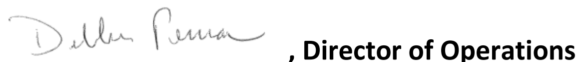
HIGHLINE MEDICAL SERVICES ORGANIZATION
CLAIMS PROCESSING POLICY/PROCEDURE

Title: Provider Dispute Resolution	Policy Number:	
	Original Issue:	January, 2000
	Revision Date(s):	July 25, 2014
	Prior Review Date(s):	

Last Review Date: June 2015  **, Director of Operations**

Policy
HMSO's health plan contracts include delegation of 1st level provider appeals, also known as requests for claim redetermination. HMSO's provider dispute resolution policy is to process appeals within the timeframes established by contract, State and Federal statute and to ensure a fair, fast and cost effective mechanism for resolving disputes.

Procedure

Medicare Advantage

<u>Health plan contracted providers</u>

- HMSO is delegated for 1st level appeals, and processes those per each health plan's administrative policy as published in their provider manual.
- Requests for reconsideration or 2nd level appeals are forwarded to the health plan for processing.

<u>Non-contracted providers</u>

- Effective January 1, 2014, CMS no longer contracts with C2C Solutions, Inc. to provide services to adjudicate disputes for non-contracted provider and MAO's.
- HMSO is delegated for 1st level appeals, and processes those per each health plan's administrative policy as published in their provider manual.
- Requests for reconsideration or 2nd level appeals are forwarded to the health plan for processing.

<u>All other providers</u>

- As published on the Noridian website
  - Requests for redetermination must be received within 120 days of receipt of the explanation of payment
  - Requests for reconsideration must be received within 180 days of receipt of the response to the provider's request for redetermination

Medicaid Apple Health

<u>All providers</u>

- As required by RCW 48.43.605
    - With the exception of COB claims, requests for additional payment must be received within 24 months after the date of the original payment determination and requests for additional payment may not be made any sooner than six months after receipt of the request
    - Requests for additional payment for COB claims must be made within 30 months after the date of the original payment determination and must be accompanied by documentation identifying the other carrier and reason for their denial

Process

- When member appeals are received by HMSO they are date stamped, logged and forwarded directly to the health plan within 24 hours as HMSO is not delegated for member appeals

- When provider appeals are received by HMSO they are date stamped and forwarded to the designated employee.

- Designated employee researches the provider appeal request:
    - Research includes a review of the initial claim determination and validation of adjudication accuracy.
    - Adjudication errors are submitted for reprocessing for inclusion in the next check run.
    - If the initial claim determination was accurate, the designated employee will issue a formal written response to the provider.

- Paper documentation prior to 2008 is stored off site.

- An electronic copy of appeal response letters and supporting documentation from 2009 to present are saved on the network, J:\Production Reports\Provider Appeals.

- All appeals are recorded in the appeals log, H:\Operational Folders\Appeals\Provider Appeals.

- All provider appeals will be responded to within 30-days of receipt.

- The Provider Dispute Resolution Policy is posted on HMSO's website including the location and telephone number where information regarding disputes may be submitted

Provider requests for payment redetermination should be sent to:
Highline Medical Services Organization
PO Box 48319
Burien, WA 98148
206.878.1985 option 3