

FCMHA Provider Complaint/Dispute Resolution Procedures

The Area Authority provides opportunity for any provider operating under a network agreement to seek resolution of complaints and concerns, or when applicable LME actions or decisions are disputed. FCMHA makes every effort to give appropriate attention both to provider rights, and to the protection of persons being served. Dispute resolution follows two (2) possible tracks of engagement:

Track One involves LME actions or decisions that pertain to a *provider's professional competency or conduct, and that potentially affects the provider's state-fund and/or endorsement status within the network*. Disputes of this nature are subject to both the Area Authority appeal process, and further appeal opportunity through the NC Division of MH/DD/SA Services. They are governed by conditions set forth in G.S. 122C-151.4c and by *The Policy and Procedures for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA Services*.

Providers who believe one or more of such conditions are met shall submit a written description of the issue and request for resolution to the Area Authority Director. A provider wishing to dispute state contract or Medicaid endorsement actions shall specify a request for “**Local Reconsideration.**” The request may be sent to the **Attention of the Area Director, Five County Mental Health Authority, 134 S. Garnett Street, Henderson, NC 27536**. The Area Director will notify FCMHA's Provider Services Director, who will initiate the resolution process.

I. State-Funded Providers:

Pursuant to URAC accreditation requirements, the following dispute resolution process applies to providers with whom the Area Authority has a state-funded contract. This process applies to state-funded providers whether or not they also have a Medicaid Agreement with the Area Authority. Track One processes for state-funded providers offers the opportunity for two (2) steps of review. The Provider Services Director will convene a first-level panel consisting of at least three (3) qualified individuals that include LME representatives and a provider clinical peer of the provider filing the dispute. The clinical peer is selected from available members of FCMHA's Provider Advisory Committee (PAC) or their designee. The Panel will meet and render a determination to be communicated in writing to the provider. The provider has the right to seek additional consideration by the LME through a second-level panel consisting of at least three (3) qualified individuals that comply with the elements of the first panel, but who were not participants in the first panel. The LME will endeavor to complete deliberation(s) and decision(s) of the panel(s), and communicate in writing to the provider, within 15 business days of receipt of the provider's request.

II. Medicaid-Only Providers:

Pursuant to NC DHHS Medicaid Endorsement policy and procedures, the following dispute resolution process applies to providers with whom the Area Authority has only a Medicaid Memorandum of Agreement (MOA). Upon the provider's request for Local Reconsideration, the Area Director will convene, or direct the Provider Services Director to convene, a panel consisting of at least three (3) qualified individuals that include LME representatives and a provider clinical peer of the provider filing the dispute. The clinical peer is selected from available members of FCMHA's Provider Advisory Committee (PAC). The Panel will endeavor to meet and render a determination to be communicated in writing to the provider within 15 business days of receipt of the provider's request.

III. State-level Appeal

At the local level, the Area Authority's process is aligned with the NC State MH/DD/SAS Appeals Panel process as established by GS 122C-151.4d). As such, no sworn testimony shall be taken and the rules of evidence do not apply. The party that appeals has the burden of proof. Any decision previously determined by the Area Authority, including suspension of authorizations, contract termination, and/or withdrawal of endorsement, shall not be stayed during the appeal process.

If the Track One dispute for either state-funded or Medicaid-endorsed providers is not resolved, the provider has opportunity to make appeal to the Division of MH/DD/SAS Appeals Panel under GS 122C-151.4, 10A NCAC 27G.0810-.0812. The Area Authority will forward whatever information assists the provider in knowing how to make contact with the DMH/DD/SAS Appeals Panel. The Provider must submit its appeal along with all supplemental documentation considered during the Area Authority dispute process to the Division of MH/DD/SASW within **15 calendar days** of the Area Authority's decision. A requested appeal along with supplemental information should be mailed (via Postal Service or UPS) to the **Attention of Division Director/Appeals Panel of NC Division of MH/DD/SAS, 3001 Mail Service Center, Raleigh, NC 27699-3001. An appeal request sent Fed Ex should be sent to Division Director/Appeals Panel of NC Division of MH/DD/SAS, 325 North Salisbury St., Office #1111, Raleigh, NC 27603.**

Track Two involves Agency action for all providers whether State-Funded or Medicaid-Endorsed *pertaining to all other types of complaints, concerns, or disputes not associated with the parameters of Track One*. These are titled Administrative Complaints/Disputes. The provider shall initially contact the Customer Services Representative from the Quality Management Department of the Area Authority, or the appropriate Departmental staff from which the issue originates. The provider is offered due consideration through the availability of review and rendered-decision by an authorized, qualified representative of the Area Authority not previously involved in the subject of complaint or dispute.

Incomplete resolution at that level initiates problem-solving from the appropriate Departmental Director and the Director of Quality Management. Incomplete resolution at the Departmental Director level initiates participation in problem-solving from the Area Director, and at her/his discretion, participation from the Quality Management Committee or Executive Management Team. For issues processed at this level, the Area Director's decision stands as final.

At any stage in any of the above referenced resolution processes, the Area Authority may request that the provider detail its issues in writing if it had not already done so. Additionally, if it believes necessary, the Area Authority may request supporting documentation. The provider shall submit this written description or supply such documentation within two (2) business days of request. The Area Authority has the right to proceed with its deliberations based on information in its possession should the provider fail to provide the additionally-requested information within this timeframe.

The Area Authority attempts to acknowledge receipt of provider contacts within one (1) business day, and address and/or resolve all documented provider issues within 15 business days.