Government Business Division
Policies and Procedures

Section (Primary Department) **Claims**		**SUBJECT (Document Title)** **Provider Claim Payment Dispute Process**	
Effective Date November 28, 2018	**Date of Last Review** May 12, 2022	**Date of Last Revision** ~~August 25, 2022~~November 02, 2022	**Dept. Approval Date** ~~August 25, 2022~~November 02, 2022
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☒ Arkansas	☒ Iowa	☒ Nevada	☒ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☒ New Jersey	☒ Texas
☐ **MMP/Duals**	☐ Colorado	☒ Louisiana	☒ New York – Empire	☒ Virginia
	☒ District of Columbia	☒ Maryland	☒ New York (WNY)	☒ Washington
	☒ Florida	☒ Minnesota	☒ North Carolina	☒ Wisconsin
	☒ Georgia	☒ Missouri	☒ South Carolina	☒ West Virginia
	☒ Indiana	☒ Nebraska		

POLICY:

Anthem ensures the timely and accurate processing for In-Network and Out-of-Network Provider claim disputes through the following Provider Claim Payment Dispute System.

DEFINITIONS:

Claims Payment Appeal: Provider's disagreement with a claim payment or a reconsideration decision. The investigation of a Claim Payment Appeal may result in a change to a claim payment.

Claims Payment Reconsideration: Provider's request to investigate the outcome of a claim decision. The investigation of a reconsideration may result in a change to a claim payment.

Medical Necessity Appeal: Provider's request to investigate issues related to pre-service authorization of Medical Services. ***Note: This policy addresses the post-service Provider Claims Payment Dispute Process only. For information regarding Medical Necessity Appeals, please refer to the Member Appeal Process.***

Provider Claim Payment Dispute Process: Refers to an internal system for In-Network and Out-of-Network Providers to dispute the denial, in whole or in part, of payment for services included on a clean claim. The Provider Claim Payment Dispute process consists of an internal two-step Claims Payment Reconsideration and Claims Payment Appeal process followed by an external state-specific process called, generally the Regulatory Complaint. Please note, not all Medicaid States support a Regulatory Complaint process.

Regulatory Complaint: General term for Medicaid State specific external state sponsored review for Providers dissatisfied with the outcome of a Claims Payment Appeal.

PROCEDURE:

1) A provider will not be penalized for filing a Claims Payment Dispute.

2) No action is required of a member for a provider Claims Payment Dispute.

3) All submitted Provider Claim Payment Disputes are captured and tracked in a reportable database. Anthem reports the status and resolution of all Provider Claim Payment Disputes. Information captured and tracked includes, at minimum: date received; identification of the Provider submitting the Dispute; identification of the associate recording the Dispute; nature of the Dispute; resolution of the Dispute; corrective action required, and the date resolved.

4) The Claims Payment Dispute records are maintained in accordance with contractual requirements.

5) Confidentiality is maintained to the extent permitted under applicable laws, rules and regulations.

Claim Payment Reconsideration Process

If a provider is dissatisfied with the outcome of a claim payment, the provider may request an investigation into the claim payment decision, called Reconsideration.

The Provider may request a Reconsideration within the state-specific guidelines from the date of the claim EOP.

The Reconsideration procedure is as follows:

1) The Provider may submit a Reconsideration in one of three (3) ways:
   a) Written: The Provider may submit a written Reconsideration request to the following address. The request must include any necessary supporting documentation.

Anthem Provider Payment Disputes
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

   b) Verbally: The Provider may call the National Customer Care Center to request Reconsideration.

c) Web Portal: The Provider may access and submit a Reconsideration through the Anthem Provider Web Portal.

2) Upon receipt of the request from the Provider, an Acknowledgment Letter is sent. This occurs no later than the market-specific days allowed after receipt of the Provider's request.

3) Upon receipt of the request from the Provider, an internal review is conducted. This includes a thorough investigation by a trained claims analyst utilizing all applicable statutory, regulatory, contractual, and Provider subcontract provisions, Anthem policies and procedures, State Policies, and all pertinent facts submitted from all parties

4) Anthem will make every effort to communicate the results through a written Determination letter to the provider within the state-specific guidelines from the receipt of the Reconsideration.
   a) If the Determination results in a claim adjustment, the payment and Explanation of Payment (EOP) will be sent separately.
   b) If the determination of the Reconsideration requires additional information to resolve, the determination may be extended according to state-specific guidelines. A written extension letter will be sent to the Provider before the expiration of the initial determination period.
   c) If the determination requires clinical expertise, it will be reviewed by appropriate clinical Anthem professionals.

