Provider reference guide: claims disputes and appeals, and clinical appeals for UM decisions

Anthem Blue Cross and Blue Shield Medicaid | Ohio Medicaid Managed Care

This guidance concerns:

- Claims payment disputes versus claims payment appeals
- Clinical appeals for adverse utilization management (UM) decisions

Claims payment disputes versus claim payment appeals

Q: What is a claims payment dispute?

A: A Claim payment dispute is the provider's initial request for a review into the outcome of a claim once it is finalized.

Q: What is a claim payment appeal?

A: If a provider disagrees with the outcome of the claim payment dispute, the provider may request a second-level review, known as a claim payment appeal.

Q: When should providers file a claim payment dispute or claim payment appeal?

A: Claim payment disputes and claim payment appeals can be filed when claims are underpaid, overpaid, denied for no authorization (additional information below), or payment was denied for any reason other than medical necessity. Review our provider manual (PDF) for additional reasons a claim payment dispute or appeal may be filed.

We accept both claim payment disputes and appeal requests within 365 days from the date of service (DOS) or 60 calendar days from the date on the *Explanation of Payment* (EOP), whichever is later.

Q: How can providers file a claim payment dispute and claim payment appeal?

A: Both the claim payment dispute and claim payment appeal can be filed via the preferred method of Availity Essentials or by mail or phone; call Provider Service at **844-912-1226**. The mailing address can be found in our provider manual (PDF).

Q: What documentation is required when filing a claim payment dispute or a claim payment appeal?

A: Required documentation includes:

- Your name, address, phone number, email, and either your National Provider Identifier or tax ID

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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

Note: We cannot process a claim payment appeal without a claim payment dispute on file.

Clinical appeals for adverse utilization management (UM) decisions

Q: When should providers file a clinical reconsideration?

A: The clinical reconsideration process is available to providers following an adverse medical determination within 30 days from the initial denial and when there is new clinical information or information that was not already provided in the initial review.

Q: How do providers file a clinical reconsideration?

A: By fax to these number:

- Physical health: Fax to **877-643-0671**
- Behavioral health: Fax to **866-577-2184**

Q: What is needed to file a clinical reconsideration?

A: During the clinical reconsideration process, providers have an opportunity to submit *additional* clinical information to substantiate medical necessity for a previously denied preservice or concurrent inpatient stay.

Providers should also include *reconsideration* on the cover sheet if submitting via fax.

Q: When can providers request a peer-to-peer consultation?

A: Providers who disagree with an adverse medical necessity decision can request a peer-to-peer by contacting Anthem within seven (7) calendar days of the initial determination or seven (7) days after the determination of clinical reconsideration. To request a peer-to-peer, call Provider Services:

- Behavioral health: **844-441-1506**
- Physical health: **833-308-3035**

When you request a peer-to-peer review, Anthem will acknowledge your request within 24 hours and offer a peer-to-peer conversation within a mutually agreed-upon time.

Q: When can providers file a pre-service clinical appeal?

A: If an authorization is denied prior to the service being rendered to the member, the provider has the option to file a pre-service clinical appeal directly with Anthem and can do so without the member's consent.

If filing without the member's consent, appeals must be submitted within 30 calendar days of the initial determination. If filing on behalf of a member, providers have 60 calendar days from the initial determination to submit their pre-service clinical appeal, along with the member's consent. Additional information can be found in our *Provider Manual* (PDF).

Q: How do providers file a pre-service clinical appeal?

A: A pre-service clinical appeal can be filed:

- Electronically using Interactive Care Reviewer (ICR) in Availity Essentials. ICR training can be found on the Digital Solutions Learning Hub (on24.com)
- Fax directly to the Appeals department at **866-587-3316**

Q: If a provider fails to request a prior authorization (PA) can the service be reviewed retrospectively?

A: Yes, providers who fail to obtain a PA can request that services already administered be reviewed for medical necessity via a claim payment dispute. The dispute should be submitted **after** the claim denies for no authorization.

Upon receipt of the claim payment dispute, Anthem will review the service retrospectively for medical necessity. When submitting a claim payment dispute, the provider **must submit medical documentation and provide the extenuating circumstances for not submitting the PA**.

Claim payment disputes are to be submitted within 365 days from the DOS or 60 calendar days from the date on the *Explanation of Payment,* whichever was later.

Q: How do providers file post-service clinical appeals?

If there is an adverse determination of medical necessity, a post-service clinical appeal can be submitted (guidance above).

Q: When can providers file an external medical review (EMR)?

A: Providers who have exhausted appeal rights can request an EMR within 30 calendar days of Anthem's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity. The EMR is available at no cost to providers.

The request for EMR must be submitted to Permedion (gainwelltechnologies.com) within 30 calendar days of the written notification that the internal appeals process has been exhausted. Providers must complete the *Ohio Medicaid MCE External Medical Review Request* (PDF), which is available on Permedion.

Providers need to upload the request form and all supporting documentation to the HMS eCenter (hmsy.com). If the provider is a new user, the provider can send documentation by secure email to **imr@gainwelltechnologies.com** to establish website access.

Services denied for reasons other than lack of medical necessity are not subject to EMR. Examples include noncovered services and timely denials.

Trainings available:

- Availity Essentials offers both live and on-demand trainings.
- Digital Solutions Learning Hub (on24.com)

If you have questions, contact your provider relationship account manager or send an email to **ohiomedicaidprovider@anthem.com**. View this map (PDF) to identify your provider relationship account manager.

Email is the quickest and most direct way to receive important information from Anthem.

To start receiving email from us (including some sent in lieu of fax or mail), submit your information using our QR code or via our online form: http://anthem.ly/signup-abcbs-oh.