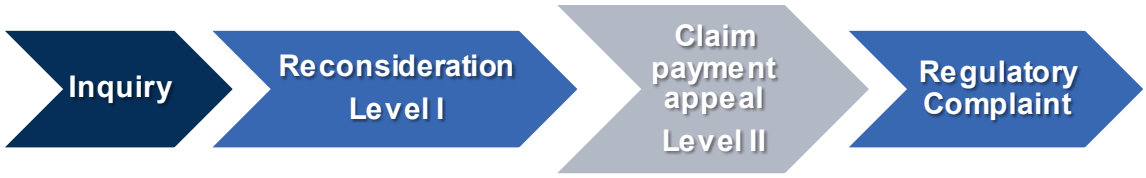
Healthy Blue

MO HealthNet Managed Care (Medicaid)

Provider Bulletin
July 2022

Claims dispute and appeals process



If you disagree with the outcome of a claim, you may begin the Healthy Blue provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized, but you disagree with the outcome.

The Healthy Blue provider payment dispute process consists of:

- **Claim payment reconsideration:** This is the first step in the Healthy Blue provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
- **Claim payment appeal:** This is the second step in the Healthy Blue provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.
- **Binding arbitration:** This is the third step in the Healthy Blue provider payment dispute process. The state of Missouri supports an external arbitrator review process if you have exhausted all steps in the Healthy Blue payment dispute process but still disagree with the outcome.
- **State fair hearing:** This process is followed when your appeal request was not resolved wholly in your favor.

Please be aware, there are three common, claim-related issues that are **not** considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below:

- **Claim inquiry:** A question about a claim but not a request to change a claim payment
- **Claims correspondence:** Request from Healthy Blue for further information to finalize a claim.
- **Peer-to-peer reconsideration:** Request a discussion with the Healthy Blue medical director who made the authorization denial determination
- **Medical necessity appeal:** A preservice appeal for a denied authorization.

The first step in the Healthy Blue claim payment dispute process is called the reconsideration. The reconsideration is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file. Reconsiderations filed more than 365 calendar days from the *Evidence of Payment* (*EOP)* will be considered untimely and denied unless good cause can be established.

* Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.

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Healthy Blue will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We have several options to file claim payment disputes:

1. Online (for reconsiderations and claim payment appeals): Use the secure **Availity Portal*** ***Payment Appeal Tool***. Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission.
2. Verbally (for reconsiderations only): Call Provider Services at **833-405-9086**. If you need to include supporting documentation (for example, *Explanation of Benefits EOB*, *Consent Form*, medical records, etc.) please **do not** use this option.
3. Written (for reconsiderations and claim payment appeals): Mail all required and supporting documentation to:
   Healthy Blue
   Payment Dispute Unit
   P.O. Box 61599
   Virginia Beach, VA 23466-1599

A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment issues.
- Inappropriate or unapproved referrals initiated by providers.
- Retrospective review.
- Disagreements over reduced or zero-paid claims.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Experimental/investigational procedure issues.
- Claim data issues.

Healthy Blue requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

1. Your name, address, phone number, email, and either your NPI number or TIN.
2. The member's name and their Healthy Blue ID number.
3. A listing of disputed claims including the Healthy Blue claim number and the date(s) of service(s).
4. All supporting statements and documentation.

We will send a determination letter within 30 business days of receiving the dispute.

Claim dispute processes not related to payments

Changes or errors on claims, responses to itemized bill requests, and submission of coordination of benefits/third-party liability information are not considered payment disputes. These should be resubmitted with a notation of corrected claim or claim correspondence to:

Healthy Blue
Claims Department
P.O. Box 61010
Virginia Beach, VA 23466-1010

Claim payment appeal

The second step in the Healthy Blue claim payment dispute process is called appeals. If you disagree with the claim dispute resolution, you may file an appeal. Appeals must be submitted within 90 days of the claim dispute resolution date. Claim payment appeals received beyond 90 calendar days will be considered untimely and upheld unless good cause can be established.

We have several options to file claim payment appeal:

1. Online (for reconsiderations and claim payment appeals): Use the secure **Availity *Payment Appeal Tool***. Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission.
2. Written (for reconsiderations and claim payment appeals): Mail all required and supporting documentation to:
   Healthy Blue
   Payment Dispute Unit
   P.O. Box 61599
   Virginia Beach, VA 23466-1599

Peer-to-peer reconsideration of adverse determination

In the event of an adverse determination following a medical necessity review, peer-to-peer reconsideration is offered to the treating physician on the notice of action (NOA) communication. Peer-to-peer reconsideration is offered when requested within three business days of the denial determination. The treating physician is provided the toll-free number of the health plan to request a discussion with the Healthy Blue medical director who made the denial determination.

Medical necessity appeal

Medical necessity appeals apply to authorization requests that were denied prior to the service or authorization concurrent requests made during an inpatient hospital confinement. Medical necessity appeals/prior authorization appeals are different than claim payment disputes must be filed within 60 calendar days of the adverse benefit determination. This step is initiated after a peer-to-peer has been completed.

Medical necessity appeals should be submitted in accordance with the medical necessity appeal process to:
Appeals and Grievances
P.O. Box 62429
Virginia Beach, VA 23466

Binding arbitration

After all internal dispute levels have been exhausted, either party may request binding arbitration, except to the extent the parties have agreed in the *Provider Agreement* to use an alternate means of binding dispute resolution. The parties will select an arbitrator who has experience and expertise in the healthcare field, in accordance with the rules of the *American Arbitration Association.*

The arbitrator will conduct a hearing and issue a final ruling. Any arbitration fees and expenses will be paid equally by Healthy Blue and the other party or parties within 30 calendar days of receipt of the bill or in a time frame otherwise required under the arbitration rules. Each party will be responsible for its own attorney's fees arising out of or related to the arbitration.

State fair hearing process

You have the right to ask for a state provider appeal **when our appeal process is complete, the denial of services has been upheld, and your appeal request was not resolved wholly in your favor.** You must ask for a state provider appeal within 120 calendar days from the date of our appeal resolution letter.

For help on how to ask for a state provider appeal, call the MO HealthNet Division Constituent Services Unit at **573-526-4274**. Send your state provider appeal to MO HealthNet. Include a *Provider Appeal Form* and a copy of our appeal resolution letter. You can send your state provider appeal via e-mail, fax, or mail:

- E-mail: MHD.PROVIDERAPPEAL@dss.mo.gov
- Fax: **573-526-3946**
- Mail: MO HealthNet Division Constituent Services Unit
  P.O. Box 6500 Jefferson City, MO 65109

State provider appeal decisions can have two outcomes:

- If MO HealthNet overturns our decision, a state provider appeal decision will be sent to you and to us containing the explanation and requesting that we remediate the issue within 10 business days.
- If MO HealthNet upholds our decision, the state appeal decision will inform you and us of an explanation followed by a notification to you informing you of your right to appeal to the Administrative Hearing Commission.
- Upon receipt of a state provider appeal decision, you may file a petition for review with the Administrative Hearing Commission:
  - You have 30 calendar days to appeal to the Administrative Hearing Commission. Claims must total at least $500.
  - You have 90 calendar days to appeal cumulative claims, upheld by MO HealthNet, once they reach $500.

MO HealthNet will promptly contact us to assist with remediating any decision overturned by the Administrative Hearing Commission.

What if I need assistance?

If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at **833-405-9086**.