SANDHILLS CENTER

# PARTICIPATING PROVIDER VIOLATIONS AND DISPUTE RESOLUTIONS (Medicaid & State Funded)

# SCOPE OF DISPUTE RESOLUTION PROCEDURE

The dispute resolution process is for Sandhills Center Network Providers that wish to dispute a Sandhills Center decision/action related to Administrative Matters and/or those related to Professional Competence or Conduct.

# PROCEDURE FOR PANEL DISPUTES CONCERNING PROFESSIONAL COMPETENCE OR CONDUCT

SHC is made aware of a provider's desire to dispute a decision/course of action by SHC through the submission of a completed "Provider Request for Dispute Resolution of an Action form".

- The form and supporting documentation must be submitted in writing to the Network Director within 7 calendar days (Medicaid) or 30 calendar days (State Funded) of notification of the decision/action by SHC.

- Return receipt should be requested whether delivered by mail or in person.

# PROCEDURE FOR PANEL DISPUTES CONCERNING PROFESSIONAL COMPETENCE OR CONDUCT

Providers are notified in writing by registered mail verifying receipt of the Dispute Resolution of an Action Form.

- Reimbursement will continue during the reconsideration process unless the provider is cited for gross negligence or suspected of committing fraud or abuse. Note: continued reimbursement is likely to increase any payback amount due if the action is upheld.
- The provider may be required to submit documentation for services delivered in order to continue to receive reimbursement during the reconsideration process.

# PROCEDURE FOR PANEL DISPUTES CONCERNING PROFESSIONAL COMPETENCE OR CONDUCT

The Network Operations Director or designee in consultation with the Chief Clinical Officer/Medical Director convenes the First Level Dispute Panel.

Panel Membership consists of Network Operations Director & at least three qualified individuals, which will consist of Sandhills Center staff & a participating provider who is a clinical peer who was not involved in the action or decision that led to the dispute and has adequate clinical expertise to evaluate the issue(s) in question.

If necessary the First Level Panel will make an ad hoc appointment for a clinical peer if one is not available within the Network.

# PROCEDURE FOR PANEL DISPUTES CONCERNING PROFESSIONAL COMPETENCE OR CONDUCT

Any identifying information will be "blinded" prior to review by providers participating on the Panel:

- The Panel reviews the information submitted by the provider and a decision is rendered based on majority vote within 14 calendar days of the receipt of the request.
- The Panel responds by registered mail return receipt requested within 7 calendar days for (Medicaid) & 30 days for (State Funded), outlining the decision and further steps in the dispute process.

# PROCEDURE FOR PANEL DISPUTES CONCERNING PROFESSIONAL COMPETENCE OR CONDUCT

SHC's Chief Executive Officer, Finance Department, Network Department, Quality Management, and Corporate Compliance will be advised of the final decision from the First Level Panel.

- All paybacks are due & payable by the provider upon completion of the reconsideration. All payments to the provider shall cease unless and until the required payback is paid in full.
- Paybacks shall be paid by withholding reimbursement payments due to the provider or by direct repayment to SHC, as specified in an approved payment plan.
- Approval of a payback payment plan shall be made by the Finance Director in writing.
- All payments due to the provider shall continue to be withheld until either the payback is paid in full or a payback payment plan is approved in writing.

# PROCEDURE FOR PANEL DISPUTES CONCERNING PROFESSIONAL COMPETENCE OR CONDUCT

If the provider presents information to challenge the findings of the First Level Dispute Panel, a Second Level Dispute Panel will be convened.

The provider has 7 calendar days (Medicaid), 30 calendar days (State Funded) from receipt of the First Level Panel response to submit the request to the Network Director with any new supporting documentation for reconsideration by the Second Level Panel.

# PROCEDURE FOR PANEL DISPUTES CONCERNING PROFESSIONAL COMPETENCE OR CONDUCT

The same review process will be followed as in the first panel review. However, clinical peers served in the first review will not serve on the Second Level Panel for the same dispute. New clinical peers will be appointed.

# PROCEDURE FOR PANEL DISPUTES CONCERNING PROFESSIONAL COMPETENCE OR CONDUCT

If the provider is not satisfied with the final SHC decision involving Medicaid funded services, the provider may file a Petition for Reconsideration Review with the Office of Administrative Hearings at the following address:

Hearings Division
Office of Administrative Hearings
6714 Mail Service Center
Raleigh, NC 27699-6714

# PROCEDURE FOR PANEL DISPUTES CONCERNING PROFESSIONAL COMPETENCE OR CONDUCT

Medicaid Appeals are governed by 10A NCAC 22J.0101 et seq. which gives the provider the right to file an appeal with the OAH within thirty (30) calendar days of the receipt of the final notification from SHC. If the request is not received within the 30 days, SHC's decision is considered final. The request for consideration review must be in writing, signed by the provider, contain provider's name, address, and telephone number. It must state the specific reason for the request and mailed to the address above.

# PROCEDURE FOR PANEL DISPUTES CONCERNING PROFESSIONAL COMPETENCE OR CONDUCT

Further appeals of the LME/MCO decision to the OAH will follow the process identified in the Rules set forth by the OAH, pursuant to Chapter 150B of the General Statutes.

# PROCEDURE FOR PANEL DISPUTES CONCERNING PROFESSIONAL COMPETENCE OR CONDUCT

If the provider is not satisfied with the decision involving State funded services, an appeal may be made to the State Mental Health, Developmental Disabilities, and Substance Abuse Appeals Panel under G.S. 122-151.4.

Providers not satisfied with the decision must file an appeal using the procedure in Session Law 2009-526, Section 10.15 (A). (e2) for appeals filed on or after July 1, 2008 and not GS 122-151.4.

# PROCEDURE FOR DISPUTES INVOLVING ADMINISTRATIVE MATTERS

This process will follow a similar procedure as Disputes concerning Professional Competence or Conduct. The Network Operations Director, Deputy Director/Chief Operating Officer, and Quality Management Director or their designees will review the information submitted by the provider within 14 calendar days of receipt of the request. A response will be sent by registered mail, return receipt requested, within 7 calendar days if involving Medicaid services, outlining the decision and further steps in the dispute process.

If State Funded services are involved the information submitted by the provider will be reviewed and responded to in writing within 30 days of receipt of the request, outlining the decision and further steps in the dispute process.

# Questions Or Comments

SANDHILLS CENTER