

Medicaid Provider Reconsiderations, Disputes and Complaints				
Definition	Submission Process	Filing Timeframe	Timeframe for Response	Next Level Available?
<b>PRE-SERVICE and CONCURRENT*</b>				
<b>Authorization Has Been Denied Requesting Re-Review</b>				
<p>Provider did not submit Medical Records timely and would like to submit them and have the Health Plan re-review authorization.</p> <p>Available only prior to the service, or in the case of inpatient stay, during the stay or within 5 days of discharge.</p>	<p>Complete and <b>fax Re-Review Request Form</b> as cover sheet along with Medical Records.</p> <p><u>Inpatient Physical Health:</u> 844-965-0317</p> <p><u>Pre-Service Physical Health:</u> 877-212-6669</p> <p><u>Behavioral Health:</u> 833-286-1086</p> <p><u>Biopharmacy/Buy&amp;Bill:</u> 855-678-6980</p>	<p>Inpatient Concurrent Review</p> <ul style="list-style-type: none"> <li>• 5 business days from decision. Retain right for peer to peer.</li> </ul> <p>Pre-Service</p> <ul style="list-style-type: none"> <li>• 45 days from denial notification. Waives right to a peer to peer.</li> </ul>	<p>Inpatient Concurrent Review:</p> <ul style="list-style-type: none"> <li>• Members still admitted - 1-3 business days</li> <li>• Member already discharged - 5 business days</li> </ul> <p>Pre-Service:</p> <ul style="list-style-type: none"> <li>• 5-14 calendar days</li> </ul>	<p><u>Inpatient Concurrent Review</u></p> <p>Peer to Peer</p> <p><u>Pre-Service</u></p> <p>Only a Claim Dispute</p>
<p>Medical Records were submitted timely, however, Provider believes denial was based on incomplete clinical information,</p> <p>OR</p> <p>At time of review by Health Plan there were pending diagnostics, procedures, or laboratory results.</p>	<p>Complete and <b>fax Re-Review Request Form</b> as cover sheet along with Medical Records.</p> <p><u>Inpatient Physical Health:</u> 844-965-0317</p> <p><u>Pre-Service Physical Health:</u> 877-212-6669</p> <p><u>Behavioral Health:</u> 833-286-1086</p> <p><u>Biopharmacy/Buy&amp;Bill:</u> 855-678-6980</p>	<p>Inpatient Concurrent Review</p> <ul style="list-style-type: none"> <li>• 10 business days from decision</li> <li>• Retain right for peer to peer</li> </ul> <p>Pre-Service –</p> <ul style="list-style-type: none"> <li>• 45 days from denial notification. Waives right to a peer to peer.</li> </ul>	<p>Inpatient Concurrent Review:</p> <ul style="list-style-type: none"> <li>• Members still admitted - 1-3 business days</li> <li>• Member already discharged - 5 business days</li> </ul> <p>Pre-Service:</p> <ul style="list-style-type: none"> <li>• 5-14 calendar days</li> </ul>	<p><u>Inpatient Concurrent Review</u></p> <p>Peer to Peer or Claim Dispute</p> <p><u>Pre-Service</u></p> <p>Only a Claim Dispute</p>
<p>Provider disagrees with authorization denial and wants to speak with Health Plan MD to discuss the case.</p>	<p>Call Peer to Peer line to schedule meeting at 1-833-661-0642</p>	<p>Inpatient Concurrent Review</p> <ul style="list-style-type: none"> <li>• 10 business days from decision</li> </ul> <p>Pre-Service</p> <ul style="list-style-type: none"> <li>• 5 business days from denial notification.</li> </ul>	<p>Peer to peers are scheduled by urgency of the requested service. Cases where the member is still admitted or receiving the denied service may be scheduled as soon as same day.</p>	<p>Only a Claim Dispute</p>
<p>Member inpatient on <i>administrative days</i> has change in clinical condition that meets inpatient criteria.</p>	<p>If member has approved administrative days and now meets IP criteria</p> <p><b>fax Change in Condition Form</b> and medical records to 1-877-212-6113</p>		<p>Inpatient Concurrent Review:</p> <ul style="list-style-type: none"> <li>• Members still admitted - 1-3 business days</li> <li>• Member already discharged - 5 business days</li> </ul>	<p>Only a Claim Dispute</p>

