Provider Bulletin
July 2023

Claims escalation, disputes, and appeals process

Below are guidelines for a claims escalation process, provider payment dispute, and appeals process relating to claim payment. We encourage providers to seek resolution of issues by using the processes outlined below prior to reaching out to your Provider Relationship Account consultant/manager with claim questions.

However, if you notice a trend in your claims, please reach out to your Provider Relationship Account consultant/manager right away with claim examples so they can assist you with resolution. More detailed information can be found in our provider manual on our website: **Home | Anthem Blue Cross and Blue Shield**.

If you are not sure who your Provider Relationship Account consultant is, select this **link** for a complete territory list with their contact information.

Anthem Blue Cross and Blue Shield (Anthem) maintains a Claims Payment Systemic Error (CPSE) report. A CPSE is defined as a systematic incident causing claims to adjudicate incorrectly, which could result in underpaying, overpaying, denying, or suspending claims. When this occurs and impacts five or more providers or has the potential to impact five or more providers, Anthem will report CPSE data on our Ohio Medicaid provider website. Before submitting a complaint, please check the plan's CPSE report for the issue in question.

View the CPSE report **here**.

Step 1: Self-service tools

Through our digital self-service options offered on the Availity Essentials* platform, you can access much of the same information you receive when calling Provider Services.

Chat with Payer, an application which is accessed through Availity Essentials Payer Spaces, is a digital alternative to making a phone call to get questions answered through a real-time, online discussion. Inquiry types include eligibility, benefits, claims, authorization status, and appeal status.

Chat with Payer is available Monday to Friday from 8 a.m. to 6 p.m. ET. Save your chat session inquiry number as a reference.

By using **Availity Essentials**, you can verify member benefits and eligibility, submit claims, view claims status, submit and view prior authorization requests, and more.

More information regarding real-time multi-payer capabilities and provider organization registration process of Availity Essentials can be found **here**.

Submit a claim payment dispute or appeal

Required documentation for claims payment disputes and appeals:

- Your name, address, phone number, email, and either your NPI or TIN

* Availity, LLC is an independent company providing administrative support services on behalf of the health plan.

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- The member's name and their Anthem or Medicaid ID number
- A listing of disputed claims, which should include the claim number and the date(s) of service(s)
- All supporting statements and documentation
- A detailed explanation of the reason for the appeal

Submit a first-level claim payment dispute: This is the provider's initial request for a review into the outcome of a claim once it is finalized:

- First-level claim payment disputes can be submitted verbally, in writing. or through the **Availity Essentials platform**.

Submit a second-level claim payment appeal: This is the second step in the claim payment dispute process. If a provider disagrees with the outcome of the claim payment dispute, providers may request a second-level review, also known as a claim payment appeal:

- Second-level claim payment appeals can be submitted verbally, in writing. or through the **Availity Essentials platform**.

Note: We accept both claim payment disputes and appeal requests through our provider website, verbally, and in writing within 12 months from the date of service (DOS) or 60 calendar days from the date on the *Explanation of Payment* (*EOP*) (see below for further details on how to submit). We cannot process a claim payment appeal without a dispute on file.

For provider post service/retrospective authorizations: If services have been rendered to the member, providers should file the claim with medical documentation as a payment dispute. A detailed explanation as to why a prior authorization was not obtained should be included with the dispute. Please refer to the provider manual for additional information.

Step 2: Contact Provider Services

Provider Services can be reached at **844-912-1226**:

- Representatives are available Monday to Friday from 7 a.m. to 8 p.m. ET:
  - If both our self-service tools and a Provider Services representative are unable to provide you with the support you need, you may request to speak with a Provider Services supervisor/escalation agent, and your call will be escalated.
  - If a supervisor/escalation agent is unable to assist you immediately, you will receive a call back within two business days. Please record your call reference number.

Step 3: Contact Provider Relationship Account consultant/manager:

- If our self-service tools, Provider Services, or submitting a claim payment dispute did not resolve the issue to your satisfaction, contact your designated Provider Relationship Account consultant/manager. Your Provider Relationship Account consultant/manager can be found at this **link**. You can also email the Provider Relationship Account Management team at OhioMedicaidProvider@Anthem.com.
- Providers should use the document below when sending claim issues to their Provider Relationship Account consultant/manager. When an issue is affecting many claims, only five examples are needed for research.

Anthem Claims Template for Escalation Dispute and Appeals