



Provider Dispute/Appeal Procedures

Providers of all types have the opportunity to request resolution of Disputes or Formal Provider Appeals that have been submitted to the appropriate internal AmeriHealth Mercy department.

Informal Provider Disputes Process

Network Providers may request informal resolution of Disputes submitted to AmeriHealth Mercy through AmeriHealth Mercy's Informal Provider Dispute Process.

What is a Dispute?

A Dispute is a verbal or written expression of dissatisfaction by a Network Provider regarding an AmeriHealth Mercy decision that directly impacts the Network Provider. Disputes are generally administrative in nature and do not include decisions concerning medical necessity.

Examples of Disputes include, but are not limited to:

- Service issues with AmeriHealth Mercy, including failure by AmeriHealth Mercy to return a Network Provider's calls, frequency of site visits by Service Representatives and lack of Provider orientation/education by AmeriHealth Mercy
- Issues with AmeriHealth Mercy processes, including failure to notify Network Providers of policy changes, dissatisfaction with AmeriHealth Mercy's Prior Authorization process, dissatisfaction with AmeriHealth Mercy's referral process and dissatisfaction with AmeriHealth Mercy's Formal Provider Appeals Process
- Contracting issues, including dissatisfaction with AmeriHealth Mercy's reimbursement rate, incorrect Capitation payments paid to the Network Provider and incorrect information regarding the Network Provider in AmeriHealth Mercy's Provider database

Filing a Dispute

Network Providers wishing to register a Dispute should contact the Provider Services Department at 800-521-6007, or contact his/her/its Provider Contracting Representative. Written Disputes should be mailed to the address below and must contain the words "Informal Provider Dispute" at the top of the request:

Provider Contracting Department
AmeriHealth Mercy Health Plan
8050 Carlson Rd., Ste. 500
Harrisburg, PA 17112

On-Site Meeting

Network Providers may request an on-site meeting with a Provider Contracting Representative, either at the Network Provider's office or at AmeriHealth Mercy to discuss the Dispute. Depending on the nature of the Dispute, the Provider Contracting Representative may also



request an on-site meeting with the Network Provider. The Network Provider or Provider Contracting Representative must request the on-site meeting within seven (7) calendar days of the filing of the Dispute with AmeriHealth Mercy. The Provider Contracting Representative assigned to the Network Provider is responsible for scheduling the on-site meeting at a mutually convenient date and time.

Time Frame for Resolution

AmeriHealth Mercy will investigate, conduct an on-site meeting with the Network Provider (if one was requested), and issue the informal resolution of the Dispute within sixty (60) calendar days of receipt of the Dispute from the Network Provider. The informal resolution of the Dispute will be communicated to the Network Provider by the same method of communication in which the Dispute was registered (e.g., if the Dispute is registered verbally, the informal resolution of the Dispute is verbally communicated to the Network Provider and if the Dispute is registered in writing, the informal resolution of the Dispute is communicated to the Network Provider in writing).

Relationship of Informal Provider Dispute Process to AmeriHealth Mercy's Formal Provider Appeals Process

The purpose of the Informal Provider Dispute Process is to allow Network Providers and AmeriHealth Mercy to resolve Disputes registered by Network Providers in an informal manner that allows Network Providers to communicate their Dispute and provide clarification of the issues presented through an on-site meeting with AmeriHealth Mercy. Network Providers may appeal most Disputes not resolved to the Network Provider's satisfaction through the Informal Provider Dispute Process to AmeriHealth Mercy's Formal Provider Appeals Process. The types of issues that may not be reviewed through AmeriHealth Mercy's Formal Provider Appeals Process are listed in the "Formal Provider Appeals Process" section of this document. Appeals must be submitted in writing to AmeriHealth Mercy's Provider Appeals Department. Procedures for filing an Appeal through AmeriHealth Mercy's Formal Provider Appeals Process, including the mailing address for filing an Appeal, are set forth in the "Formal Provider Appeals Process" section. The filing of a Dispute with AmeriHealth Mercy's Informal Provider Dispute Process is not a prerequisite to filing an Appeal through AmeriHealth Mercy's Formal Provider Appeals Process.

