HIGHLINE MEDICAL SERVICES ORGANIZATION
CLAIMS PROCESSING POLICY/PROCEDURE

Title: Provider Dispute Resolution	Policy Number:	
	Original Issue:	January, 2000
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	Prior Review Date(s):	06/15, 07/16, 08/17, 08/18, 08/19

Last Review Date: August 20, 2020  **, 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
In an effort to eliminate paper transactions, HMSO has worked diligently with providers to transition all disputes to an electronic environment. Effective August 1, 2020, providers are required to submit their provider disputes via fax at (206) 834-6000 or by secure email to info@hmsoinc.org.

Medicare Advantage

Health plan contracted providers

- 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 processed by the health plan.

Non-contracted providers

- 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 adjudicated by the health plan.
- To dispute a claim payment, non-contracted providers must submit a written request within 120 calendar days of the remittance notification date and include at a minimum:
    - A statement indicating factual of legal basis for the dispute
    - A copy of the original claims
    - A copy of the remittance notice showing the claim payment
    - Any additional information, clinical records or documentation to support the dispute

All other providers

- As published on the Noridian website

- Requests for redetermination must be received within 120 days of receipt of the explanation of payment (EOP)
- 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

Dispute Resolution Process

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

- Provider appeals received by HMSO are date stamped and forwarded to the designated employee for processing.
- Designated employee researches the provider appeal request:
  - Research includes a review of the initial claim determination and validation of adjudication accuracy, review of claim and authorization history and research to be certain the provider appeal is not a duplicate.
  - If adjudication errors are found, the claim is 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.
  - If the initial claim determination was incorrect, the claim is submitted for reprocessing for inclusion in the next check run and the claim payment will include interest. The designated employee will issue a formal written response to the provider indicating an overturned decision.
  - Provider appeals that require Medical Management involvement are forwarded to the Medical Management Team for review and resolution. Once the appeal has been researched, the results of the review are discussed with the Claims Manager. A formal written response is then sent to the provider via fax.
  - Claims Manager monitors the appeal log for accuracy and timely turnaround response to the provider.
- Paper documentation prior to 2019 is stored off site during the 10- year retention period.
- An electronic copy of appeal response letters and supporting documentation from 2010 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 including the process for submitting requests for redetermination is posted on HMSO's website. Provider Dispute Resolution information is also published on the first page of the EOP.
- Provider requests for payment redetermination should be faxed or secure emailed to
    - Highline Medical Services Organization
      (206) 834-6000
    - info@hmsoinc.org