

## ***Provider Dispute/Appeal Procedures***

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

### **Informal Provider Disputes Process**

Network Providers may request informal resolution of Disputes submitted to Keystone Mercy through its Informal Provider Dispute Process.

### **What is a Dispute?**

A Dispute is a verbal or written expression of dissatisfaction by a Network Provider regarding a Keystone 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 Keystone Mercy, including failure by Keystone Mercy to return a Provider's calls, frequency of site visits by Keystone Mercy's Provider Account Executives and lack of Provider Network orientation/education by Keystone Mercy
- Issues with Keystone Mercy processes, including failure to notify Network Providers of policy changes, dissatisfaction with Keystone Mercy's Prior Authorization process, dissatisfaction with Keystone Mercy's referral process and dissatisfaction with Keystone Mercy's Formal Provider Appeals Process
- Contracting issues, including dissatisfaction with Keystone Mercy's reimbursement rate, incorrect capitation payments paid to the Network Provider and incorrect information regarding the Network Provider in Keystone 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 Account Executive. Written Disputes should be mailed to the address below and must contain the words "Informal Provider Dispute" at the top of the request:

Provider Network Management Department  
Keystone Mercy Health Plan  
200 Stevens Drive  
Philadelphia, PA 19113  
Attention: Provider Solutions Specialist

**See Section VI, Claims and Claims Disputes, for specific filing requirements related to Claims Disputes.**

### **On-Site Meeting**

Network Providers may request an on-site meeting with a Provider Account Executive, either at the Network Provider's office or at Keystone Mercy to discuss the Dispute. Depending on the nature of the Dispute, the Provider Account Executive may also request an on-site meeting with the Network Provider. The Network Provider or Provider Account Executive must request the on-site meeting within seven (7) calendar days of the filing of the Dispute with Keystone Mercy.

The Provider Account Executive assigned to the Network Provider is responsible for scheduling the on-site meeting at a mutually convenient date and time.

### **Time Frame for Resolution**

Keystone 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 Keystone Mercy's Formal Provider Appeals Process**

The purpose of the Informal Provider Dispute Process is to allow Network Providers and Keystone Mercy to resolve Disputes registered by 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 Keystone Mercy. Network Providers may appeal most Disputes not resolved to the Provider's satisfaction through the Informal Provider Dispute Process to Keystone Mercy's Formal Provider Appeals Process. The types of issues that may not be reviewed through the Keystone Mercy Formal Provider Appeals Process are listed in the "Formal Provider Appeals Process" section of this Manual. Appeals must be submitted in writing to Keystone Mercy's Provider Appeals Department. Procedures for filing an appeal through Keystone 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 Keystone Mercy's Informal Provider Dispute Process is not a prerequisite to filing an appeal through Keystone 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 Keystone Mercy's Member Complaint, Grievance and Fair Hearings Process is located in this Section of the Manual. Additionally, information on the relationship with Keystone 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 this Section of the Manual.

### **Formal Provider Appeals Process**

Both Network and Non-Participating Providers may request formal resolution of an appeal through Keystone 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 Keystone 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 Keystone Mercy's Formal Provider Appeals Process are:

- Disputes not resolved to the Network Provider's satisfaction through Keystone Mercy's Informal Provider Dispute Process
- Denials for services already rendered by the Health Care Provider to a Member including, denials that:
  - (a) 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
  - (b) 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 Keystone 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 Keystone Mercy. The Health 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 Keystone Mercy is issued to a Member without the Health Care Provider obtaining Prior Authorization from Keystone Mercy (e.g., bone stimulator). The Health Care Provider submits a Claim for reimbursement for the DME and it is denied by Keystone 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 Keystone Mercy reimburses at the observation rate, in accordance with the hospital's contract with Keystone Mercy.

