

## Chapter 15: Provider Claims Disputes

### Provider Claim Dispute/Grievance Process

Health Choice Insurance Co. (HCE) has established a claim dispute and resolution process for resolving payment disputes and other contractual grievances with contracted and non-contracted health care providers. Grievable issues involve any disagreement with the adjudication of a claim (including claim adjustments), or non-payment issue. Examples of grievance issues include but are not limited to the following:

- Timely filing of a claim or grievance
- Timely filing of a claim
- Timely payment of a claim
- Systemic issues
- Amount paid / Fee schedules / Pricing issues
- Interest payment amounts or timeliness
- Adjustments/Recoupment's
- Co-insurance/ Deductibles
- Denials/Non-covered services or Authorizations
- Interest payment amounts or timeliness
- Network Adequacy
- Bundling/unbundling / Modifiers/multiple & exclusive procedure billing

### Filing a Provider Claim Dispute/Grievance (Level 1)

All grievances and appeals must be submitted in writing to the HCE. Grievance and Appeals Department within one year from the claim was paid or denied, or sixty days after the date of the last adverse action (whichever is later). Please note: on a case by case basis, time-limit may be extended for "good cause", or if a longer period is required by state or federal law. Examples of "Good cause" circumstances would include matters/instances beyond the reasonable control of the provider which prevented the provider from submitting a timely grievance request.

#### **Please submit the following documentation with the written claim dispute:**

- Cover Letter stating the problem and the relief requested
- Name of the person filing the dispute and that person's phone number
- Provider address – where we should send the decision letter
- Copy of the claim (including EOB's from any primary payors, if applicable)
- Copies of all supporting documentation, which may include, but is not limited to:
- Medical records to support your argument
- Documentation of phone calls or other correspondence to support your argument
- Documentation of reference materials (such as policies, medical standards, or coding information) to support your argument

Mail Level 1 Claim Disputes/Grievances and supporting documentation to:

Health Choice Insurance Co.  
 Attention: Claim Dispute Department  
 410 N. 44<sup>th</sup> St. Ste 928  
 Phoenix, AZ 85008

Once HCE receives the dispute, HCE will send you an acknowledgment letter by regular mail within 5 working days. Health Choice will issue a decision on all claim disputes within thirty (30) days from the date that the Health Plan received the claim dispute. If an extension is necessary, HCE will notify the Provider. If the claims dispute is overturned (approved), HCE will reprocess the claim(s) in a manner consistent with the Decision within 15 business days of the date of the Decision.

## Filing a Provider Claim Dispute/Grievance (Level 2)

If the filing provider disagrees with HCE's resolution/decision of your Level 1 Grievance, the provider may request a Level 2 Grievance. The Level 2 Grievance must be submitted in writing to Health Choice Insurance Co. within 30 days after the receipt of the Level 1 Grievance determination. A provider may extend the 30 day time period for up to an additional 30 days if the provider requires additional time to gather information to support the case, and files the request for the extension within the initial 30-day period.

The Level 2 Cover letter and supporting information must include the following:

- Cover letter stating the problem and the relief requested
- Name of the person filing the dispute and that person's phone number
- Provider address – where we should send the decision letter
- Copy of the Level 1 Decision Letter
- Copies of all supporting documentation (in addition to the information provided at the Level 1 Grievance)

Mail Level 1 Claim Disputes/Grievances and supporting documentation to:

Health Choice Insurance Co.  
Attention: Claim Dispute Department  
410 N. 44<sup>th</sup> St. Ste 928  
Phoenix, AZ 85008

The Provider Grievance Process described on the previous pages does not apply to:

- HCE network/contracting status including contract termination from the network;
- The member grievance and appeals process (which is separate from the provider grievance process);

You will receive an Acknowledgement Letter within 5 working days. This will let you know that we have your case and that we are working on it.

