WORK PROCESS

DEPARTMENT: Provider Services, Provider Relations, Grievance and Appeals	**REFERENCE NUMBER:**
	WORK PROCESS NAME: MyCare/Medicaid Provider Process for Claim Denial/Payment Dispute
EFFECTIVE DATE:	**RETIRED DATE:** N/A
PAGE: 1 OF 5	**REVIEWED/REVISED DATE:**

SCOPE:
This process applies to Buckeye Health Plan's Provider Service, Provider Relations, Grievance and Appeals, and Provider Relations' Website Coordination teams.

PURPOSE:
The purpose of this document is to provide the prescribed methods and different options for Buckeye Health Plan providers to follow when disputing the processing of MyCare and Medicaid claims denial or payment.

WORK PROCESS:
Regardless of provider type or participating status, when a provider disagrees with a MyCare or Medicaid claim denial or payment, they can dispute using any of the four options below:

OPTION 1: Provider Services Department
Timeline Requirement for Completion: 30 Days

1. If a PAR or Non PAR Provider has a question or is not satisfied with the information they have received related to a claim, the provider should contact:
   a. Buckeye Provider Services Department at 1-866-296-8731; opt. 0 (to speak with a Provider Service Representative) between the hours of 8:00am – 5:00pm EST.
   b. Key in 10 digit NPI# (once connected to Provider Services Representatives). Providers may discuss questions with Buckeye Provider Services Representatives regarding amount reimbursed or denial of a particular service and request for claim to be reconsidered.

2. Unsatisfactory Claim Payment: If a provider has a question or is not satisfied with the information they have received related to a claim, they should contact Buckeye Provider Services 1-866-296-8731.
   a. When submitting a paper claim for review or reconsideration of the claims disposition, the claim must clearly be marked as "Resubmission" and include the claim number. Failure to mark the claim as a resubmission and include the claim number or Explanation of Payment (EOP) may result in the claim being denied as a duplicate, or for exceeding the filing limit deadline.
   b. Providers may discuss questions with Buckeye Provider Services Representatives regarding amount reimbursed or denial of a particular service. Providers may also submit in writing, with all necessary documentation, including the EOP for consideration of additional reimbursement.
   c. Any response to approved adjustments will be provided by way of check with accompanying explanation of payment. All disputed claims will be processed in compliance with the claims payment resolution procedure as described in Section XII of The Provider Manual.

   Reference: Page 56 of the Provider Manual (https://www.buckeyehealthplan.com/content/dam/centene/Buckeye/medicaid/pdfs/BHP-OH_ProviderManual_2020.pdf)

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OPTION 2: Provider Relations Department

Timeline Requirement for Completion: 30 Days

Providers may contact their designated Provider Relations (PR) Representative by telephone or email for any question regarding Buckeye operations, including claim payment. The Provider Relations Representative will complete the following steps:

1. Document pertinent details regarding the issue in question and, where applicable, review the claim and/or authorization, etc. to determine next steps.
2. If the PR Representative can independently identify resolution/actions needed, the Representative will advise the provider and close the issue in question. If additional steps are needed, the PR Representative will direct the provider accordingly. The PR may direct providers to the informal dispute process, administrative appeal, or medical management appeal process, if necessary.
3. If the PR Representative cannot determine or resolve root cause, the issue will be forwarded to the appropriate departments for review. The PR Representative will monitor status of the issue following up internally at least weekly until the issue is resolved.
4. Upon resolution, the PR Representative will contact the provider to advice of resolution or any needed next steps. Next steps may include submission of corrected claim or submission of an appeal.
5. If the Provider does not know who their designated PR Representative is, they can call Provider Services at 1-866-296-8731. The Provider Services Department can arrange contact between the PR Representative for the Provider's area and the Provider.

OPTION 3: Grievance and Appeals Department (Via mail)

Timeline Requirement for Completion: 30 Days from Receipt

The following three mail options below can be located between pages 57-60 of the Provider Manual: https://www.buckeyehealthplan.com/content/dam/centene/Buckeye/medicaid/pdfs/BHP-OH_ProviderManual_2020.pdf

A. Informal Claim Payment Dispute Resolution

If a provider believes that an improper payment of a claim for covered Medicaid services has occurred through either the omission of information, submittal of incorrect claims data, and/or systems error, an adjustment may be requested:

1. Have a copy of the EOP.
2. Complete an Adjustment form that can be found on the Buckeye website.
3. Submit the Adjustment within 180 days from the date of the EOP.