   The Determination letter includes:
   a) Date of notice
   b) A statement of the provider's Reconsideration request;
   c) A statement of what action Anthem intends or has to take;
   d) The reason for the action;
   e) Support for the action, including applicable statutes, regulation, or policies and claims, codes, or provider manual references;
   f) An explanation of the Provider's right to request a Claim Payment Appeal.
   g) Address to submit the Claim Payment Appeal.
   h) The provider's right to represent him/herself or be represented by legal counsel or another spokesperson when requesting an appeal

   Reconsideration Resolution letters will be sent at the time of the reconsideration decision.

Claim Payment Appeal Process

If a Provider is dissatisfied with the outcome a Reconsideration determination, the Provider may submit a Claim Payment Appeal.

The provider may request a Claim Payment Appeal within the state-specific guidelines of the date of the claim EOP or the date of the Reconsideration decision.

The Claim Payment Appeal process is as follows:

1) The Provider or the Providers authorized representative may submit a Claim Payment Appeal in one of two (2) ways:
   a) Written: The Provider may submit a written Claim Payment Appeal to the following address. The request must include any necessary supporting documentation.

Anthem Provider Payment Disputes
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

   b) Web Portal: The Provider may access and submit a Claim Payment Appeal through the Anthem Provider Web Portal:

2) Upon receipt from the Provider, an Acknowledgment Letter is sent.

3) Upon receipt from the Provider, an internal review is conducted. This includes a thorough investigation by a trained claims appeal analyst utilizing all applicable statutory, regulatory, contractual, and Provider subcontract provisions, Anthem policies and procedures, State policies, and all pertinent facts submitted from all parties.

4) The results are communicated through written Determination letter to the provider within state-specific guidelines of the receipt of the Claim Payment Appeal.
   a) If the decision results in a claim adjustment, the payment and Explanation of Payment (EOP) will be sent separately.
   b) If the determination of a Claim Payment Appeal requires clinical expertise, it will be reviewed by appropriate clinical Anthem professionals.
   c) If the determination of the Claim Payment Dispute Appeal requires additional information to resolve, the determination may be extended according to state-specific guidelines. A written extension letter will be sent to the Provider before the expiration the initial determination period.

   The Determination letter includes:
   a) Date of notice
   b) Date of appeal resolution
   c) A statement of the provider's Claim Payment Appeal request;
   d) A statement of what action the Anthem intends to take or has taken;
   e) The reason for the action;
   f) Support for the action, including applicable statutes, regulation, or policies and claims, codes, or provider manual references;

g) A statement about how to submit a state-specific Regulatory Complaint, if applicable.
h) The provider may represent him/herself or use legal counsel, a relative, a friend, or a spokesperson.

Regulatory Complaint

If the Provider has completed Anthem Claim Payment Dispute Process / exhausted their Anthem Dispute rights but their claim issue remains unresolved to their satisfaction, the Provider may submit a request for a Regulatory Complaint according to state-specific guidelines.

Important Claim Payment Dispute Provisions:

1) Reconsideration Timely Filing: A provider must submit Reconsideration no later than state-specific guidelines from the date of the claim EOP. Reconsiderations requested outside of this time frame will be deemed untimely, and denied.

2) Claim Payment Appeal Timely Filing: A Provider must submit a Claim Payment Appeal no later than state-specific guidelines from the determination letter of Reconsideration. Claim Payment Appeals requested outside of this time frame will be deemed untimely, and denied.

3) Multiple Claims: Providers may submit multiple claims of similar issue for investigation through one Claim Payment Dispute request.

4) Claim Payment Dispute Submission Limits: The Provider has one (1) Reconsideration and one (1) Claim Payment Appeal request per claim.

5) Providers must first complete the Claim Payment Appeal process before submitting a Regulatory Complaint, unless otherwise noted in state-specific guidelines.

6) The Provider Claim Payment Dispute process will not address Anthem's decision to not contract with a Provider, decision to terminate a contract with a Provider, or non-related policies and procedures or administrative functions.