In addition to the Informal Provider Dispute Process and the Formal Provider Appeals Process, Health Care Providers may, in certain instances, pursue a Member Complaint or Grievance appeal on behalf of a Member. A comprehensive description of AmeriHealth Mercy's Member Complaint, Grievance and Fair Hearings process is located in this Section of the Manual. Additionally, information on the relationship to the AmeriHealth Mercy's Informal Provider Dispute and Formal Provider Appeal Processes can be found in "Relationship of Provider Formal Appeals Process to Provider Initiated Member Appeals" and "Requirements for Grievances filed by Providers on Behalf of Members" in the Provider Manual.



Formal Provider Appeals Process

Both Network and Non-Participating Providers may request formal resolution of an Appeal through AmeriHealth Mercy's Formal Provider Appeals Process. This process consists of two levels of review and is described in greater detail below.

What is an Appeal?

An Appeal is a written request from a Health Care Provider for the reversal of a denial by the AmeriHealth Mercy, through its Formal Provider Appeals Process, with regard to two (2) major types of issues. The two (2) types of issues that may be addressed through AmeriHealth Mercy's Formal Provider Appeals Process are:

- Disputes not resolved to the Network Provider's satisfaction through AmeriHealth Mercy's Informal Provider Dispute Process
- Denials for services already rendered by the Health Care Provider to a Member including, denials that:
 - do not clearly state the Health Care Provider is filing a Member Complaint or Grievance on behalf of a Member (even if the materials submitted with the Appeal contain a Member consent) or
 - do not contain a Member consent for a Member Complaint or a consent that conforms with applicable law for a Grievance filed by a Health Care Provider on behalf of a Member (see Provider Initiated Member Appeals in this Section of the Manual for required elements of a member consent for a Grievance. **Note: these requirements do not apply to Complaints.**)

Examples of Appeals include, but are not limited to:

- The Health Care Provider submits a Claim for reimbursement for inpatient services provided at the acute level of care, but AmeriHealth Mercy reimburses for a non-acute level of care because the Health Care Provider has not established medical necessity for an acute level of care.
- A Home Care Provider has made a total of ten (10) home care visits but only seven (7) visits were authorized by AmeriHealth Mercy. The Home Care Provider submits a Claim for ten (10) visits and receives payment for seven (7) visits.
- Durable Medical Equipment (DME) that requires Prior Authorization by AmeriHealth Mercy is issued to a Member without the Health Care Provider obtaining Prior Authorization from AmeriHealth Mercy (e.g., bone stimulator). Health Care Provider submits a Claim for reimbursement for the DME and it is denied by AmeriHealth Mercy for lack of Prior Authorization.
- Member is admitted to the hospital as a result of an Emergency Room visit. The inpatient stay is for a total of fifteen (15) hours. The hospital provider submits a Claim for reimbursement at the one-day acute inpatient rate but AmeriHealth Mercy reimburses at the observation rate, in accordance with the hospital provider's contract with AmeriHealth Mercy.



Types of issues that may not be appealed through AmeriHealth Mercy’s Formal Provider Appeals Process are:

- Claims denied by AmeriHealth Mercy because they were not filed within AmeriHealth Mercy’s 180-day filing time limit; Claims denied for exceeding the 180-day filing time limit may be appealed through AmeriHealth Mercy’s Informal Provider Dispute Process outlined in this Manual.
- Denials issued as a result of a Prior Authorization review by AmeriHealth Mercy (the review occurs prior to the Member being admitted to a hospital or beginning a course of treatment); denials issued as a result of a Prior Authorization review may be appealed by the Member, or the Health Care Provider, with written consent of the Member, through AmeriHealth Mercy’s Member Complaint and Grievance Process outlined in the in the Section titled Complaints, Grievances and Fair Hearings for Members following the Provider Appeal Process.
- Provider terminations based on quality of care reasons may be appealed in accordance with the AmeriHealth Mercy Provider Sanctioning Policy outlined in Section VIII; and credentialing/recredentialing denials may be appealed as provided in the credentialing/recredentialing requirements outlined in Section VIII.