Adjustments may be submitted to the following address:

Buckeye Health Plan
P.O. Box 3000
Farmington, MO 63640-3800

For the Informal Claim Payment and Dispute Resolution, the adjustment form can be located at: https://www.buckeyehealthplan.com/content/dam/centene/Buckeye/medicaid/pdfs/Provider-Adjustment-Request-Form-MedicareUpdated20160520.pdf

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B. Administrative Claim Appeal

A provider may request that a specific issue be re-evaluated by Buckeye.

1. Draft an administrative claim appeal.
2. Clearly mark "APPEAL" on the letter.
3. Included in the letter should be why the claim or issue merits reconsideration.
4. Include a copy of the EOP and if applicable.
5. Include medical records, chart notes and/or other pertinent information to support the request for reconsideration.
6. Submit the Administrative claim appeal within 180 days of the adverse finding. Providers should not send a copy of the disputed claim.

Administrative claim appeals should be submitted to:

Buckeye Health Plan
Appeals Department
P.O. Box 3000
Farmington, MO 63640-3800

C. Medical Management Appeals

Providers may file an appeal when a decision is made by Medical Management to deny a service, in whole or in part (including type or level), or to reduce, suspend, or terminate a service previously authorized for a member.

1. If a provider wishes to speak with the physician reviewer, he or she may elect the Peer to Peer process within 5 business days from the date of the Buckeye denial letter. To initiate a peer to peer phone review, the provider should call a Peer to Peer Coordinator at 1-866-246-4356, ext. 24084.

2. Providers wishing to appeal a Medical Management decision on the member's behalf should submit the request in writing. A provider must have the member's written consent to file an appeal (Buckeye will accept a copy of the consent signed by the member at the time of treatment to satisfy this requirement.). A provider must submit any necessary supporting clinical documentation with the appeal. Submit the Medical Management Appeal within 180 days from the date of the Notice of Action.

   These types of appeals should be sent to:

   Buckeye Health Plan
   Attn: Appeals and Grievances Department
   4349 Easton Way, Suite 300
   Columbus, OH 43219

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OPTION 4: Provider Web Portal (Website Coordination Team under Provider Services)

Timeline Requirement for Completion: 30 days

A. Claim Reconsideration via Buckeye Health Plan Web Portal

1. Go to https://www.buckeyehealthplan.com/login.html. Once logged in, the Dashboard will appear.
2. Select the Tax ID from dropdown menu.
3. Choose the appropriate Product.
4. Select Go.
5. Click Patients, then hit enter.
6. Enter Member's ID or Last Name along with Birthdate.
7. To access the claims information while in the patient record, select Claims on the left.
8. Click on the claim that needs to be reconsidered.
9. Then, select Reconsider Claim. From the dropdown box, choose the appropriate reconsider type and Submit.
10. This will open up the previous submitted claim where you can edit the claim and attach any necessary documents to have view for reconsidering.

REFERENCE:https://provider.buckeyehealthplan.com/sso/login?service=http%3A%2F%2Fprovider.buckeyehealthplan.com%2Fcareconnect%2Fj_spring_cas_security_check%3Bjsessionid%3DIQpZo3NLLRjQ1FgjJIjieQ__.nwebprodNode03#features

B. Secure Message Portal

Claim reconsideration requests can be submitted through a Secure Message Portal, which are received and reviewed by a Buckeye Provider Service Representative.

1. Go to https://www.buckeyehealthplan.com/login.html. Once logged in, the Dashboard will appear.
2. Select the Tax ID from dropdown menu.
3. Choose the appropriate Product.
4. Select Go.
5. Click on Messaging in the upper right corner.
6. Click orange Create Message button.
7. Select the plan and subject from available drop down.
8. Enter the member ID and date of birth.
9. In the body of the message, enter the claim information and the actions requested.
10. Click Send.