REFERENCES:

- Louisiana Contract Section 17.6., 2.18.12 Claims Dispute Management Provider Payment Dispute Process
- Maryland COMAR 10.67.09.03 Provider Complaint Process
- Maryland Insurance Statute §15-1005 Prompt Payment of Claims
- Nebraska Contract Section IV.S.8 Claims Dispute Management

- New Jersey MCO Contract
- SC_GAXX_051 Member Appeal Process Standard
- SC_GAXX_053 Provider Appeals
- SCDHHS MCO Contract
- SCDHHS Policy and Procedure Guide
- SCDHHS Reports Companion Guide
- TennCare Contract Section A.2.22.5
- TN - TCA §56.32.126
- VA - 42 CFR §422
- VA - Commonwealth Coordinated Care Plus Contract § 15.5.1, 15.5.2, 15.5.3 and 15.5.4
- VA - Medallion 4.0 Contract § 12.7
- VA - Member Appeals - Core Process
- WA - Integrated Managed Care Contract K4167 §7.9
- WI - Badger Care Plus and Medicaid SSI Contract for January 1, 2018 – December 31, 2019, Article VIII – Provider Appeals, Sections A and B.

RESPONSIBLE DEPARTMENTS:

Primary Department: Claims Department

Secondary Department (s): Anthem Health Plan Operations
Anthem Provider Relations

EXCEPTIONS:

STATE-SPECIFIC GUIDELINES

State-specific	Reconsideration Timely Filing	Reconsideration Turnaround Time	Claim Payment Appeal Timely Filing	Claim Payment Appeal Turnaround Time
Arkansas	90 Calendar	30 Business	30 Business	30 Business
California	365 Calendar	45 Business	60 Calendar	45 Business
District of Columbia	90 Calendar	30 Calendar	30 Calendar	30 Calendar
Florida	120 Calendar	30 Calendar	30 Calendar	30 Calendar
Georgia	90 Calendar	30 Calendar	30 Calendar	30 Calendar
Indiana	60 Calendar	30 Business	30 Calendar	45 Calendar
Iowa	120 Calendar	30 Calendar	30 Calendar	30 Calendar
Louisiana	180 Calendar	30 Calendar	30 Calendar	30 Calendar
Maryland	90 Business	30 Business	30 Calendar	30 Business
Minnesota	90 Calendar	60 Calendar	60 Calendar	60 Calendar
Missouri	365 Calendar	45 Calendar	30 Calendar	30 Calendar
Nebraska	90 Calendar	30 Calendar	30 Calendar	30 Calendar
Nevada	90 Calendar	30 Calendar	30 Calendar	30 Calendar
New Jersey	90 Calendar	30 Calendar	30 Calendar	30 Calendar
New York	- 45 Calendar - Essential Plan members: 180 Calendar - Non-Participating Providers: No timely filing limits - 365 Calendar days if we are at fault	30 Calendar	30 Calendar	30 Calendar
North Carolina	60 calendar days	30 Business days	30 calendar days form receipt of first level determination letter	30 business days
South Carolina	90 Calendar	30 Calendar	30 Calendar (extension of 15 calendar days may be needed if additional information is required)	30 Calendar
Tennessee	365 Calendar	30 Calendar (may apply extension)	30 Calendar	30 Calendar (may apply extension)
Texas	120 Calendar	30 Calendar	30 Calendar	30 Calendar
Virginia	365 Calendar	30 Calendar	15 Months from DOS or 180 Calendar Days from the adverse determination date (original claim EOP or last Reconsideration determination), whatever is later.	30 Calendar
Washington	24 Months	30 Calendar	30 Calendar	30 Calendar
West Virginia	180 Calendar	45 Business	60 Calendar	30 Calendar
Western NY	- 45 Calendar - Non-Participating Providers: No timely filing limits - 365 Calendar days if we are at fault	30 Calendar	30 Calendar	30 Calendar
Wisconsin	365 Calendar	45 Calendar (may apply extension)	45 Calendar	45 Calendar (may apply extension)

FLORIDA

1) In accordance with FL Statute 408.7057, a contracted or non-contracted provider may request an external review of a claim appeal after exhausting the Health Plan's internal appeal resolution process.

2) If the provider does not agree with the Health Plan determination of the payment appeal, the provider has the right to request a review by the Florida Provider and Managed Care Organization Claim Appeal Resolution Program. Currently, the contracted review agency is Maximus. For further information and requirements for the process, they can be reached at 1-800-356-8151, ask for Florida Claim Appeal Process.