First Level Appeal Review

Filing a Request for a First Level Appeal Review

Health Care Providers may request a First Level Appeal review by submitting the request in writing within 60 calendar days of: (a) the date of the denial or adverse action by AmeriHealth Mercy or the Member's discharge, whichever is later or (b) in the case where a Health Care Provider filed an Informal Provider Dispute with AmeriHealth Mercy, the date of the communication by AmeriHealth Mercy of the informal resolution of the Dispute. The request must be accompanied by all relevant documentation the Health Care Provider would like AmeriHealth Mercy to consider during the First Level Appeal review.

Requests for a First Level Appeal Review should be mailed to the appropriate Post Office Box below and must contain the words "First Level Inpatient Formal Appeal" or "First Level Outpatient Formal Appeal", as appropriate at the top of the request:

**Inpatient Appeal:
Provider Appeals Department
AmeriHealth Mercy Health Plan
P.O. Box 7307
London, KY 40742**

**Outpatient Appeal:
Provider Appeals Department
AmeriHealth Mercy Health Plan
P.O. Box 7316
London, KY 40742**

AmeriHealth Mercy will send the Health Care Provider a letter acknowledging AmeriHealth Mercy's receipt of the request for a First Level Appeal Review within seven calendar days of AmeriHealth Mercy's receipt of the request from the Health Care Provider.



Physician Review of a First Level Appeal

The first level Appeal review is conducted by a board-certified Physician Reviewer who was not involved in the decision making for the original denial or prior appeal review of the case. The Physician Reviewer will issue a determination to uphold, modify or overturn the denial based on:

- Clinical judgment
- Established standards of medical practice
- Review of available information including but not limited to:
 - AmeriHealth Mercy medical and administrative policies
 - Information submitted by the Health Care Provider or obtained by AmeriHealth Mercy through investigation
 - The Network Provider's contract with AmeriHealth Mercy
 - AmeriHealth Mercy's contract with DPW and relevant Medicaid laws, regulations and rules

Time Frame for Resolution of a First Level Appeal

Health Care Providers will be notified in writing of the determination of the First Level Appeal review, including the clinical rationale, within 60 calendar days of AmeriHealth Mercy's receipt of the Health Care Provider's request for the First Level Appeal review. If the Health Care Provider is dissatisfied with the outcome of the First Level Appeal review, the Health Care Provider may request a Second Level Appeal review. See the "Second Level Appeal Review" topic in this Section of the Manual.

In order to simplify resolution of Emergency Department payment level issues, which often arise because the Claim was submitted without an Emergency Department summary and/or requires a review of medical records, participating hospital Providers are encouraged to address such payment issues through AmeriHealth Mercy's informal Emergency Department Payment Level Reconsideration Process before attempting to resolve such issues through the Formal Provider Appeals Process.

Second Level Appeal Review

Filing a Request for a Second Level Appeal Review

Health Care Providers may request a Second Level Appeal by submitting the request in writing within thirty (30) calendar days of the date of AmeriHealth Mercy's First Level Appeal determination letter. The request for a Second Level Appeal Review must be accompanied by any additional information relevant to the Appeal that the Health Care Provider would like AmeriHealth Mercy to consider during the Second Level Appeal Review.



Requests for a Second Level Appeal Review should be mailed to the appropriate Post Office Box below and must contain the words "Second Level Outpatient Formal Appeal" or "Second Level Inpatient Formal Appeal", as appropriate at the top of the request:

**Inpatient Appeal:
Provider Appeals Department
AmeriHealth Mercy Health Plan
P.O. Box 7307
London, KY 40742**

**Outpatient Appeal:
Provider Appeals Department
AmeriHealth Mercy Health Plan
P.O. Box 7316
London, KY 40742**

AmeriHealth Mercy will send the Health Care Provider a letter acknowledging AmeriHealth Mercy's receipt of the request for a Second Level Appeal Review within seven calendar days of AmeriHealth Mercy's receipt of the request from the Health Care Provider.

Appeals Panel Review of a Second Level Appeal

A board certified Physician Reviewer, who was not involved in the decision-making for the original denial or prior Appeal review of the case, will review the Appeal. The Physician Reviewer will issue a recommendation, including the clinical rationale, to AmeriHealth Mercy's Appeals Panel to uphold, overturn or modify the denial based upon clinical judgment, established standards of medical practice, and review of AmeriHealth Mercy medical and administrative policies, available information submitted by the Health Care Provider or obtained by AmeriHealth Mercy through investigation, the Health Care Provider's contract with AmeriHealth Mercy, AmeriHealth Mercy's contract with DPW and relevant Medicaid laws, regulations and rules. The Physician Reviewer's recommendation will be provided to the Appeals Panel for consideration and deliberation.

