

Provider Dispute Processes: A Comparison of Available Alternatives

	Peer to Peer review	IDR Informal Dispute Resolution Process	PDR HealthChoices Provider Dispute Resolution Process	Act 68 Provider Grievance on Behalf of Member
Origin And Legal Basis	Required by NCQA as part of UR process; required by DPW for HealthChoices Plans – no legal requirement	Plan-Provider contract; allowable under the DOH MC Regulations	Required by DPW contract standards and Plan-Provider contract	Required by Act 68 statute and DOH MC Regulations
Applicability	Plan initial UR denials of prospective or concurrent medical care or services; frequently used prior to initiating formal appeal	Concurrent and retrospective denials based on procedural errors and medical necessity/ appropriateness in which the enrollee is held financially harmless	Retrospective denials based on medical necessity/ appropriateness of services already provided or any administrative, contract, quality of care or credentialing disputes*	Prospective, concurrent or retrospective denials based only on medical necessity and appropriateness
Appropriate Issues	Ordering provider-plan disagreement about proposed treatment or services	Any participating provider – plan disagreement about the level or types of health care service provided	Any provider – plan “dispute” about denial of services already provided, plan policies, administrative requirements, credentialing and recredentialing denials* or terminations*	Only denials of medical necessity and appropriateness of services that are or arguably are otherwise covered benefits
Prospective Denials	Yes	No	No	Yes
Concurrent Denials	Yes	Yes	No	Yes

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Retrospective Denials	No	Yes	Yes	Yes
Who Can Use	Any Provider	Participating Provider only	Any Provider	Any Provider with the written consent of the enrollee
Enrollee Written Consent Required	No	No	No	Yes
Can Collect Payment For Denied Services From Enrollee	Yes – if enrollee is informed of denial in writing and consents to treatment anyway	No, regardless of appeal outcome	No, regardless of appeal outcome unless DPW rules/regulations dictate otherwise	Only after all appeal options are exhausted
Key Features	Phone consultation with MCO physician involved in the initial review; phone consultation with second plan clinician or medical director not involved in initial denial	Whatever is provided for in contract – usually some form of review by different plan medical reviewers or an independent third party	Review by committee comprised of plan staff and ¼ provider peers	First level committee of at least 1 individual w/o prior involvement, same/similar specialty input; second level committee w/o prior involvement includes same/similar specialty input
Number Of Steps	1	Steps are defined in provider contract	Two steps as approved by DPW (informal and formal)	2 internal by plan; 1 external assigned by DOH to certified review entity (CRE)

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Same Or Similar Specialist Input	No	Whatever is provided for in contract	None required but formal committee is composed of Plan staff and “peers” defined by DPW as providers practicing in the community	Each level of review must include input from same or similar specialist
Cost Of Appeal	None	Whatever cost sharing is provided for in contract	None	Provider pays for CRE fee if the plan is upheld in full. Average = \$800. Provider may be required to place ½ of the estimated cost of the review in escrow prior to the review.
Approximate Time To Complete All Steps	2 days	Whatever is provided for in contract, usually 60 days from date of appeal	Timeframes requires approval by DPW but usually 60 days	Approximately 8 months through third level. Appeal may be expedited w/ provider certification that member’s life, health, or ability to regain maximum function may be jeopardized if the process is delayed.
Subject To Further Levels Of Review	Yes, Act 68, PDR or IDR	Results to be “enforceable” but could be reviewed under Act 68 if time to appeal remains and the contract permits	No further review to DPW or to DOH	External review decision may be appealed by either party to a court of competent jurisdiction within 60 days

Other

Remember:

- A valid consent signed by the member or member's representative is required before a provider may proceed with the Act 68 grievance appeal process
- The member may revoke his/her provider consent at any step during the grievance process
- Once a provider assumes responsibility for filing an Act 68 grievance, the provider may not bill the member or the member's representative for services provided that are the subject of the grievance until the external grievance review has been completed or the member or member's representative rescinds consent for the provider to pursue the grievance.
- A provider may not go through the IDR appeal process and then jump to a third level Act 68 external appeal.
- An expedited review may be requested at any stage within the Act 68 grievance process upon the Provider's certification that the member's life, health or ability to regain maximum function would be placed in jeopardy by delaying the review process.
- After a member consent has been obtained, the provider has 10 days from the receipt of the written UR, first, second, or external grievance decision, upholding the plan's denial decision, to inform the member or member's representative of his/her intent to not pursue a grievance.
- Other appeal rights may be available to providers and enrollees of self-funded or Medicare+Choice plans
- Provider appeals concerning prompt payment of claims are reviewed by the Pennsylvania Insurance Department

Third Level External Review

Act 68 affords a provider the right to appeal an adverse second level grievance decision to a Certified Review Entity (CRE) on behalf of the member, with the member's written consent. In the event the provider chooses to pursue the Act 68 external appeal process, the provider must notify the appropriate plan of their intent to appeal. The plan will then notify the Pennsylvania Department of Health, Bureau of Managed Care (the Bureau) of the provider's external grievance appeal request. The Bureau will assign the appeal to a CRE. The external review is completed by a licensed physician or psychologist working in the same or similar specialty as the service under review.

The term "alternate dispute resolution" process or ADR, is described in Act 68 as an alternative to the third level external grievance review only. Instead of third level grievances being routed by the Department to independent, certified review entities, a plan and contracted provider could agree to use some other process at the third level. Such an alternative process requires advance approval from the Department, must be agreed upon in a contract, must be final and binding and must adhere the rules of fundamental fairness set forth in the Department's regulations and Act 68. To date, no ADRs have been submitted to the Department of Health for approval.