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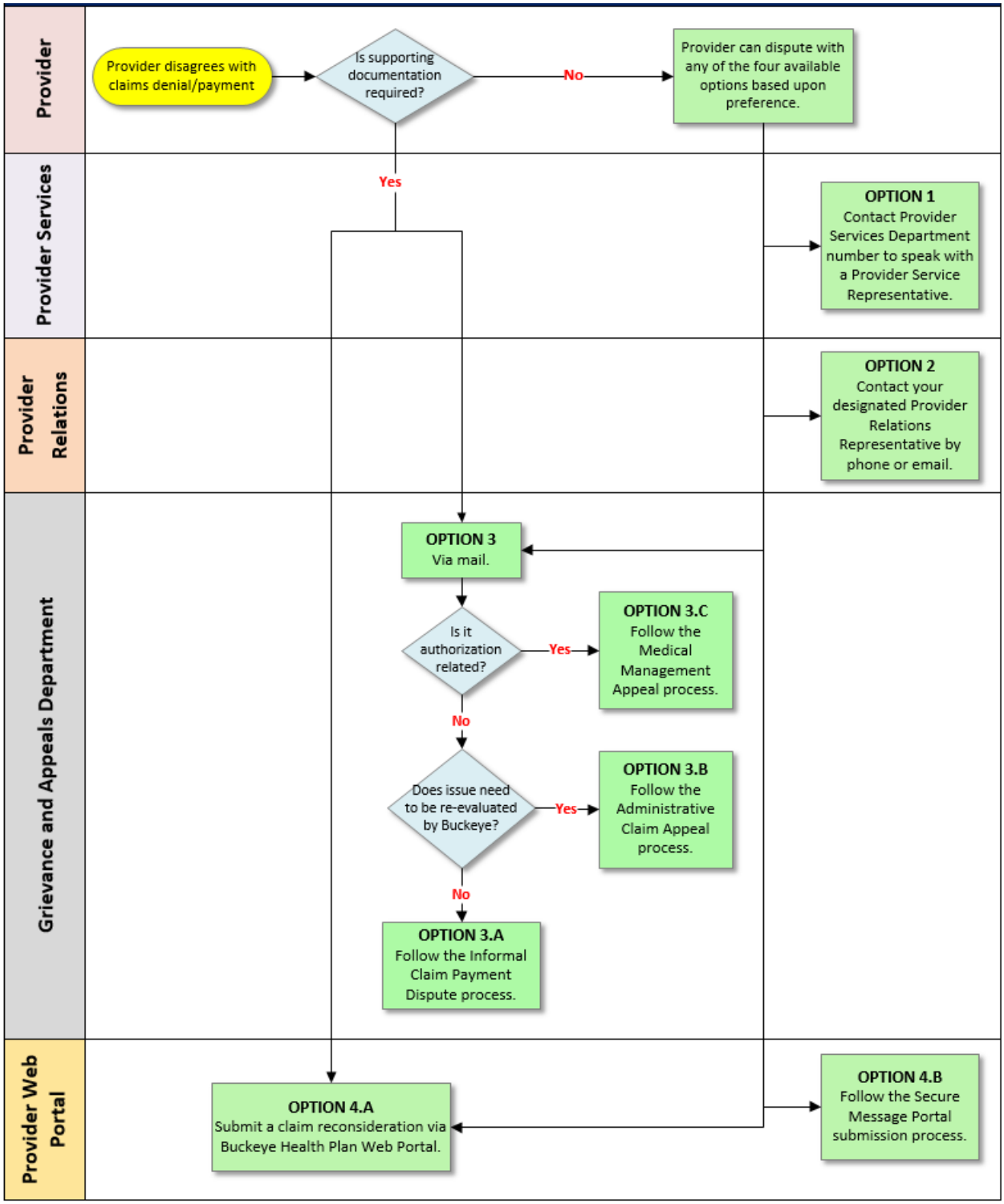
MyCare/Medicaid Provider Workflow for Claim Denial/Payment Dispute



LEGEND

Start | Action Step | Decision Yes/No

Click each Option box with hyperlink to the detailed instructions.