged within 2 working days for disputes submitted electronically and 15 working days of receipt for those submitted on paper, unless the dispute is resolved within that timeframe. The dispute will be resolved within 45 business days of receipt of the complete, written dispute.

Provider Disputes will be resolved and a written determination will be sent within 45 working days of receipt of the complete, written dispute. If the provider dispute involves a claim and it is determined to be in favor of the provider the payment will consist of any outstanding money due, including interest and penalties within 5 working days of the decision. Accrual of the interest and penalties will commence on the day following the date by which the claim should have been processed.

Copies of provider disputes and the determinations, including all notes, documents and all other information that was used to reach the decision will be retained for at least 5 years.

If the provider is not satisfied with the initial determination of the Provider Dispute and the determination is related to Medical necessity or UM the provider has the right to appeal directly to Canopy Health within 60 working days of receipt of the written determination. All appeals regarding claims must be submitted and processed using the same claim number assigned to the original claim. The Chief Medical Officer will be responsible for oversight of this Canopy Health review process and will make a final determination regarding the appeal.

Neither Canopy Health, nor its delegates, will discriminate or retaliate against a provider for filing an appeal. No charge will be applied for the appeal but the costs incurred by the provider for filing a Provider Dispute will not be reimbursed.

Canopy Health's delegated providers must make records of provider appeals available to Canopy Health. Canopy Health may take over the provider's appeal process if the capitated provider is not meeting the requirements of state and/or federal regulations related to Provider Disputes.

Medicare Disputes

A "Provider Dispute" is a Non-Contracted provider's first level written notice disputing the amount paid for a covered service that is less than the amount that would have been paid under Original Medicare or disputes the decision to make payment on a more appropriate code (down coding).

This Medicare Provider Dispute Resolution process does not include

- Payment disputes from Contracted Providers.
- Local and National Coverage Determinations
- Medical Necessity Determinations
- Payment Disputes for which no initial determination has been made.

The submission of a first level Provider Dispute by Medicare HMO Out-of-Network Providers must be made within 120 calendar days after the notice of the initial determination. Canopy Health may allow an additional 5 calendar days for mail delivery.

When a Non-Contracted provider has failed to establish a good cause for late filing of a provider dispute, the payer dismisses the provider dispute as untimely filed. The resolution to the Provider must explain the reason for the dismal and that the provider or supplier has up to 180 calendar days from the date of the dismissal notice to provide additional documentation for good cause.

If provider submits evidence within 180 calendar days of dismissal that supports a finding of good cause for late filing, the payer makes a favorable good cause determination and issues a redetermination. If the payer does not find good cause, the dismissal remains in effect and payer issues a letter or PRA explaining that good cause has not been established.

When necessary documentation has not been submitted for review of the Provider Dispute, the payer advises the provider to submit the required documentation. Request can be made via phone or in writing. If the additional documentation that was requested is not received within 14 calendar days from the date of request, the payer conducts the review based on the original information received.

In the event that the documentation is received after the 14 calendar day deadline, the payer must consider the evidence before making and issuing the final determination.

Dispute decision must be made within 30 calendar days from the date the payment dispute is first received. Interest does apply if applicable to adjustments.

The Non-Contracted provider may request an independent decision from Canopy Health if the provider has received an initial dispute decision from the payer's internal dispute process or if the payer has not responded within 30 calendar days from the date the payer received the dispute. This information is provided in the Dispute Resolution Upheld Letter.

To support the review of these second level disputes Canopy Health may request the original documentation from the Medical group/IPA (payer) on behalf of the payer that processed the first level provider dispute. All requested materials must be received by Canopy Health on or before the eighth day of the request. Canopy Health will issue a decision within 60 calendar days.

If Canopy Health's review results in additional payment to the provider, Canopy Health will notify the payer of the decision to change the reimbursement and the payer will adjust the claim(s). Payer shall make payment on the identified claim(s) within 30 calendar days of Canopy Health's decision. The payer is required to send confirmation of payment to Canopy Health within 7 calendar days of payment.

Copies of provider disputes and the determinations, including all notes, documents and all other information that were used to reach the decision are scanned and must be retained for not less than 10 years.

Information on submitting first level internal payment disputes to the payer is communicated to the non-contracted provider as follows:

- Payer's website should have the CMS Provider Dispute Resolution Process detailed with timeframes, forms and 2nd level appeal process stated.
- Non-contracted providers should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records or other documentation that supports the provider's argument for reimbursement.
- Non-contracted providers must mail the reconsideration to the plan. The address is posted on the provider portal.

All Provider Disputes

Quarterly reports of provider disputes are reviewed by Canopy Health to ensure timely resolution of disputes. Annual audits of Provider Disputes are conducted to ensure the delegates processes are timely and accurate.

Revision History:

Version Date	Edited By	Reason for Change
1/2021	R. Scott	Clarify Canopy Health role in resolving Provider Disputes.