3) Per Florida Statute §408.7057 Claims Disputes must be resolved within 60-days of receipt.

GEORGIA

1) The health plan will allow a provider that has exhausted the internal appeal process the option to pursue a Fair Hearing or to select binding arbitration. All arbitration costs, not including attorney's fees, shall be shared equally between parties. Providers are allowed to consolidate appeals of multiple claims that involve same or similar payment or coverage issues, regardless of the number of patients or claims included in the bundled appeal.

2) All records pertaining to the performance under Georgia contract must be retained for a period of seven (7) years from the date of final payment. Records that relate to appeals, litigation or the settlement of claims arising out of the performance of this contract or costs and expenses of any such agreements as to which exception has been taken by the State Contractor or any of his duly Authorized Representatives, must be retained by the contractor until such appeals, litigation, claims or exceptions have been disposed of.

3) The Health Plan must process, and finalize, all appealed claims to a paid or denied status within thirty (30) business days of receipt of the appeal claim.

LOUISIANA

1) Healthy Blue will:
   a) Allow providers the option of binding arbitration for denied or underpaid claims by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternate dispute resolution.
   b) If Healthy Blue and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply.
   c) The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this section shall be binding on all parties.

d) The arbitrator will conduct a hearing and issue a final ruling within ninety (90) calendar days of being selected unless Healthy Blue and the provider mutually agree to extend this deadline.
All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

~~2) Healthy Blue may, within sixty (60) days, elect to file suit in any jurisdictional court to further review the decision and recover any awarded funds and reasonable attorney's fees.~~

~~3)~~2) Healthy Blue shall adjudicate all disputed claims to a paid or denied status within thirty (30) business days of receipt of the appealed claim.

~~4) The MCO shall resolve all disputed claims, no later than twenty-four (24) months from the date of service.~~

MARYLAND

1) If the health plan made a processing error, the claim will be reprocessed and timely submission guidelines will be waived allowing a max of three-hundred sixty-five (365) calendar days from EOP date. (Per Maryland Insurance Statute §15-1005).

2) All Disputes will be acknowledged by the Intake in writing within five (5) business days of receipt.

3) Providers have 90 business days from the date of a denial to file an initial Dispute.

4) Providers have at least 15 business days from the date of dispute disposition to file each subsequent level of Dispute.

5) The health Plan shall resolve Dispute, regardless of the number of Dispute levels allowed by the health plan, within 90 business days of receipt of the initial Dispute

6) If the decision is to uphold a previous decision at either level, the provider must receive written communication of the decision within thirty (30) calendar days of the decision.

7) If the decision is to overturn a previous decision at either level, the claim must be paid within thirty (30) calendar days of the decision.

8) At the outcome of any Dispute level, if requested, the providers have an opportunity to be heard by the MCO's chief executive officer, or the chief executive officer's designee.

9) A contracted or non-contracted provider may request an external review of a claim appeal after exhausting the Health Plan's internal appeal resolution process.

10) If the provider does not agree with the Health Plan determination of the payment appeal, the provider has the right to request a review by an Independent Review Organization (IRO) designated by the State. Currently, the contracted review agency is Maximus.

11) In order to file a complaint with the IRO, the provider must complete the IRO complaint form no later than 30 calendar days following the date of an MCO's adverse decision and submit the form via the IRO web portal.

12) The following IRO process will be followed after receiving the provider complaint form:
    a) A review of an adverse decision shall be based on the case record
    b) The IRO shall, after reviewing the case record, issue a final decision as to whether the health care services that are the subject of the complaint were medically necessary.
    c) The final decision shall state in writing the factual bases for the decision of the expert reviewer and reference the criteria and standards on which the expert reviewer's decision was based
    d) Final decisions shall be rendered within 45 days of submission of the case record, unless the time period is extended by the State.
    e) An MCO that receives an adverse decision from an independent review organization may file an appeal in accordance with COMAR 10.67.10.02.

13) If a provider complaint is unsuccessful, the provider is responsible for paying to the IRO the case review charge established by the State. The case review charge established by the State shall be based on the contract between the State and the IRO arrived at through a competitive procurement process.

14) An MCO that is determined by the IRO to have improperly denied, either in whole or in part, a provider's claim on medical necessity grounds is subject to the following:
    a) Within 60 calendar days of the date of an adverse decision by an IRO, the MCO shall fully reimburse the provider for claims determined to be medically necessary by the IRO, including any interest owed under Health Insurance Article, §15-1005(f), Annotated Code of Maryland; and
    b) Within 60 calendar days of the date of invoice by the IRO, the MCO shall reimburse the IRO the fixed case review charge established by the State.

