Medicaid Advisory Committee

Provider Grievances and Appeals

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
February 27, 2020

Denials or Disagreements

- Providers can receive denials or have disagreements on two primary areas:
  - Improper claims payment, including reimbursement
  - Adverse benefit determinations

Grievance

- Federal regulation defines “grievance” as “An expression of dissatisfaction about any matter other than an adverse benefit determination”.

- The MCEs may use the terms claims dispute or claims grievance to describe these provider actions.

Adverse Benefit Determination

Federal regulation defines an “adverse benefit determination” to include the following*:

- Denial or limited authorization of a requested service, including determinations of medical necessity
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of a payment of a service
- Failure to provide services in a timely manner

*For a complete list, please refer to 42 CFR 438.400

How do I appeal/dispute/grieve a decision (without losing my mind)?

Claims Payment
(Denial Not Related to Medical Necessity)

Anthem

Step	Process Name	Timeframe	Methods of Submission
1	Claim Payment Reconsideration (Informal Dispute)	60 calendar days from Explanation of Payment	Phone: Provider Services Online: availity.com Mail: Provider Dispute Resolution Request Form
2	Claim Payment Appeal (Formal Dispute)	60 calendar days from the reconsideration determination letter	Online: availity.com Mail: Provider Dispute Resolution Request Form

CareSource

Step	Process Name	Timeframe	Methods of Submission
1	Claim Dispute (Formal Dispute)	60 calendar days from the written determination of the claim	Fax: (937) 531-2398 Online: CareSource Provider Portal Mail: Appeal and Claim Dispute Form

MDwise

Step	Process Name	Timeframe	Methods of Submission
1	Informal Claim Dispute	60 calendar days from a claims determination	Email: cdticket@MDwise.rog Mail: Claims Dispute Form
2	Formal Claim Dispute	60 days from the date of the 1st level resolution	Email: cdticket@MDwise.rog Mail: Claims Dispute Form

MHS

Step	Process Name	Timeframe	Methods of Submission
1	Informal Claim Dispute	67 calendar days from date on Explanation of Payment (EOP)	Mail: Informal Claim Dispute/Objection Form*
2	Formal Claim Dispute / Administrative Claim Appeal	67 calendar days from receipt of the informal dispute resolution notice (or 90 calendar days from the date the informal notice was submitted if MHS does not response)	Mail: formal letter

*Online claims dispute option will become available April 5, 2020.

Adverse Benefit Determination
(Authorization Denial Due to Medical Necessity)

Anthem

Step	Process Name	Timeframe	Methods of Submission
1	Reconsideration	Within 7 business days of the denial	Phone: refer to Anthem Provider Manual for appropriate phone number
2	Peer-To-Peer	Within 7 business days of the denial	Phone: refer to Anthem Provider Manual for appropriate phone number
3	Appeal	60 calendar days from the date on the Notification Letter of Denial	Phone: Provider Services Online: availity.com Mail: Provider Dispute Resolution Request Form
4	External Independent Review	60 calendar days (for HHW and HIP members) or 120 days (for HCC members) of appeal decision	Fax: (855) 516-1083
5	State Fair Hearing	Within 60 days of all internal appeal procedures	Mail: FSSA Office of Hearings and Appeals

CareSource

Step	Process Name	Timeframe	Methods of Submission
1	Peer-To-Peer	Within 5 business days of the denial	Phone: (844) 607-2831, extension 12830
2	Dispute	60 calendar days from the date on the Notification Letter of Denial	Fax: (937) 531-2398 Online: CareSource Provider Portal Mail: Appeal and Claim Dispute Form
3	Appeal	60 calendar days from the date on the Notification Letter of Denial	Fax: (937) 531-2398 Online: CareSource Provider Portal Mail: Appeal and Claim Dispute Form
4	External Independent Review		
5	State Fair Hearing	Within 60 days of all internal appeal procedures	Mail: FSSA Office of Hearings and Appeals

MDwise

Step	Process Name	Timeframe	Methods of Submission
1	Peer-To-Peer	Within 7 business days of the denial	Phone: (888) 961-3100
2	Appeal	60 calendar days from the date on the Notification Letter of Denial	Mail: MDwise Medical Management Attn: Appeals PO Box 44236 Indianapolis, IN. 46244-0236
3	External Independent Review	33 calendar days of receiving an appeal determination	Mail: MDwise Medical Management Attn: Appeals PO Box 44236 Indianapolis, IN. 46244-0236
4	State Fair Hearing	Within 60 days of all internal appeal procedures	Mail: FSSA Office of Hearings and Appeals

MHS

Step	Process Name	Timeframe	Methods of Submission
1	Peer-To-Peer	Within 10 calendar days of the denial	Phone: (877) 647-4848, extension 87058
2	Appeal	Within 60 calendar days of the denial determination letter	Email: appeals@mhsindiana.com Fax: (866) 714-7993 Mail: formal letter
3	External Independent Review	Within 120 calendar days of the appeal decision letter	Email: appeals@mhsindiana.com Fax: (866) 714-7993 Mail: formal letter
4	State Fair Hearing	Within 60 days of all internal appeal procedures	Mail: FSSA Office of Hearings and Appeals

Dispute/Appeals Statistics

Claim Disputes

	Anthem		CareSource		Mdwise		MHS	
	Informal*	Formal**	Informal	Formal	Informal	Formal	Informal	Formal
Total Disputes	89,752	5,949	N/A	15,892	18,785	1,203	10,314	407
Resolved	76,132	3,908	N/A	14,565	14,229	1,084	10,098	405
Percentage of Disputes Resolved	84.82%	65.69%	N/A	91.65%	75.75%	90.11%	97.91%	99.50%
Percentage Resolved Timely	90.56%	95.34%	N/A	65.55%	38.83%	91.24%	98.06%	100.00%
Resolved In Favor of Provider	29,646	1,657	N/A	3,745	2,748	185	3,853	174
Resolved In Favor of MCE	46,486	2,251	N/A	10,820	11,481	899	6,245	231
Disputes Per 100,000 Claims Received	3,605.90	239	0	5,228.80	1,790.50	114.7	1,409.50	55.6

Q4 2019 Data

*Must be resolved within 30 days of receipt

**Must be resolved within 45 days of receipt

OMPP Oversight

- OMPP uses the following means to provide oversight over our fiscal agent and our MCEs on issues related to claims dispute and appeals:

Oversight Measures
Monthly onsite meetings
Quarterly reporting
Readiness reviews over claims payers
Ad-hoc reporting
Sanctions for poor performance
External quality review audits
Provider education through provider relations

Recap

- Each MCE has a process for claims disputes as well authorization denials.
- Providers have multiple steps to pursue to resolve both claims issues as well as denials around medical necessity.

Questions?

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