Provider Problem Resolution and Payment Appeal Procedures

Issue Date: 10/27/2025

Procedure for Policy: 7.1.28, Provider Problem Resolution and Payment Appeal Process

PROCEDURES:

A. Scope of Provider Concerns and Appeals

Providers may raise concerns or file appeals related to, but not limited to, the following:

1. Contract issues, including payment agreements and scope of work.
2. Disagreements with monitoring or audit review findings by the Department of Health Services – Behavioral Health Division (DHS-BHD) Quality Assurance (QA) staff (appeals on monitoring/audit reviews must be filed within **15 calendar days** of receiving findings/audit reports).
3. Disagreements with service decisions made by DHS-BHD staff.
4. Payment disputes, including denied or modified payment requests or delays in processing claims.
5. Appeal Payment Authorizations for Psychiatric Inpatient Hospital or Psychiatric Health Facility Services.
6. Any other concerns or complaints.

B. Initiating the Process

1. Providers have the right to initiate the Provider Problem Resolution or the Provider Payment Appeal process at any time, either before, during, or after efforts to resolve issues informally.
2. DHS-BHD Provider Relations will inform the provider whether initiating the Problem Resolution process will affect timelines for accessing the payment appeal process.
3. For concerns NOT related to payment appeals, DHS-BHD will attempt to resolve the concerns at the lowest possible level of involvement. However, providers may submit a Provider Problem Resolution & Payment Appeal Form (BHD 405), at any time to formalize their concerns.

C. Payment Appeal Eligibility and Submission

1. Payment appeals may only be filed for:

    a. Denied payment requests.

    b. Modified payment requests.

    c. Disputes involving the processing or payment of claims, including payment delays.

2. Appeals must be submitted within **90 calendar days** of:

    a. Receipt or fax date of the notification of payment denial or modification; or

    b. DHS-BHD's failure to act upon the payment request.

3. Appeals must include a completed Provider Problem Resolution & Payment Appeal Form, along with any supporting documentation, such as written statements, chart documentation, or other relevant materials.

D. Review and Resolution Process

1. The Quality Assurance and Performance Improvement (QAPI) QA Manager will:

    a. Collect and review any/all applicable documents.

    b. Initiate the Provider Payment Appeal or Problem Resolution Form.

    c. Request additional information from the Department of Health Services (DHS), Revenue Management Unit (RMU), or other applicable units if needed.

    d. Present the appeal/problem and supporting documents to the Behavioral Health Plan Administration (BHPA) committee.

2. The BHPA committee will:

    a. Review the QA manager's initial recommendation and supporting information.

    b. For payment appeals, make a recommendation to uphold, deny, or modify the appeal.

    c. For other issues, make a recommendation for the best course of action to resolve the identified issue/problem.

E. Compliance Review and Final Determination

1. The recommendation, and all applicable documentation and date resolution due, will be sent to the DHS Compliance Unit for review via the Provider Payment Appeal and Problem Resolution Form:

a. If the Compliance Unit agrees, the QAPI QA Manager will submit the recommendation to the Behavioral Health (BH) Director for approval.

b. If there is a disagreement, the Compliance Unit and the Assistant Director of Compliance will coordinate with the BHPA committee to reach a consensus.

c. If a consensus is not reached, the BH Director and the Assistant Director of Compliance will consult before (jointly) escalating the appeal to the DHS Director.

d. The BH and DHS Directors make the final determination.

2. The final decision must be made within **60 calendar days** of DHS-BHD's receipt of the appeal.

3. If no decision is issued within **60 calendar days**, the appeal is considered denied in full.

F. Communication of Appeal Decision

1. Upon decision, the QAPI QA Manager will:

a. Complete and issue a Notice of Appeal Resolution Letter to the provider.

b. Copy the DHS Compliance Unit and RMU Manager.

2. The letter will include:

a. A summary of the initial denial by DHS-BHD, including specific monetary amounts and dates.

b. The provider's rationale for the appeal.

c. The rationale for the final decision, final monetary amounts if applicable, and next steps.

3. For appeals regarding payment authorizations for Psychiatric Inpatient Hospital or Psychiatric Health Facility Services, all Payment Appeals process steps shall be followed, in addition to the following:

a. If the decision involves a modification to an existing authorization, the provider may be required to submit a revised Treatment Authorization Request (TAR) within **30 calendar days**.

b. If the appeal is approved and the response so indicates, the provider may be asked to submit a revised TAR to DHS-BHD within **30 calendar days** of receipt of the approval.

c. The BHPA appeals group will submit a copy of the approved TAR to the provider and submit the TAR to the Medi-Cal Fiscal Intermediary (FI) within **14 calendar days** from receipt of the provider's revised request.

d. Hospitals and the individual, group, or organizational providers who have provided Specialty Mental Health Services (SMHS) in an emergency to a member during a psychiatric inpatient hospital stay that is the subject of the appeal, may appeal separately to the Department of Health Care Services (DHCS), unless they have agreed to another arrangement as a term of their contract with DHS-BHD.

e. If a provider chooses to appeal the DHS-BHD's denial or modification of payment authorization, the provider shall submit an appeal to DHCS in writing, along with supporting documentation, within **30 calendar days** from the date the DHS-BHD decision of denial or modification is submitted to the provider. The provider may appeal to DHCS within **30 calendar days** after **60 calendar days** from submission of the appeal to DHS-BHD, if DHS-BHD fails to respond.

G. Denial Overturned: Revised Request for Payment

a. If the appeal is approved in full, no further action is required.

b. If the appeal is modified, a provider shall submit a revised request for payment within **30 calendar days** of receipt of appeal decision. The DHS RMU will process the provider's revised request for payment within **14 calendar days** from the date of receipt of a provider's revised request.

H. Appeals concerning the denial or modification of a Mental Health Plan (MHP) Payment Authorization Request for the SMHS provided in an Emergency Psychiatric Inpatient Hospital.

1. A provider may appeal to the Department for a denial in full, or in part, by DHS-BHD on the basis that the provider did not comply with the following:

a. Timelines for notification or submission of the DHS-BHD payment request.

b. Medical necessity criteria were not met, see Cal. Code Regs. Tit. 9 Section 1820.205.

c. Requirements for approval of administrative days were not met, see Cal. Code Regs. Tit. 9 Section 1820.220.

2. A hospital may not appeal the denial or modification of DHS-BHD payment authorization to the Department, when the denial or modification is based on DHS-BHD's determination that a hospital has failed to comply with mandatory provisions of the contract between the provider and DHS-BHD.

FORMS:

1. BHD 405 Provider Problem Resolution & Payment Appeal Form
2. Provider Problem Resolution and Payment Appeal Resolution Form