## Alternative to Filing a Claim Dispute

All providers have the right to file a claim dispute in response to any adverse action or decision made by HCE however; we encourage Providers to exhaust all other means of resolution before using the claim dispute process. See options below:

Claims status options:

- **Claims Customer Service.** The Claims Customer Service line is a group of dedicated personnel

trained to answer questions about claims and status claims for the provider. Providers may contact HCE Claims Resolution Services Unit at 1-855-452-4242 to resolve claims reimbursement issues informally. The Claims Resolution Services Unit provides assistance with claim issues including denied claims and incorrectly paid claims. Providers and office staff may also contact Claims Resolution Services to discuss questions about a remittance advice and/or to check the status of a claim.

- **Electronic EOB (835).** The electronic EOB or electronic remittance advice (sometimes referred to as the ERA or 835) is a more automated way of posting payments from the EOB that can be directly inputted into your practice management system. Contact your clearinghouse or software/system vendor to see if you have this capability.

### **Claim Resubmissions**

If your claim has denied for additional information or corrections, it is considered a Resubmission. Claim resubmissions should be sent back to the plan for reconsideration with a stamp or legible notice that the claim is a "Resubmission". If the services were performed by a facility, the appropriate bill type must be used to indicate a replacement claim. Appropriate documentation is required to re-evaluate the claim's original disposition in addition to the correct claim form with the services listed in detail.

All claim resubmissions can be mailed to:

Health Choice Insurance Co.  
Attention: Claim Dispute Department  
410 N. 44<sup>th</sup> St. Ste 500  
Phoenix, AZ 85008

### **Provider Disputes/Administrative Disputes**

If HCE suspects or receives sufficient information to cause concern for a member's health, welfare or safety, HCE will immediately suspend the provider contract and immediately initiate an investigation. In the even this occurs, Health Choice immediately removes the provider from the provider directory and notifies the provider of the suspension or termination in writing.

HCE offers a process for contracted/network providers to challenge Health Choice decision to terminate a contract for lack of professional competence or for professional misconduct, or for consumer safety. Examples may include the following:

- Trend or pattern of quality of care issues; or presence of or belief that a quality of care issue exists
- Adverse action taken by a hospital
- Disciplinary action taken by a hospital
- Disciplinary action taken by a licensing board
- Insufficient or no professional liability insurance
- Sanction by Medicare/Medicaid
- Exclusion from any Federal Programs
- A change in license status
- Fraudulent activity



To initiate a first level review of a provider termination, submit the following information in writing within 30 calendar days of the date of the provider termination notice:

- A letter outlining the appeal issue, including the reason for the appeal and any supporting basis for the appeal
- A copy of the original termination notice
- Supporting documentation for reconsideration

Requests for reconsideration/appeal, and supporting documentation should be sent to:

Health Choice Insurance Co.  
Attention: Claim Dispute Department  
410 N. 44<sup>th</sup> St.  
Phoenix, AZ 85008

The Health Choice Management Company Credentialing Committee, consisting of at least 3 qualified individuals with at least one participating clinical peer provider will consider the reconsideration request. The Committee will provide a response to the provider within 10 business days.

If the provider is not satisfied with the committee decision, the provider may pursue a level 2 appeal within 30 calendar days from the Level 1 appeal decision. A panel of three individuals who did not participate in the first level decision, including at least one participating provider who is a clinical peer, will consider the second level appeal, and the decision will be communicated to the provider in writing within 10 business days.

## Member Appeals

A member or a treating provider can file an appeal on behalf of a member in response to an action. Most member appeals are filed because HCE has denied a request for a service (Authorization for future service). Please refer to Chapter 6 for details on Medical Authorizations and Referrals. If HCE does not make a decision on an authorization within the required time (as outlined in Chapter 6), then the member can consider the request “denied” and he/she can file an appeal.

When we deny a request for authorization, a *Notice of Action (NOA)* is mailed to the member, and an explanation letter is mailed to the requesting provider. The member’s NOA will advise the member on their right to file an appeal.

Please see Exhibit 15-1, Health Care Insurer Appeals Process Information Packet.

If Health Choice Insurance Co. is reducing, suspending or terminating an existing service, there are additional rights and rules that apply, other than just being able to file an appeal. Please refer to the Member Evidence of Coverage on the Health Choice website at [www.healthchoiceessential.com](http://www.healthchoiceessential.com), or call our Member Services Department for details.