The Appeals Panel is comprised of at least one-quarter (1/4) peer representation. At the request of the Appeals Panel, the Reviewing Physician may present his/her recommendation in person at the Appeals Panel meeting. The panel is comprised of at least three individuals, including one Physician Reviewer in current practice contracted by AmeriHealth Mercy but not employed with AmeriHealth Mercy (peer representative) and two other management staff from AmeriHealth Mercy's Provider Contracting, Provider Appeals, or Claims Departments.

The Appeals Panel will issue a determination including clinical rationale, to uphold, modify, or overturn the original determination based upon:

- Clinical judgment
- Established standards of medical practice
- Review of available information including but not limited to:
 - AmeriHealth Mercy medical and administrative policies
 - Information submitted by the Health Care Provider or obtained by AmeriHealth Mercy through investigation



- The Network Provider's contract with AmeriHealth Mercy
- AmeriHealth Mercy's contract with DPW and relevant Medicaid laws, regulations and rules

Time Frame for Resolution

Health Care Providers will be notified in writing of the determination of the Second Level Appeal Review within 60 calendar days of AmeriHealth Mercy's receipt of the Health Care Provider's request for a Second Level Appeal Review. The outcome of the Second Level Appeal Review is final.

Claims Disputes

Claims Disputes include Claim denials, payments the Network Provider feels were made in error by AmeriHealth Mercy, or involve a larger volume of Claims than can easily be handled by phone. Network Providers must submit these Claims Disputes to AmeriHealth Mercy within 365 days from the date of service or the date compensable items were provided, with a written explanation of the error to:

Provider Contracting
AmeriHealth Mercy Health Plan
Claims Research
8040 Carlson Road, Suite 500
Harrisburg, PA 17112

For accurate and timely resolution of issues, Network Providers should include the following information:

- Provider Name
- Provider Number
- Tax ID Number
- Number of Claims involved
- Claim numbers, as well as a sample of the Claim(s)
- A description of the denial issue

If numerous Claims are impacted by the same issue, they may all be included in a single letter/email with an attached list of Claims or spreadsheet. **An electronic version of the spreadsheet is highly preferred. Do not combine multiple denials for different reasons in the same letter/spreadsheet.**

Emergency Department Payment Level Reconsideration For Participating Providers

In certain cases, it is not necessary for a hospital Provider to appeal a Claim decision when they are not in agreement with AmeriHealth Mercy's level of payment for Emergency Room services.



If a Claim has been reimbursed at the lower degree of acuity rate, and the original Claim submission did not include medical records or the Emergency Room summary, the hospital Provider may resubmit the Claim along with medical records (or Emergency Room summary) for payment level reconsideration. AmeriHealth Mercy's clinical staff will review the medical records and render a decision based on the nature of treatment rendered to treat presenting symptoms. These Claims should be submitted to the Claims Medical Review Department at the following address:

**Claims Medical Review Department
AmeriHealth Mercy Health Plan
P.O. Box 7118
London, KY 40742**

Hospital Providers will be notified via the remittance advice of any decisions to pay at the higher degree of acuity rate. If review of the medical records does not indicate services should be paid at the higher degree of acuity rate, a letter will be sent to the hospital Provider upholding the original Claim determination.

If the hospital Provider disagrees with this determination, the Provider may file a Formal Provider Appeal for further reconsideration of the level of payment. For information on how to file, please refer to Formal Provider Appeal procedures outlined in Section VII.

Payment Limitations

No payment will be made for Emergency Room services if:

- The Member is not eligible for benefits on the date of service
- The Member is admitted to an SPU, Observation or Inpatient setting within 24 hours of the Emergency Room stay. In such cases, Emergency Room charges should be reported on the SPU, Observation or Inpatient bill. See the Emergency Admissions, Surgical Procedures and Observations Stays topic in Section II for notification requirements