Summit COMMUNITY CARE

Provider update

Claim payment dispute process

Summary of update: We are in the process of updating the Summit Community Care provider manual to include information on how providers can submit claim payment disputes through the Availity Portal, as well as some additional information on the process. This communication is an update to the options outlined in the current Summit Community Care provider manual, which states that providers may file a claim payment dispute by completing the *Payment Dispute Form* and mailing it to Summit Community Care. This communication outlines the means by which a provider may file a dispute electronically via the Availity Portal.

To learn how to submit a claim payment dispute using Availity, sign up for a scheduled webinar or listen to a recorded session:

1. Log in to the Availity Portal > Help & Training > Get Trained.
2. Search the catalog for the term *appeal* to find a listing of the scheduled webinars. Select the date that you wish to register for and then select **Enroll** in the top right-hand corner.
    - To access a recorded session, when you search for the term *appeal*, you'll see the *On-Demand* and *Training Demo* courses at the bottom of the search results. Select the course and then select **Enroll**.

By leveraging Availity for claim payment disputes, providers can:

- Submit disputes through the Availity Portal any time of the day.
- Send supporting documentation.
- Check the status of a claim payment dispute.
- View claim payment dispute history.
- Download a copy of the dispute outcome letter.
- Indicate there are multiple claims tied to the same issue on one submission, reducing the amount of disputes to submit.
    - **Please note**: Claim payment disputes that are submitted with multiple claims tied to one issue will be reviewed and processed. If there are multiple claims tied to multiple issues on one dispute submission, the claim payment disputes will be rejected.

Provider claim payment dispute process

If you disagree with the outcome of a claim, you may begin the provider payment dispute process. The simplest way to define a claim payment dispute is: the claim is finalized, but you disagree with the outcome.

Please be aware there are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we've defined them briefly here:

1. **Claim inquiry**: a question about a claim but not a request to change a claim payment
2. **Claims correspondence**: occurs when Summit Community Care requests further information to finalize a claim — typically includes medical records, itemized bills or information about other insurance a member may have
3. **Medical necessity appeals**: a pre-service appeal for a denied service in which a claim has not yet been submitted

All services referenced in this material are funded and provided under an agreement with the Arkansas Department of Human Services.
ARPEC-0455-19 September 2019

The provider payment dispute process consists of two internal steps and a third external step. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member.

1. **Claim payment reconsideration:** This is the first step in the provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. **Claim payment appeal:** This is the second step in the provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.
3. **State fair hearing:** Arkansas Medicaid supports an external review process if you have exhausted both steps in the payment dispute process but still disagree with the outcome. **Note**: Providers should complete both the dispute and/or appeal defined herein **prior to** filing for a state fair hearing with Arkansas Medicaid.

Providers may submit a claim payment dispute for multiple reason(s), including:

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

* We will consider reimbursement of a claim denied for failure to meet timely filing upon receipt of either 1) documentation the claim was submitted within the timely filing requirements or 2) documentation that claim submission resulted from provider's reasonable efforts to determine the extent of liability.

Claim payment reconsideration

The first step in the claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. **Note:** We cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through the Availity Portal within 90 business days from the date on the *EOP* (see below for further details on how to submit). Reconsiderations filed more than 90 business days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, the appropriate clinical professionals will review.

We will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail a written extension letter before the expiration of the initial 30 calendar days.

We will send our decision in a determination letter, which will include:

- A statement of the provider's reconsideration request.
- A statement of what action Summit Community Care intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.
- An explanation of the provider's right to request a claim payment appeal within 30 calendar days of the date of the reconsideration determination letter.
- An address of where to submit the claim payment appeal.
- A statement that the completion of the claim payment appeal process is a necessary requirement before requesting a state fair hearing.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

Claim payment appeal

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal. **Note**: We cannot process a claim payment appeal without a reconsideration on file.

We accept claim payment appeals in writing within 30 calendar days of the date on the reconsideration determination letter.

Claim payment appeals received more than 30 calendar days after the claims reconsideration determination letter will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Summit Community Care professionals.

Summit Community Care will make every effort to resolve the claim payment appeal within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which will include:

- A statement of the provider's claim payment appeal request.
- A statement of what action Summit Community Care intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.
- A statement about how to submit a state fair hearing.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

How to submit a claim payment dispute

To file a claim payment dispute:

- Verbally (for reconsiderations only), call Provider Services at 1-844-462-0022.
- Online (for reconsiderations and claim payment appeals), use the secure provider Availity payment appeal tool. Through the Availity Portal, you can upload supporting documentation and will receive immediate acknowledgement of your submission.
- In writing (for reconsiderations and claim payment appeals), mail all required documentation (see below for more details), including the *Claim Payment Appeal Form* or the *Reconsideration Form,* to:
  Payment Dispute Unit
  Summit Community Care
  P.O. Box 62429
  Virginia Beach, VA 23466-2429

Submit reconsiderations on the *Reconsideration Form* or written claim payment appeals on the *Claim Payment Appeal Form*. To access these forms, visit https://provider.summitcommunitycare.com/arkansas-provider/forms.

Required documentation for claims payment disputes

Summit Community Care requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email address, TIN and NPI (or Arkansas Medicaid ID number, **whichever number is registered with Arkansas Medicaid**)
- The member's name and their Summit Community Care or Medicaid ID number
- A listing of disputed claims, which should include the Summit Community Care claim ID number(s) and the date(s) of service(s)
- All supporting statements and documentation

Claim inquiries

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience program helps with claim inquiries. Just call 1-844-462-0022 and choose the *Claims* prompt within our voice portal. We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim correspondence
Claim correspondence is different than a payment dispute. Correspondence occurs when Summit Community Care requires more information to finalize a claim. Typically, Summit Community Care makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Summit Community Care will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of issue	What do I need to do?
Rejected claim(s)	Call the EDI Hotline at 1-800-590-5745 if your claim was submitted electronically but was never paid or was rejected. We're available to assist you with setup questions and help resolve submission issues or electronic claims rejections.
EOP requests for supporting documentation (sterilization/ hysterectomy/abortion consent forms, itemized bills and invoices)	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the supporting documentation to: **Claim Correspondence** **Summit Community Care** **P.O. Box 62429** **Virginia Beach, VA 23466-2429**
EOP requests for medical records	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the medical records to: **Claim Correspondence** **Summit Community Care** **P.O. Box 62429** **Virginia Beach, VA 23466-2429**
Need to submit a corrected claim due to errors or changes on the original submission	**Option 1:** Submit the correct claim via the Availity Portal by selecting *7 – Replacement Claim* in the *Billing Frequency* field under *Claims Information*. **Option 2:** Submit a *Claim Correspondence Form* and your corrected claim to: **Claim Correspondence** **Summit Community Care** **P.O. Box 62429** **Virginia Beach, VA 23466-2429** Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Summit Community Care to adjust the other

Type of issue	What do I need to do?
	health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOP*.
Submission of coordination of benefits (COB)/third-party liability (TPL) information	**Option 1:** Dispute the claim via the Availity Portal and include the *EOP* and/or COB/TPL information as an attachment. **Option 2**: Submit a *Claim Correspondence Form*, a copy of your *EOP* and the COB/TPL information to: **Claim Correspondence** **Summit Community Care** **P.O. Box 62429** **Virginia Beach, VA 23466-2429**

Medical necessity appeals

Medical necessity appeals refer to a situation in which an authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process as defined in the Summit Community Care provider manual.