n05678

Provider Dispute/Appeal Policy

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

This reimbursement policy outlines Network Health Plan's process, for all lines of business, when submitting a provider dispute or a provider appeal.

Policy Detail:

All providers must be registered users on Network Health's provider portal in order to submit a provider dispute or a provider appeal. If a paper dispute/appeal is submitted, it will be returned to the provider.

If the provider is not a registered user on the provider portal, they may go to https://networkhealth.com/provider-resources/Index and click **Sign Up Now** under **Provider Portal Access** to begin the registration process.

I. **Provider *Dispute* Timeframes**:

A. Participating and non-participating providers have one hundred and twenty (120) calendar days from the date of the original remittance advice to submit a provider dispute. Included in the 120-day timeframe are:

1. Commercial provider disputes (participating and non-participating providers)
    a. All decisions are final.
2. Medicare Advantage participating provider disputes (partial and full claim denial)
    a. All decisions are final.
3. Medicare Advantage non-participating provider disputes (**partial** claim denial)
    a. All decisions are final.

B. If the provider dispute is not submitted timely, it will be rejected.

II. **Provider *Appeal* Timeframes**:

A. Medicare Advantage non-participating providers have sixty (60) calendar days from the date of the original remittance advice to submit a provider appeal. Included in the 60-day timeframe are:

1. Medicare Advantage non-participating provider appeals (**full** claim denial)
    a. Commercial participating and non-participating providers **do not** have appeal rights.

i. Commercial non-participating providers require a member appeal.

B. Appeal requests must include pertinent clinical information, if applicable, and a signed Waiver of Liability (WOL) formally agreeing to hold the Medicare Advantage member harmless regardless of the outcome, as required by the Centers for Medicare & Medicaid Services (CMS). If Network Health upholds the claims denial, your appeal will be forwarded to Maximus Federal Services.

III. Qualified Payment Amount:

A. Network Health does not manage the dispute process for Qualified Payment Amount (QPA) related services. Please review your provider remittance advice, which outlines this process.

IV. Corrected Claims:

A. Corrected claims are not considered provider disputes or provider appeals and should not be submitted via the Provider Dispute application.

1. Provider's may review Network Health's Claim Submission Policy for information related to corrected claim submissions and timelines.

B. If a corrected claim is submitted as a provider dispute/appeal, it will be rejected.

Definitions:

Provider Appeal: The entire claim was denied, and there was no payment made by Network Health.

Provider Dispute: There was a partial payment made by Network Health. The provider is disputing the payment that was made, or the denial of other services billed on the claim.

Regulatory Citations:

Centers for Medicare and Medicaid Services (CMS)

Related Policies:

Claim Submission Policy
Provider Dispute Procedure

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