Policy & Procedure			
Subject:	**Provider Complaint and Dispute Processing and Resolution Policy**		
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Supersedes:		**Attachment(s):**	A

Department:	Plan Operations & Administration
Policy Owner:	Bridgette Robertson
Stakeholder(s):	Provider Network Operations, Provider Network Management, Research & Analysis, Provider Claim Services Unit (PCSU), Utilization Management, Quality Management, and Provider Maintenance
Applicable Parties:	
Signature(s):	

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Contract Reference(s):	Section 2.10.9 – Provider Complaint System
NCQA Reference(s):	N/A

POLICY

As outlined below, all AmeriHealth Caritas Louisiana (ACLA) **in-network and out-of-Network** Providers have the opportunity to request a timely review of Complaints and Claim Disputes directly with the Plan or with LDH. ACLA Provider Complaints and Claim Disputes will be tracked and resolved via the procedures outlined below.

ACLA will ensure that provider complaints are acknowledged within 3 **business** days of receipt. Thereafter, ACLA will resolve and/or communicate the stated result to the provider **as soon as possible or** within 30 calendar days of receipt**, whichever is sooner** (this includes referrals from LDH).

If the Plan, LDH, or its **S**ubcontractors **or Providers** discover errors made by the Plan when a claim was adjudicated, the Plan shall make corrections and reprocess the claim within 15 calendar days of discovery **or notification**, or if circumstances exist that prevent the Plan from meeting this time frame, **by** a specified date **subject to LDH written approval**. The Plan shall automatically recycle all impacted claims for all providers and shall not require the provider to resubmit the impacted claims.

In accordance with The Health Insurance Portability and Accountability Act of 1996 (HIPAA), ACLA is committed to protecting the privacy of Members' health information. This is

accomplished through compliance with HIPAA policies and procedures by incorporating applicable federal and state laws that protect the privacy and security of Members' health information. Pertinent HIPAA policies and procedures utilized in this procedure are identified in the Cross Reference/Reference Materials section outlined below.

PURPOSE

The Provider Complaint and Dispute policy defines a system and maintains a process for receipt and prompt internal resolution of ACLA Provider Complaints and Claim Disputes as set forth in the contract with LDH.

DEFINITIONS

ACLA (or Plan) – AmeriHealth Caritas Louisiana, Inc.

Adverse Action - The denial or limited authorization of a requested service, including the type or level of service, the reduction, suspension, or termination of a previously authorized service, failure to provide services in a timely manner, or failure of ACLA to act within the timeframes provided in Section.

Provider - A person, firm, or corporation that provides medical services or supplies to ACLA members. Providers include, but are not limited to: physicians, hospitals, home care companies, durable medical equipment companies, and pharmacies.

Provider Complaint - A verbal or written expression by a provider which indicates dissatisfaction or dispute with the Contractor's policy, procedure, Claims processing and/or payment, or any aspect of the Contractor's functions.

Claim Dispute – A dispute is defined as a request from a health care provider to change a decision made by AmeriHealth Caritas Louisiana related to a claim payment or denial for services already provided. A provider dispute is **not** a pre-service appeal of a denied or reduced authorization for services or an administrative complaint.

First-Level Dispute – An initial written request for post-service review of claims.

Second-Level Dispute – A secondary written request for review of first-level claim dispute resolution.

EXP - The product used by departments throughout the Family of Companies as a workflow, document, and contact management tool, allowing us to capture important information as it enters the Plan, and electronically distribute it through our daily workflows.

Provider Claim Dispute Form – The required form a provider must submit when requesting a First-Level or Second-Level Dispute.

Service Form (SF) - Form used within the EXP documentation system to record and track inquiries, issues, and any other contact with callers.

SharePoint: A platform from Microsoft that is used to create intranets (internal Web sites) for team collaboration, blogs, wikis, and company news.

NEMT – Non-Emergency Medical Transportation

PROCEDURE

I. Filing

- Complaints may be filed by phone, in writing or in person.
- Providers may desire to escalate an issue to the attention of the Plan's executive team for claim or non-claim related issues as an Escalation.
- Claim Disputes must be filed in writing with the required Provider Claim Dispute Form.
    - If multiple claims are impacted by the same issue, the provider may submit the dispute via the claim project spreadsheet located at http://www.amerihealthcaritasla.com/pdf/provider/resources/manual/appendix/19.pdf. Multiple claims with different denial reasons should not be submitted on the same form.
    - **Any instance where a provider claim is denied, the consent of the enrollee who received services shall not be required for the provider to dispute the denial of the claim. The provider may pursue a claim dispute based on nonpayment for rendered services under the terms and conditions outlined in their provider contract with AmeriHealth Caritas Louisiana or as otherwise provided by Louisiana law. The enrollee who received the services shall not be required to sign an authorized representative form, or provide other forms of written consent, for the provider to dispute the denied claim for payment. For each denied claim, providers must be notified of the amount and reason for the denial.**
- **Complaints will be thoroughly investigated including collecting pertinent facts from all parties during the investigation.**
- **AmeriHealth Caritas Louisiana staff receive on the job training that helps with**

identification of key words and terminology to differentiate complaints, disputes, appeals, and enrollee grievances.

II. Timeframes

The provider will receive acknowledgment of complaints and disputes within three (3) **business** days of receipt.

