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CONCORD, NC 28025

PBH Network Management Communication Bulletin

FY-0809-NM-07

To: PBH Network Providers

From: Chuck Hill, Coordinator for Data Analysis and Decision Support

Date: April 9, 2009

Re: Reconsideration Review Process for Providers

Please be aware that PBH has made changes to the **Reconsideration Review Process for Providers**. Section XIII (items F through I) of the Provider Manual has been updated to reflect these changes. For your convenience the revised text from the Provider Manual has been listed below. Please note that a printed copy of the updated Provider Manual will be made available to you upon request.

PBH

PROVIDER MANUAL

Fiscal Year 08/09
(April 8, 2009 Update)

SECTION XIII: RECONSIDERATION REVIEW PROCESS FOR PROVIDERS

F. Reconsideration Process:

1. Provider Request for Reconsideration:

- a. When a Provider receives a notice of an action, the Provider has seven (7) calendar days to request reconsideration of the action. All requests for reconsideration must be in writing and must be specifically directed to the Chair of the Reconsideration Committee. Requests for Reconsideration should be sent return receipt requested. If delivered in person, a receipt shall be issued to the Provider by PBH. It is the Provider's responsibility to request a receipt if one is not offered. The Provider must provide any additional written documentation to be considered during the Reconsideration Process at the time the Request for Reconsideration is filed.
- b. All requests for Reconsideration will be recorded by the Assistant to the Chair of the Reconsideration Committee and the document will be date stamped with the date of receipt.

- c. The Assistant to the Chair of the Reconsideration Committee will send a response to the provider indicating the date of receipt, such notice will be sent by registered mail, return receipt requested.
- d. The Assistant to the Chair of the Reconsideration Committee will notify the Director of Quality Management or designee by providing a copy of the Request for Reconsideration if the reconsideration request is due to an action initiated by Quality Management or to the Chair of the Network Cross Functional Team if the action was initiated by the Network Cross Functional Team
- e. Reimbursement will continue during the Reconsideration Process unless the provider is cited for gross negligence, the provider is suspected of committing fraud or abuse or in the sole discretion of PBH, continued reimbursement is likely to increase any payback amount due.
- f. The Provider may be required to submit documentation of services provided in order to continue to receive reimbursement during the Reconsideration process. This determination will be made by the Quality Management Department.

2. Reconsideration by PBH:

- a. The Reconsideration Committee will make a decision regarding all Requests for Reconsideration within fourteen (14) calendar days of the receipt of the Request for Reconsideration.
- b. The Chair of the Reconsideration Committee will send notice of the decision to the Provider within seven (7) calendar days of the decision, registered mail, return receipt. The return receipt will be maintained with the Reconsideration documents.
- c. Notice of the decision of the Reconsideration Committee will be communicated to Finance, Network, Quality Management Departments, and the Office of the General Counsel.

G. Paybacks due and payable upon completion of the Reconsideration

All paybacks are due and payable by the provider upon completion of the Reconsideration. All reimbursement 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 PBH, 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. The requirement for a payback is not stayed by an appeal to the State MH/DD/SA Appeals Panel under G.S. 122C-151.4.

H. Right to File an Appeal

If the Provider is not satisfied with the PBH decision regarding its Request for Reconsideration, the Provider may file an appeal to the Area Authority Board of Appeals Panel, State MH/DD/SA Appeals Panel, NC Department of Health and Human Services, Division of MH/DD/SAS, 3013 Mail Service Center, Raleigh, NC 27699-3013 in accordance with General Statute 122C – 151.4.

- 1. General Statute 122C – 151.4 subsections c (1), (2), (3) provides Consumers, Contractors and former Contractors the right to file Appeals to the state MH/DD/SA Appeals Panel after they have exhausted the appeals (Provider Reconsideration or Consumer Grievance)

process at PBH. Contractors can file an appeal with the State MH/DD/SA Appeals Panel as follows:

- a. A contractor or former contractor who claims that an area authority or county program is not acting or has not acted within applicable State law or rules in imposing a particular requirement on the contractor on fulfillment of the contract;
 - b. A contractor or former contractor who claims that a requirement of the contract substantially compromises the ability of the contractor to fulfill the contract;
 - c. A contractor or former contractor who claims that an area authority or county program has acted arbitrarily and capriciously in reducing funding for the type of services provided or formally provided by the contractor or former contractor.
2. Chapter 150B Appeal: a Provider that is dissatisfied with the decision of the Appeals Panel may file a contested case under Article 150B of the General Statutes. Notwithstanding G.S. 150B-2(1a), PBH as an area authority is considered an agency for purposes of the limited appeal authorized by this section. The Secretary shall make a final decision in the contested case.

I. DEFINITIONS:

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. (Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care, October 2000)

Action: An action is defined as an event in which PBH applies sanctions such as the requirement for a Plan of Correction, payback, referral freeze or termination of a contract. The action is the result of findings from audits, quality of services evaluations, investigations, or report by outside investigative authorities. An action also includes a denial (in whole or in part) of a provider's request to employ a family member to serve a consumer.

Fraud: A deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care, October 2000)

Reconsideration Committee: The Reconsideration Committee and its Chair are appointed by the Area Director. The Committee has authority to make final determinations on provider Requests for Reconsideration of PBH Actions.

Reconsideration Review: a review of an action based on the Provider's Reconsideration Request and any additional materials presented by the Provider. This process includes a review of the decisions of the Network Cross Functional Team. The Reconsideration Committee makes the final determination as to whether the Provider's request is approved or denied by PBH.

PBH
Provider Request for Reconsideration
of an Action

Action: An event by which PBH responds to findings from a provider audit, review, investigation, or report by outside investigative authorities. The action includes but is not limited to: paybacks, plans of correction, sanctions (such as frozen referrals), and contract terminations.

Provider (Agency or Licensed Practitioner):

Principle, Director or CEO:

Address:

Phone number/fax number:

Date of PBH Action:

Nature of PBH Action:

Reasons for Request for Reconsideration:

Desired Outcome:

Signature of Authorized Agency Official:

Printed Name of Official:

Date: