Provider Dispute Resolution Mechanism
Turnaround Time Frame

Description	Turnaround Time Frame
Deadline for Receipt of Provider Dispute	
For a dispute related to an individual claim, billing dispute or contractual dispute	Cannot impose a deadline of less than 365 days after the most recent action or, in the case of inaction, 365 days after time for contesting or denying claim has expired.
For a dispute related to a demonstrable and unfair payment pattern by the plan or the plan's capitated provider.	Cannot impose a deadline of less than 365 days after the most recent action or, in the case of inaction, 365 days after time for contesting or denying claim has expired.
Submission of Amended Provider Dispute	
Amended Provider Dispute.	A provider may submit within 30 working days of the date of receipt of a returned provider dispute for purposes of requesting missing
Time Period for Acknowledgement	
Electronic Provider Dispute	Provided within 2 working days of the date of receipt of the electronic provider dispute
Paper Provider Dispute	Provided within 15 working days of the date of receipt of the paper provider dispute
Time Period for Resolution and Written Determination	
Resolution and issuance of written determination for each provider dispute or amended provider dispute.	Resolution and a written determination must be completed within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.
Right of Provider to Request a De Novo Review	
Any provider that submits a claim dispute to the plan's capitated provider's dispute resolution mechanism(s) involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to the plan's dispute resolution process.	A provider has the right to submit an appeal for a de novo review and resolution to the Plan for a period of 60 working days from the capitated provider's Date of Determination.

Description	Turnaround Time Frame
Past Due Payments and Interest and Penalties	
Resolution of a provider dispute or amended provider dispute involving a claim which is determined in whole or in part in favor of the provider, shall include the payment of any outstanding monies determined to be due, and all interest and penalties.	Payment is due within 5 working days of the issuance of the Written Determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" of the complete claim.
Time Period for Provider Dispute Documentation Retention	
Retention includes copies of provider disputes and determinations, including all notes, documents and other information used to reach decision.	Documents shall be retained for at least 5 years.
Submission of Required Reports	
"Annual Plan Claims Payment and Dispute Resolution Mechanism Report" shall include information disclosing the claims payment compliance status of the plan and each of its claims processing organizations and capitated providers. *The Annual Plan Claims Payment and Dispute Resolution Mechanism Report for 2004 shall include claims payment and dispute resolution data received from October 1, 2003 through September 30, 2004.*	The plan shall submit Annual Plan Claims Payment and Dispute Resolution Mechanism Report in electronic format to the DMHC no more than 15 days after the closure of the calendar year. The first report shall be due on or before January 15, 2005.
A Quarterly Claims Payment Performance Report ("Quarterly Claims Report") shall include a tabulated record of each provider dispute received.	The report shall be submitted to the plan within 30 days of the close of each calendar quarter.
Demonstrable and Unjust Payment Pattern	
The plan may submit a written response documenting that their practice, policy or procedure was a necessary and reasonable claims settlement practice and consistent with the requirements.	The plan may submit a written response within 30 days of receipt of notice that the DMHC is investigating whether the plan's or the plan's capitated provider's practice, policy or procedure constitutes a demonstrable and unjust payment pattern.