A. First-Level Claim Disputes

- Must be received within 180 calendar days of the denial. A determination will be made within 30 calendar days of receipt, which includes adjudication of all disputed claims to a paid or denied status.

B. Second-Level Claim Disputes

- If the provider remains unsatisfied with the first-level claim dispute resolution, he/she may file a second-level claim dispute within thirty (30) calendar days of the date on the first-level dispute determination letter. A determination will be made within 30 calendar days of receipt.

C. Arbitration

- Providers have the option to request binding arbitration for claims that have denied or underpaid claims or a group of claims bundled, by a private arbitrator who **is certified** by a nationally recognized association that provides training and certification in alternative dispute resolution. If the Contractor and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Section shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within **ninety (**90) Calendar Days of being selected, unless the Contractor and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney fees, shall be shared equally by the parties.
- The Plan shall systematically capture the status and resolution **of all** claim disputes as well as all associated documentation.

- The Plan shall adjudicate all disputed claims to a paid or denied status within thirty (30) Calendar Days of receipt of the disputed claim.
- The provider shall have one hundred eighty (180) Calendar Days from the date of denial to dispute the denied claim.

Providers do not have the right to a State Fair Hearing for claims issues.

In-network **and out-of-network** providers may request an on-site meeting with a Network Management Account Executive, either at the network **provider '**s office or at ACLA to discuss the complaint. Depending on the nature of the complaint, the Network Management Account Executive may also request an on-site meeting with the network provider. The network provider or Network Management Account Executive must request the on-site meeting within seven (7) calendar days of the filing of the formal dispute with ACLA. The Network Management Account Executive assigned to the network provider is responsible for scheduling the on-site meeting at a mutually convenient date and time.

III. NEMT Claim Disputes

Transportation providers have been given options for pursuing resolution of claims payment issues. Providers must first seek resolution with **Verida** directly, prior to contacting ACLA or LDH. Claim disputes cannot be considered without first completing the claim reconsideration step with **Verida**.

- For issues related to transportation claims, the transportation provider must contact:

  Verida470-819-4349
- claimsdispute@verida.com The transportation provider must submit a claim reconsideration within 180 calendar days of the Remittance Advice paid date or original denial date.
  - **Verida** will make a determination within 30 days of receipt.
- If the transportation provider is dissatisfied with the decision of the claim reconsideration, the provider must submit a claim appeal to ACLA within 30 calendar days of the date on the determination letter from the original request for the claim reconsideration from **Verida.**
  - Requests should be mailed to:

    AmeriHealth Caritas Louisiana
    Attn: 2nd Level Provider Dispute
    P.O. Box 7323
    London, KY 40742
  - ACLA will make a determination within 30 calendar days of receipt.

IV. Recording and Reporting

The Grievance System Manager (or designee) will log all provider complaints on the ACLA Provider Complaints Tracking SharePoint Site. Provider Complaints are tracked on a monthly basis and submitted to LDH. The log contains date filed, provider ID, and summary of complaint, status, resolution/response given, and resolution date. To the extent possible, and in accordance with applicable law, the Grievance System Manager (or designee) will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

V. ACLA will not prohibit, discourage, intimidate or in any other way take retaliatory action against a provider that reports any complaint to LDH.

REFERENCES (Cited Policies and Procedures and Source Documents)

N/A

ATTACHMENTS

Attachment A – Provider Dispute Form

AmeriHealth Caritas Louisiana

AmeriHealth Caritas Louisiana

Provider Claim Dispute Form

Mail this form, a listing of claims (if applicable), and supporting documentation to:
AmeriHealth Caritas of Louisiana
Provider Dispute Department
P.O. Box 7323
London, KY 40742

A dispute is defined as a request from a health care provider to change a decision made by AmeriHealth Caritas Louisiana related to a claim payment or denial for services already provided. A provider dispute is **not** a pre-service appeal of a denied or reduced authorization for services or an administrative complaint.

☐ First-level dispute ☐ Second-level dispute

Submitter/contact information:	
Name (last, first):	Phone number:

Provider information (correspondence):	
Name (last, first):	Phone number:
Provider address:	City, state, ZIP:
NPI number:	Tax ID:
Date:	
☐ I am a participating provider. ☐ I am **not** a participating provider.	

Member information:	
Name (last, first):	Member date of birth:
Member ID:	

Claim information:	
Claim number:	Billed amount: $
Date(s) of services:	

To ensure timely and accurate processing of your request, please complete the payment dispute section below by checking the applicable reason for your dispute and attach documentation to support this dispute. Documentation should include a copy of the original claim (if available), remittance advice, and a narrative explaining why you are disputing denial of the claim(s).

Reason for payment dispute:

☐ Inaccurate payment
☐ Denied for no primary payer EOB (EOB attached)
☐ Post-service authorization denial
☐ Denied for no authorization (service does not require authorization)
☐ Denied as a duplicate
☐ Denied for no authorization (authorization number on file:_____)
☐ Clinical edit limitation or denial
☐ Untimely filing (proof of timely filing attached)
☐ Other: _____

Additional information:

REVIEW/REVISION DATES

Keep all review and revision dates in this area. Only add a date when the document has been approved by the Policy and Procedure Subcommittee.

[-End of Policy-]

Policy and Procedure Approval

Policy and Procedure Type:

New **xx**□ Revision □ Review, No revision

□ Replacement (Replaced policy & procedure No._____)

Approval Signatures:

Bridgette S Robertson

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