NEBRASKA

1) Healthy Blue will:
    a. Allow providers the option to request binding arbitration for claims that have been denied, underpaid, or bundled, by a private arbitrator who is certified by a nationally-recognized association that provides training and certification in alternative dispute resolution.

b. If Healthy Blue and the provider are unable to agree on an association, the rules of the American Arbitration Association apply.
c. The arbitrator must have experience and expertise in the health care field and must be selected according to the rules of his/her certifying association. Arbitration conducted pursuant to this section shall be binding on all parties.
d. The arbitrator must conduct a hearing and issue a final ruling within 90 calendar days of being selected, unless Healthy Blue and the provider mutually agree to extend this deadline.
e. All costs of arbitration, not including attorneys' fees, must be shared equally by the parties. Each party shall bear its own attorneys' fees, if any.

2) Information regarding payment Disputes is reported to the Department of Banking and Insurance annually.

3) Healthy Blue shall adjudicate each disputed claim to a paid or denied status within 30 business days of receipt.

NEW JERSEY

6.5 PROVIDER GRIEVANCES AND APPEALS:

B. Grievances and Appeals. The Contractor shall establish and maintain provider grievance and appeal procedures for any provider who is not satisfied with the Contractor's policies and procedures, or with a decision made by the Contractor, or disagrees with the Contractor as to whether a service, supply, or procedure is a covered benefit, is medically necessary, or is performed in the appropriate setting. The Contractor procedure shall satisfy the following minimum standards:

1. The Contractor shall have in place formal grievance and appeal processes which network providers and non-participating providers can use to complain in writing. The Contractor shall issue a written response to a grievance and to appeals within the time frames required by federal and State law and regulation.
2. Such procedures shall not be applicable to any disputes that may arise between the Contractor and any provider regarding the terms, conditions, or termination or any other matter arising under contract between the provider and Contractor.

C. Using Table 3C and pursuant to Article 6.5D, the Contractor shall log, track and respond to nonutilization management provider grievances and appeals. Provider grievance and appeal logs are subject to on-site review by DMAHS staff.

D. The Contractor shall electronically submit quarterly a Provider Grievances and Appeals Report using the Table 3C database format. This report shall include, but not be limited to, the following data elements: E. The Contractor shall notify providers of the mechanism to appeal a Contractor service decision on behalf of an enrollee, with the enrollee's written consent, through the DOBI Independent Utilization Review Organization process and that the provider is not entitled to request a Fair Hearing except when doing so on behalf of the Member and then

only with the Member's written consent to the provider to act as the Member's authorized representative.

NEW YORK

1) There are no timeframes identified associated with payment appeals. Par providers follow the process as identified in their contract with the Health Plan. Non-par providers cannot be held to these timeframes for submitting claims appeals.

2) We shall permit a par provider to request reconsideration of a claim that is denied solely because it was submitted untimely. The Health Plan will pay the claims if the provider can demonstrate both that:
    a) The provider's non-compliance was a result of an unusual occurrence; and
    b) That the provider has a pattern or practice of timely submitting claims.

For further guidance refer to the Reimbursement Policy "Requirements for Documentation of Proof of Timely Filing."

NEVADA

1) A provider may file an oral Claim Payment Appeal, but must follow up with a written request within ten (10) calendar days of filing the oral appeal. The written request must include the identification number provided by the National Customer Care (NCC) associate. Oral requests will be received in the NCC or the health plan and documented in the identification number and routed to the Payment Dispute Unit. The oral request date will be used as the date of receipt.

2) If a written request is not received within the specified time frame, the appeal will be closed, and no review will take place. A letter will be mailed to the provider explaining that their required written follow-up was not received and their payment appeal has been closed.
    a) If the written appeal request is received beyond ten (10) calendar days from when the oral appeal was made, the date the letter received will be the new aging date used when determining compliance with expected turnaround time.

3) If a provider's Claims Payment Appeal results in the health plan upholding the previous claim and Reconsideration decision, a determination letter will be mailed to the provider with an explanation of the decision and the Fair Hearing rights. The letter will direct the provider to file a written request to DHCFP within ninety (90) calendar days of the date the determination letter was mailed. The health plan is bound by the decision of the Fair Hearing Officer and will comply with any decision resulting from the Fair Hearing process.