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<b>POST CLAIM SUBMISSION</b>				
<b>Claim Payment Reconsideration / Claim Dispute</b>				
Provider is uncertain of the basis for the original claim outcome (payment amount, denial reason, etc.) or has other questions about the claim.	Medicaid - 877-644-4613	24 months from date of claims processing	30 days from Plan's receipt of Recon/Dispute	Request for reconsideration
Provider disagrees with the claim outcome and is submitting medical records or other documentation to support the disagreement.	Submit via portal or mail with <i>Reconsideration Form</i> to: Coordinated Care Attn: Claim Dispute PO Box 4030 Farmington, MO 63640-4197  <b>Disputes of Denials for Lack of Medical Necessity:</b> Disputes must include an explanation outlining why the original decision is incorrect. Simply sending in records will not result in further review.  <b>Disputes of Denials for Failure to Pre-Authorize:</b> Disputes must include documentation of the extenuating circumstance preventing a prior authorization from occurring. Simply sending in records will not result in further review. The documentation of the extenuating circumstance will be compared to the Retrospective Review policy (CC.UM.05.01) to see if the case qualifies for medical necessity review.  <b>Disputes of Denials for Code Editing Policy</b> (e.g., NCCI edits, MUE edits, bundling edits, modifier 25/59, etc.):	24 months from date of claims processing	30 days from Plan's receipt of Recon/Dispute	Yes**

Medicaid Provider Reconsiderations, Disputes and Complaints				
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	Disputes must include an explanation of why the provider disagrees with the code editing policy. Medical records are usually also required to support the dispute.			

\* Administrative denials for lack of timely notification do not apply to the UM re-review process; these must be submitted as a claim dispute

\*\* Next Level Claim Dispute for Post-Claims Submission Disputes: A second claim dispute of an upheld denial is allowed, but must be received within the standard 24 months from date of claims processing. A second dispute of an upheld denial will be considered only if further information or explanation is provided. Submitting the same explanation a second time will not result in further review. Two reviews are the maximum that will be completed.

**Coordinated Care of Washington, Inc. Apple Health (Medicaid)  
Potentially Preventable Readmission (PPR) Process**

**Submit ALL PPR related inquires, records, etc. to:  
WA\_UM\_PPR@coordinatedcarehealth.com or  
(fax) 833-693-0033**

<b>Process Step</b>	<b>Provider Timeline</b>	<b>Coordinated Care Timeline</b>	<b>Additional information if applicable</b>
<b>PPR initial request for records</b>	45 calendar days	N/A	Records can be sent by provider via fax or email through designated PPR email or fax number. Also may be released via EMR.
<b>PPR initial review</b>	NA	30 days from date medical records received	Calendar days
<b>PPR Reconsideration</b>	30 days from Coordinated Care decision	30 days	Calendar days. Provider to supply additional information to support your dispute.
<b>PPR Appeal</b>	30 days from Coordinated Care decision	30 days	Calendar days. Provider to supply additional information to support your dispute.
<b>PPR HCA Appeal</b>	30 days from Coordinated Care decision	30 days	Calendar days. Provider to supply additional information to support your dispute.
<b>PPR Additional Request for more information</b>	5 business days	30 days	For PPR review or any of the appeals process. Business days. Provide the information requested to allow for review to be completed.

**PLEASE NOTE: The PPR dispute process does not follow the normal dispute process. Please use the above email and fax numbers for communications with the plan. Additionally, the PPR process has its own timeframes as defined by the HCA.**