INDEPENDENT CLINICS OF WASHINGTON
CLAIMS PROCESSING POLICY/PROCEDURE

Title: Provider Dispute Resolution	Policy Number:	
	Original Issue:	01/00
	Revision Date(s):	07/14, 08/17, 06/19, 08/20, 07/23, 08/23
	Prior Review Date(s):	06/15, 07/16, 08/17, 08/18, 08/19, 08/20, 07/21, 07/22

Last Review Date: August 16, 2023 Dallas Penna **, Director of Operations**

Policy
ICW's health plan contracts include delegation of 1st level provider reconsiderations, also known as requests for claim redetermination. ICW's provider dispute resolution policy is to process reconsiderations within the timeframes established by contract, State and Federal statute and to ensure a fair, fast, and cost-effective mechanism for resolving disputes.

Procedure
To eliminate paper transactions, ICW has worked diligently with providers to transition all disputes to an electronic environment. Effective August 1, 2020, providers are required to submit their provider disputes via fax at (206) 834-6000 or by secure email to claims@ic-wa.org

Medicare Advantage

Health plan contracted providers
- ICW is delegated for 1st level reconsideration, and processes those per each health plan's administrative policy as published in their provider manual.
- Requests for reconsideration or 2nd level requests are processed by the health plan.

Non-contracted providers
Reconsideration process for Non-contracted Medicare Providers directed to UnitedHealthcare:
Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination including issues related to bundling or down coding of services. To appeal a claim denial, submit a written request within 60 calendar days of the remittance notification date and include at a minimum:

- To dispute a claim payment, non-contracted providers must submit a written request within 60 calendar days of the remittance notification date and include at a minimum:
    - A statement indicating factual of legal basis for the dispute
    - A signed Waiver of Liability form (you may obtain a copy by going to https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.html, at the bottom of the page under the "Downloads" section select the zip file for 'Model Waiver of Liability_Feb2019v508').
    - A copy of the original claims
    - A copy of the remittance notice showing the claim payment
    - Any additional information, clinical records, or documentation to support the dispute

Mail the payment dispute to:
UnitedHealthcare
P.O. Box 6106
Cypress, CA 90630
MS: CA124-0157

Reconsideration process for Non-contracted Medicare Providers directed to ICW:
Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider disagrees with the amount paid. To dispute a claim payment, submit a written request within 120 calendar days of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for the dispute
- A copy of the original claim
- A copy of the remittance notice showing the claim payment
- Any additional information, clinical records or documentation to support the dispute

Mail the payment dispute to:
ICW
PO Box 24897
Seattle, WA 98124-0897

Non-contracted providers will submit their disputes directly to United Healthcare for the following dispute types:

- Down coding
- Bundling issues and disputed rate of payment
- Diagnosis code/DRG payment denials
- Level of care or rate of payment denials

Non-contracted providers will submit their payment disputes directly to ICW for the following dispute types:

- Disputed rate of payment

Medicaid Apple Health

All providers

- As required by RCW 48.43.605
    - Except for COB claims, requests for additional payment must be received within 24 months after the date of the original payment determination and requests for additional payment may not be made any sooner than six months after receipt of the request
    - Requests for additional payment for COB claims must be made within 30 months after the date of the original payment determination and must be accompanied by documentation identifying the other carrier and reason for their denial

Medicare Advantage Part C Reopenings

Bulletin Number: MM4147 (cms.gov)

CMS requires appropriate handling of reopening a prior claim determination. A reopening is the action taken to change a final determination or decision, even though the determination or decision was correct based on the evidence of the record.

Reopening reason categories:

- New and material evidence – documentation not previously available or known during the decision-making process that could possibly result in a different decision
- Clerical Error – human and mechanical errors as mathematical or computational mistakes, inaccurate coding and computer errors, inaccurate data entry and denial of claims as duplicates
- Fraud or similar fault – post-service decision when reliable evidence shows the decision was procured by fraud or similar fault when the claim is auto-adjudicated in the system

Reopening requests made by a member, member's authorized representative, or a non-contracted health care provider must be:

- Clearly stated
- Include the specific reason for the reopening
- In writing or verbal
- Filed within the appropriate periods
- **NOTE:** ICW is not delegated for member or member authorized representative reopening requests. If a member or member authorized representative request is received by ICW, ICW will forward directly to the health plan within 24 hours.

A request for reopening may occur under the following conditions:

- A binding determination or decision has been issued
- The 60-calendar-day time frame for filing a reconsideration is expired
- There is no active appeal pending at any level

Dispute Resolution Process

- Member appeals received by ICW are date stamped, logged, and forwarded directly to the health plan within 24 hours as ICW is not delegated for member appeals.

- Provider reconsideration received by ICW are date stamped and forwarded to the designated employee for processing.
- Designated employee researches the provider reconsideration request:
    - Research includes a review of the initial claim determination and validation of adjudication accuracy, review of claim and authorization history and research to be certain the provider reconsideration is not a duplicate.
    - If adjudication errors are found, the claim is submitted for reprocessing for inclusion in the next check run.
    - If the initial claim determination was accurate, the designated employee will issue a formal written response to the provider.
    - If the initial claim determination was incorrect, the claim is submitted for reprocessing for inclusion in the next check run and the claim payment will include interest if applicable. The designated employee will issue a formal written response to the provider indicating an overturned decision.
    - Provider reconsiderations that require Medical Management involvement are forwarded to the Medical Management Team for review and resolution. A formal written response is then sent to the provider via fax or USPS mail.
    - Claims Manager monitors the reconsideration log for accuracy and timely turnaround response to the provider.
- Paper documentation prior to 2019 is stored off site during the 10- year retention period.
- An electronic copy of reconsideration response letter and supporting documentation from 2010 to present are saved on the network, J:\Production Reports\Provider Appeals.
- All provider reconsiderations will be responded to within 30-days of receipt.
- The Provider Dispute Resolution Policy including the process for submitting requests for redetermination is posted on ICW's website. Provider Dispute Resolution information is also published on the first page of the EOP.
- Provider requests for payment redetermination should be faxed or secure emailed to:

    Fax: (206) 834-6000
    claims@ic-wa.org