    Providers are eligible for State Fair Hearing in the following circumstances:
    a) Denial or limited authorization of a requested service;

b) Reduction, suspension or termination of a previously authorized service;
c) Denial, in whole or in part, of payment for a service;
d) Demand for recoupments; or,
e) Failure of the MCO to meet specified time frames (e.g., authorization, claims processing, appeal resolution).

The health plan will provide Division of Health Care Financing and Policy (DHCFP) with quarterly reports documenting and summarizing the number and types of provider appeals received in accordance with contract requirements. Required reporting will be submitted to DHCFP within forty-five (45) business days after the close of the quarter. Comprehensive records of all provider appeals must be maintained for DHCFP review.

VIRGINIA
State Appeal: DMAS
Medallion 4.0
If a Provider has complied with the Payment Dispute process as outlined above, has exhausted all Levels within the reconsideration processes, and is dissatisfied with the outcome, the provider may appeal to DMAS for a state level review. All provider appeals to DMAS must be submitted in writing and within 30 days of Anthem's last date of denial to:

DMAS Appeals Division
600 East Broad Street
Richmond, VA 23219

Anthem's HealthKeepers Plus final denial letter must include a statement that the provider has exhausted its internal appeal rights with the Anthem and that the next level of appeal is with the Department of Medical Assistance Services. The final denial letter must include the standard appeal rights to DMAS (including the time period and address to file the appeal). Anthem's HealthKeepers Plus is permitted to offer additional types of provider appeal rights at the MCO-level of review only. Network providers may not appeal termination decisions to the DMAS. Anthem is required to report on all terminations and credentialing failures to the DMAS as specified in the MCTM.
DMAS normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern Time. Any documentation or correspondence, including but not limited to notices of appeal, case summaries, pleadings, briefs or exceptions, submitted to the Department after 5:00 p.m. shall be date stamped on the next day the DMAS is officially open. Any document that is filed with the DMAS's Appeals Division after 5:00 p.m. on the deadline date shall be untimely.
Upon receipt of notice that DMAS has received an appeal from a provider involving services provided or to be provided to Anthem's member, Anthem should verify that the provider has exhausted all of Anthem's reconsideration processes. Further Anthem must verify, based upon Anthem's records, that the appeal to DMAS meets DMAS timeliness requirements (i.e., within 30 days of Anthem's last date of denial). Anthem must notify DMAS within two (2) business

days of the receipt of the appeal notice to the State, of any appeals where the provider has not exhausted Anthem's reconsideration process and/or where the appeal does not appear to meet the DMAS's timeliness requirements (based upon Anthem's records).

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in§ 2.2-4000 *et. seq.* and 12 VAC 30-20-500 et. seq. There are two levels of administrative appeal: (i) the informal appeal and (ii) the formal appeal. The informal appeal is before an informal appeals agent employed by the DMAS. The formal appeal is before a hearing officer appointed by the Supreme Court of Virginia, and an administrative hearing representative employed by the DMAS helps present the DMAS's position. The Supreme Court hearing officer writes a recommended decision for use by the DMAS Director in issuing the final agency decision.

Informal Appeal

Providers appealing an Anthem HealthKeepers Plus decision shall file a written notice of informal appeal with the DMAS's Appeals Division within thirty (30) days of the provider's receipt of the Anthem's final reconsideration decision. Anthem's notice of informal appeal shall identify the decision being appealed. Failure to file a written notice of informal appeal within thirty (30) days of receipt of the Anthem's final reconsideration decision shall result in an administrative dismissal of the appeal.

Formal Appeal

Any provider appealing a DMAS informal appeal decision shall file a written notice of formal appeal with the DMAS Appeals Division within thirty (30) days of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal shall identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within thirty (30) days of receipt of the informal appeal decision shall result in dismissal of the appeal.

Commonwealth Coordinated Care Plus

If a provider has rendered services to a member enrolled with Anthem HealthKeepers Plus in a Medicaid program and has either been denied authorization/reimbursement for the services or has received reduced authorization/ reimbursement, that provider can request a reconsideration of the denied or reduced authorization/ reimbursement. Before appealing to the DMAS, Anthem providers must first exhaust the Anthem's reconsideration process. Providers in Anthem's network who are not also enrolled with the DMAS may not appeal termination actions to DMAS.