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

- Claims denied by Keystone Mercy because they were not filed within Keystone Mercy's 180-day filing time limit; Claims denied for exceeding the 180-day filing time limit may be appealed through Keystone Mercy's Informal Provider Dispute Process outlined in this Manual.
- Denials issued as a result of a Prior Authorization review by Keystone 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 Keystone Mercy's Member Complaint and Grievance Process outlined 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 Keystone 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 Keystone 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 Keystone Mercy, the date of the communication by Keystone Mercy of the informal resolution of the Dispute. The request must be accompanied by all relevant documentation the Health Care Provider would like Keystone 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 Outpatient Formal Provider Appeal", or "First Level Inpatient Formal Provider Appeal", as appropriate at the top of the request:**

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

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

Keystone Mercy will send the Health Care Provider a letter acknowledging Keystone Mercy's receipt of the request for a First Level Appeal Review within seven calendar days of Keystone 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:
  - Keystone Mercy medical and administrative policies
  - Information submitted by the Health Care Provider or obtained by Keystone Mercy through investigation
  - The Network Provider's contract with Keystone Mercy

- Keystone 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 Keystone 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.

## ***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 Keystone 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 Keystone Mercy to consider during the Second Level Appeal Review. Requests for a Second Level Appeal Review of an Appeal should be mailed to the appropriate Post Office Box below and must contain the words "Second Level Outpatient Formal Provider Appeal" or "Second Level Inpatient Formal Provider Appeal", as appropriate, at the top of the request.

#### **Inpatient Appeals:**

**Provider Appeals Department  
Keystone Mercy Health Plan  
P.O. Box 7307  
London, KY 40742**

#### **Outpatient Appeals:**

**Provider Appeals Department  
Keystone Mercy Health Plan  
P.O. Box 7316  
London, KY 40742**

Keystone Mercy will send the Health Care Provider a letter acknowledging Keystone Mercy's receipt of the request for a Second Level Appeal Review within seven calendar days of Keystone 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 Keystone Mercy's Appeals Panel to uphold, overturn or modify the denial based upon clinical judgment, established standards of medical practice, and review of Keystone Mercy medical and administrative policies, available information submitted by the Health Care Provider or obtained by Keystone Mercy through investigation, the Health Care Provider's contract with Keystone Mercy, Keystone 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 Keystone Mercy but not employed with Keystone Mercy (peer representative) and two other management staff from Keystone Mercy's Provider Network Management, 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:
  - Keystone Mercy medical and administrative policies
  - Information submitted by the Provider or obtained by Keystone Mercy through investigation
  - The Provider's contract with Keystone Mercy
  - Keystone 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 Keystone 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.

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 Keystone Mercy's informal Emergency Department Payment Level Reconsideration Process before attempting to resolve such issues through the Formal Provider Appeals Process.

### **Appeal Procedure for Claims Denied for Missing Information**

Claims that pass the initial pre-processing edits and are accepted for adjudication but DENIED because required information from the Health Care Provider is missing must be resubmitted for correction. Some examples are a missing Tax ID number, incomplete information or incorrect coding. These are Claims that can be resubmitted and re-adjudicated once missing information is supplied. Health Care Providers have 365 calendar days from the date of service or date compensable items were provided to re-submit a corrected Claim.

Claims denied for missing information can be re-submitted to the following address. Please clearly indicate **“Corrected Claims”** on the Claim form:

**Corrected Claims/Adjusted Claims  
Keystone Mercy Health Plan  
P.O. Box 7115  
London, KY 40742**

### **Adjusted Claims**

Claims with issues where resolution does not require complete re-submission of a Claim can often be easily adjusted. Adjusted Claims cannot involve changing any fields on a Claim (for example an incorrect code) and can often be corrected over the phone. Adjusted Claims usually involve a dispute about amount/ level of payment or could be a denial for no authorization when the Network Provider has an authorization number. **If a Network Provider has Claims needing adjustment and there is a manageable volume of Claims (five or less), the Network Provider can call Keystone Mercy's Provider Claim Services Unit (PCSU) at 1-800-521-6007 to report payment discrepancies.** Representatives are available to review Claim information and make on-line adjustments to incorrectly processed Claims.

### **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 Keystone 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. Keystone 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  
Keystone Mercy Health Plan  
P.O. Box 7180  
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 hospital 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

**If your Claim issues are not resolved following the steps outlined above, the following procedures may be followed.**

### **Claims Disputes**

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

**Keystone Mercy Health Plan  
Provider Network Management  
200 Stevens Drive  
Philadelphia, PA 19113  
ATTN: Provider Solutions Specialist**

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