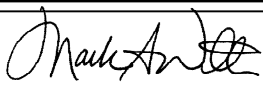


Policy & Procedure

POLICY/PROCEDURE TITLE: Provider Dispute Resolution POLICY/PROCEDURE #: 704 Section: Provider Network Developed and maintained by: Provider Network Manager Scope: <input checked="" type="checkbox"/> OnPoint Staff <input type="checkbox"/> MH/IDD, <input type="checkbox"/> Housing, <input type="checkbox"/> SUD, <input type="checkbox"/> Integrated Health, <input checked="" type="checkbox"/> OnPoint Contract Providers <input type="checkbox"/> Other _____	Approved By:  (Chief Executive Officer)					
	Approved By: _____ (Medical Director; <i>as applicable</i>)					
	DATES					
	<table border="1"> <tr> <td>First Effective</td> <td>06/2005</td> </tr> <tr> <td>Revised</td> <td>03/2025</td> </tr> <tr> <td>Reviewed</td> <td>03/2025</td> </tr> </table>	First Effective	06/2005	Revised	03/2025	Reviewed
First Effective	06/2005					
Revised	03/2025					
Reviewed	03/2025					

PURPOSE

To outline a process where providers contracted with OnPoint can request a dispute resolution for decisions for non-service-related issues.

POLICY

OnPoint shall monitor contracted services to assure that a continuum of quality supports/services are provided by members of the Provider Network. When contract disputes occur between parties, OnPoint will work to effectively resolve such disputes in an equitable manner. Providers contracted with OnPoint can lodge complaints and request reconsideration (appeal) of decisions rendered by OnPoint through the Provider Dispute Resolution Process.

PROCEDURES

A. Application

1. The Provider Dispute Resolution applies to the following:
 - a. Denial or suspension of provider panel status with cause
 - b. Request for Proposal awards/denials
 - c. Claims payments and authorizations
 - d. Reduction, suspension or adjustments of payments to providers
 - e. Results from provider monitoring activities
 - f. A sanction or decision to place provider on provisional status
 - g. Credentialing or re-credentialing decisions
 - h. Other non-clinical issues
2. This procedure does not apply to the following areas which can be referenced in OnPoint Policy 1103:
 - a. Medicaid Fair Hearing Appeals and Grievances
 - b. Medical Necessity Appeals
 - c. Consumer rights regarding appeals and grievances, in accordance with MCL 330.1784.

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B. Informal Complaints

Providers are encouraged to resolve concerns and disagreements with the appropriate OnPoint staff prior to making a formal request for dispute resolution. OnPoint staff can be contacted regarding the disputes:

Dispute	OnPoint Contacts
Denial or suspension of provider panel status with cause	Provider Network Manager and/or Chief Executive Officer
Request for Proposal (RFP) awards/denials	Provider Network Manager
Claims payment and authorizations	Finance and Reimbursement Departments
Reduction, suspension, or adjustments of payments to providers	Finance and Reimbursement Departments
Results from provider monitoring activities	Provider Network Manager and/or Credentialing Committee
A sanction or decision to place provider on provisional status	Provider Network Manager and/or Credentialing Committee
Credentialing or re-credentialing decisions	Provider Network Manager and/or Credentialing Committee

C. Right to Dispute

Providers shall be notified of their right to request dispute resolution via the RFP decision; sanction notice; notice of change to claims payment and authorizations; notice of reductions; suspension, or adjustments of payments; and in the contractual agreements with OnPoint. Providers will be informed of a progressive appeal process as part of the notification of a decision by OnPoint.

D. Dispute Resolution

1. When a dispute cannot be resolved informally, the provider has the option of filing a formal written request for dispute resolution. OnPoint reserves the right to use on-site claims, utilization, provider monitoring reviews and interviews with involved parties to make decisions. Requests for Dispute Resolution can be made to the Provider Network Manager or OnPoint Customer Service.
2. OnPoint must notify the provider in writing of a decision regarding a grievance within 30 calendar days of receipt of the request and offer an appeal request.
3. If the provider fails to submit a complete and timely request for reconsideration or a request for dispute resolution, the provider will be deemed to have accepted the OnPoint's determination of the issues raised by the provider and to have waived all further internal or external processes regarding the issue.

E. Appeals

Appeals of decisions made by OnPoint through the dispute resolution process must be filed in writing 30 calendar days after receiving adverse notification from OnPoint. A written request for appeal can be made to the Provider Network Manager or Customer Service. All claims are permanently denied after one year (365 days) from the date of service.

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1. Level 1 Appeal

The appeal shall be reviewed by the OnPoint department overseeing the area the appeal addresses. A written decision will be issued within 30 calendar days to the provider by the department making the decision. Appeals involving more than \$5,000 will automatically be moved to level 2 appeal.

2. Level 2 Appeal

The provider has the option of filing a Level 2 appeal, if dissatisfied with the decision of Level 1 appeal. A Level 2 appeal must be filed in writing within 20 calendar days to the Chief Executive Officer. A written decision will be issued by the Chief Executive Officer to the provider within 30 calendar days.

3. Level 3 Appeal

The provider has the option of filing a Level 3 Appeal, if dissatisfied with the decision of a Level 2 Appeal. A Level 3 Appeal must be filed in writing within 20 calendar days to the OnPoint governing board, whose decision will be considered final. A written decision will be issued by the governing board to the provider within 30 calendar days.

REFERENCES

- MDHHS Appeal and Grievance Resolution Technical Requirement
- MCL 330.1784
- Lakeshore Regional Entity Provider Dispute Resolution Policy & Procedure
- OnPoint Policy 1103