Upon receipt of notice that the Department has received an appeal from a provider involving services provided or being provided to the Contractor's Member, the Contractor must verify within one (1) business day that the provider has exhausted the Contractor's reconsideration process. Further the Contractor must verify, based upon the Contractor's records, that the

appeal to the Department meets the DMAS timeliness requirements (i.e., within 30 calendar days of the Contractor's last date of denial).

WASHINGTON
This policy applies both to Integrated Managed Care (IMC) and Behavioral Health Services Only (BHSO).

Providers are not required to complete the Anthem Claim Payment Dispute Process or exhaust their Anthem Dispute rights to submit a Regulatory Complaint.

WEST VIRGINIA
Mailing Address
UniCare Health Plan of West Virginia
Attn: Provider Payment Dispute Unit
P.O. Box 91
Charleston, WV 25321-0091

Customer Care Center Phone Number
1-800-782-0095
Hours: Monday to Friday, 8am-6pm PST

WISCONSIN
1) The forty-five (45) calendar day response timeframe may be extended by fourteen (14) calendar days if deemed necessary to fully resolve the appeal. If an extension is required, the Plan will notify the provider of the extension and will provide a new date for completion. The Plan must respond to appeals from ambulance providers within the time frame described. Failure will constitute the Plan's agreement to pay the appealed claim to the extent FFS Medicaid would pay.
2) If a provider claim(s) remains denied, partially paid, or they continue to disagree, the provider may file a second level appeal in writing. Second level verbal appeals will not be accepted. The Second-Level appeal must be received by the Plan within thirty (30) calendar days from the date of the First Level decision/resolution letter. Second-Level appeals received after this will be upheld for untimely filing and will not be considered for further payment. The provider must submit a written Second Level appeal to the centralized address for disputes. A more senior appeal associate, or one that did not complete the first level review, will conduct the second level review. If additional information is submitted to support payment, the denial is overturned. Otherwise, the appeal associate conducts the review as per the steps in the first level process.
3) Once the dispute is reviewed for the second level, the appeal associate will notify the provider of the decision via their preferred method of communication within forty-five (45) calendar days of receipt of the second level payment appeal. The forty-five (45) calendar day response timeframe may be extended by fourteen (14) calendar days if deemed

necessary to fully resolve the appeal. If an extension is required, the Plan will notify the provider of the extension and will provide a new date for completion. If the provider requests an extension, it will be granted.

REVISION HISTORY:

Review Date	Changes
11/02/2022	• Off-Cycle Review for LA Rebid 2023 Readiness (Req. ID CLM-1 Section 2.18.12.1) • Updated LA references and LA exceptions
08/25/2022	• Off-Cycle Review • NC added to state specific guidelines table
05/12/2022	• Annual Review • Updated references and placed references in alphabetical order • Updated exceptions for NJ and WA
03/04/2022	• Off-Cycle Review • Moved State Specific guidelines to Exceptions • Revised MD state specific guidelines by adding IRO language
12/06/2021	• Off-Cycle Review • Updated CA, SC, WV state-specific guidelines
04/08/2021	• Annual Review • NE state approved 02/11/21; no MO State Approval Needed • MO and NE added as applicable markets • MO and NE added to STATE-SPECIFIC GUIDELINES table • Added MO state-specific language • Revised VA state-specific language • Added WA state-specific language • Revised Procedure • Added NE and WA references • Revised VA reference
02/13/2020	• Off-cycle edit to Maryland - changed calendar days to business days, updated exceptions and references.
12/20/2019	• Annual Review • Added CA, FL, GA, IN, IA, LA, MN, NY, WNY, SC, TN, TX, VA • Update to procedure and state specific guidelines chart • Added FL, GA, LA, NY, SC, TN, VA, WI exception language • Updates to MD exception language • Added market references
10/10/2019	• Off-cycle edit • Added NC, WI and WV as applicable markets

Section (Primary Department) **Claims**	**SUBJECT (Document Title)** **Provider Claim Payment Dispute Process**

Review Date	Changes
	• Added WV and WI exceptions • Updated WI state-specific guideline timeframe
05/20/2019	• Off-cycle edit to add DC and NV state specific guidelines
01/25/2019	• Off-cycle edit to add AR and AR state-specific guidelines
01/16/2019	• New Policy
~~10/24/2022~~	~~• Updated Language per new contract~~