SECTION XIII – PROVIDER FISCAL PROBLEM RESOLUTION PROCESS

The Local Mental Health Plan (LMHP) has a process to assist Individual and Group Providers with resolving problems related to the payment of their claims for services provided. This process offers providers and billing agents who are dissatisfied with the processing or payment of a claim a method to address the dispute.

Time is of the essence and network providers should take all necessary steps to submit a claim to the Department as soon as possible after providing the service. Delay in the submission of a claim may attribute to a State denial that would have otherwise been a valid claim

There is no commitment to pay all claims. This process offers the provider an opportunity to have a review of their denial. The burden of proof will be on the provider to establish the LMHP is at fault for the denial.

STEPS IN THE FISCAL PROBLEM RESOLUTION PROCESS

1. Network providers and billing agents must ensure the timely submission of a claim. Contractor must submit claims within six (6) months after the end of the month in which the services were rendered. In the event the State or Federal government or any funding source denies any or all claims submitted by County on behalf of Contractor, County will not be responsible for any payment obligation and, accordingly, Contractor shall not seek or retain payment from County and shall indemnify an hold harmless County from any and all liabilities for payment of any or all denied claims, except any claims which are denied due to the fault of the County (Refer to Contract: Payment Provision Exhibit B, Section C. Billing Procedure (2)(a)).

- Prepare and submit a claim for payment within six (6) months after the end of the month in which the services were rendered.
- Check the system 835 file for claim disposition; network providers are strongly encouraged to submit and reconcile claims weekly and no later than one month after the date of service.
- If the claim is denied, the claim denial reason code should immediately be accessed to determine whether a claim is eligible for correction.
- Prepare and submit a new and corrected claim as soon as possible.
- If steps above in timely submitting a claim do not result in a provider reimbursement, then the network provider or billing agent should contact the Provider Relation Unit (PRU) for consultation about the claim at (213) 738-3311 or by email at FFS2@dmh.lacounty.gov.
- If the problem is not resolved following consultation the network provider should contact the Help Desk at (213) 351-1135 to open a Heat Ticket.
    - This ticket will ensure that this claim is sent to all relevant DMH processing and payment units to determine resolution.
    - The provider will receive direction related to the outcome of the submitted claim.

Provider Appeal

A network provider or billing agent may submit a formal Appeal if they are not satisfied with the outcome of the submitted claim following heat ticket direction. Provider may submit an appeal (Title 22, Section 51015).

- The Appeal must be submitted to the LMHP within 90 calendar days of the denial.
- The LMHP will acknowledge the written appeal within 15 days of its receipt.
- The LMPHP has 60 calendar days from the receipt of the appeal to provide a written statement of the decision and any action to be taken by the network provider (Title 9, Section 1850.320 b).

DOCUMENTATION REQUIREMENTS FOR AN APPEAL

Network providers who wish to submit an Appeal must provide the following documentation:

- A detailed cover letter explaining the reason for the dispute, the circumstances concerning the denial and why the network provider or billing agent determined the fault was that of the LMHP;
- Any correspondence related to the processing of the disputed claim(s) from the LMHP;
- A completed Appeal Form (see Attachment I);
- A printout of a system report(s) that lists the history of the disputed claim(s) and error reason(s) or discussion of the original electronic claim(s);
- Proof of Medi-Cal beneficiary eligibility for the date of service;
- A copy of the claim(s); and
- Copy of an approved inpatient hospital treatment authorization request (TAR), if applicable.

Mail and fax all appeal documents to:

Department of Mental Health
Provider Relations Unit
510 S. Vermont Ave., 20th Floor
Los Angeles, CA 90020

After these procedures have been followed, a provider who is not satisfied with the appeal decision by the LMHP, may seek appropriate judicial remedies in compliance with Section 14104.5 of the Welfare and Institutions Code, no later that one year after receiving notice of the decision.

INSTRUCTIONS FOR COMPLETION OF THE APPEAL FORM

Each item on the next page refers to an area on the *Appeal Form* (Attachment I).

Item Description

A. **Appeal Number**. For LMHP use only.
B. **Appeal Reference Number**. For LMHP use only.
C. **Provider Name/Address.** Enter contracted individual or group network provider's name and mailing address, city, state, and zip code.
D. **Provider Telephone/Fax numbers**. Enter network provider's telephone and fax numbers.
E. **Rendering Provider Number**. Enter the nine-digit network provider number (ex. MF0000000, 00A000000, PSY000000, etc.) Without the correct network provider number, appeal acknowledgment and processing may be delayed.
F. **Claim Type.** Enter an "X" in the appropriate box to indicate whether the claim type is in an inpatient or outpatient setting. Only one box may be checked.
G. **Statement of Appeal.** Network provider's attestation statement.
H. **Client's Name.** Last name, First name.
I. **Client's Medi-Cal ID.** Enter the Medi-Cal beneficiary's CIN (client index number) obtained from the beneficiary identification card (BIC).
J. **Reason for the Appeal.** Indicate the reason for filing the appeal. Be as specific as possible. All supporting documentation must be included and attached to the appeal form in order for the examiners to consider all relevant issues concerning the dispute.
K. **Denial Code.** Enter the denial code.
L. **Number of Minutes**. Enter the number of minutes used by the provider for services.
M. **Claim ID #.** Enter the claim ID number, which can be obtained from one of the adjudication detail reports that displays the disputed claim(s).
N. **POS (Place of Service).** Enter the appropriate service location/facility type code of the place where the service was rendered.
O. **Date of Service.** Enter the date on which services were rendered to the Medi-Cal beneficiary.
P. **Procedure Code.** Enter the procedure code.
Q. **Diagnosis Code.** Enter the diagnosis code.
R. **Common Appeal Reasons.** Check one of these boxes, if applicable. Include a copy of the claim and supporting documentation.
S. **Signature and Date.** The network provider or an authorized representative (i.e., billing agent, individual or group provider administrator) must sign and date the Appeal Form.