BHS Policies and Procedures

City and County of San Francisco Department of Public Health San Francisco Health Network BEHAVIORAL HEALTH SERVICES	1380 Howard Street, 5th Floor San Francisco, CA 94103 415.255-3400 FAX 415.255-3567

POLICY/PROCEDURE REGARDING: **Provider Problem Resolution and Appeal Process**

Issued By: Kavoos Ghane Bassiri, LMFT, LPCC Director of Behavioral Health Services Date: March 23, 2017	Manual Number: 3.12-01 References: Welfare & Health Services Institutions Code, 1850.305 & 1850.310 Title 9, Div. 1, Chapter 11, CCR, Section 1850.305

Technical Revision. Replaces Policy 3.12-01 of February 25, 2011.

Purpose:

To provide guidance on resolving problems and responding to appeals brought to San Francisco Behavioral Health Services (BHS) by any of its contracted organizational, group and individual practitioner providers.

Scope:

This policy applies to all organizational, group and individual practitioner providers contracted through the BHS.

Policy:

I. Provider Problem Resolution Process

Organizational providers may bring concerns or problems to the attention of the BHS Systems-of-Care Directors for Children, Youth & Families (CYF) and for Adults and Older-Adults (AOA) via the main BHS number, (415) 255-3400.

BHS Private Provider Network (PPN) providers contracted through the San Francisco Mental Health Plan may bring concerns or problems to the PPN Director via the main BHS number, (415) 255-3400.

If the concern or problem involves a PPN billing claim, practitioner providers may call the BHS Claims Unit number at (415) 252-3029. The Claims Unit will respond to the practitioner providers' call within three (3) business days.

The role of the Directors, or their designated staff, is to resolve problems and issues as soon as possible. The Systems-of-Care and PPN will keep a log of provider concerns, problems, or appeals submitted.

At any time before, during or after the Systems-of-Care or PPN Directors' resolution of the provider concern or problem, providers may avail of the appeal process described below.

II. Provider Appeal Process

BHS providers may appeal a decision of BHS to deny or modify treatment authorization requests, or on the processing of payment of providers' claims. Appeals have to be made in writing.

A. Provider May File a Written Appeal Within 90 Days

A provider may appeal a denied or modified request for treatment authorization, or a decision regarding the processing or payment of a claim, within 90 calendar days of the provider's receipt of the decision, or within ninety (90) days of the date payment was due according to BHS payment guidelines. The appeal may include the reasons why BHS should have made the authorization or payment decision in the provider's favor. The appeal may include supporting documentation, which can include, for example:

1. A copy of the original decision received from BHS. For inpatient services provided, this may include a copy of the Treatment Authorization Request.
2. Documentation supporting any lack of timely response, authorization or payment from BHS.
3. Documentation supporting medical necessity, if at issue.

The appeal should contain the provider's name, address and phone number, and should be sent to:

Appeals
Provider Relations Office
1380 Howard Street, 2nd floor
San Francisco, CA 94103-2614

(*EXCEPTION:* Hospital providers who receive payments through the State's fiscal intermediary may file appeals concerning claim payments or processing directly to the fiscal intermediary.)

B. SFMHP's Response Timeframe to a Grievance or Appeal

A written acknowledgement will be issued by the Provider Relations Office within three (3) working days of the receipt of an appeal. BHS will send the provider a written response to the appeal within sixty (60) calendar days from the date the appeal was received by the Provider Relations Office.

However, if the client involved in the provider appeal is a member of Healthy Families or Healthy Workers, the written response to the appeal must be sent to the provider within 30 calendar days from the date the appeal was received by the Provider Relations Office.

The written response from BHS Systems-of-Care, PPN or the BHS Inpatient Authorization Team (for hospital authorization and payment decisions) shall include the reasons for the decision on the appeal, that address the issues raised by the provider, and actions needed to be performed by the provider and/or BHS. A copy of the written response to the appeal will be provided to appropriate authorizers of BHS services, if involving modification to an authorization decision.

(NOTE: In the case of appeal decisions involving hospital stays, the BHS written responses will include information on the hospital's right to appeal to the State if services to a Medi-Cal beneficiary are involved. Please see section D. below.)

C. The Provider May be Required to Submit a Payment Revised Authorization Request Within 30 Calendar Days

Written responses to appeals may include instruction to providers to submit revised payment authorization requests to the BHS Provider Relations Office within thirty (30) days of receipt of the response. The Provider Relations Office will forward to the Claims Unit for payment or to the appropriate BHS Systems-of-Care authorization unit for processing.

D. Hospital Providers May Appeal to the State Department of Health Care Services a BHS Denial of an Appeal for Payment Authorization of Emergency Services

State regulations define an emergency psychiatric condition as one which requires voluntary or involuntary hospitalization, and which meets medical necessity criteria for psychiatric inpatient services.

Within thirty (30) days from the date of the written response from BHS denying an appeal for payment authorization of emergency services, a provider may file an appeal with the California Department of Health Care Services (DHCS). This process is described in Chapter 11, Title 9, Division 1, CCR, section 1850.305 *Provider Problem Resolution and Appeal Processes.* BHS shall provide any documentation requested by DHCS related to the appeal, including for example, a copy of the agreement between BHS and providers, within twenty-one (21) calendar days of request.

If DHCS resolves the appeal in favor of the provider, BHS may require the provider to submit a revised authorization request within thirty (30) calendar days of the appeal's resolution.

Contact Persons:
Director, Adult & Older-Adult Systems-of-Care
Director, Children, Youth & Families System-of-Care
Director, Private Provider Network

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