UM-3-4310.2-MOLINA-OH-D | Provider Claim Disputes – Molina of Ohio, Inc.

Utilization Management		Department	**Appeals, Complaints & Grievances**
Initial Approval Date	**June 8, 2023**	Last Review Date	**June 8, 2023**
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Approval Signature	*Kimberly West*	Kimberly West, Manager Appeals, Complaints & Grievances	

Purpose

This SKYGEN USA, LLC policy outlines and defines the Provider general claim dispute/appeal process for any business related to the administration of dental benefits for Molina of Ohio, Inc.

Policy

The Appeals Department at SKYGEN is responsible for processing Provider Claim Disputes and Appeals. Providers have the right to file a claim dispute within 12 months from the date of service or 60 calendar days after the payment, denial or partial denial of a timely claim submission, whoever is later. Providers may submit disputes in writing or initiate a verbal appeal by calling the Customer Care department during contracted business hours.

Dispute logs will capture the following information at a minimum:

- Beneficiary Name
- Beneficiary identification number
- Provider Identification/NPI
- Date received
- Date of the acknowledgement (within 5 business days, verbally or in writing)
- Dispute reference number (created by SKYGEN or in some cases, the client)
- Description of Dispute
- Reimbursement Analyst findings
- The disposition of the Dispute determination
- Description of generally accepted dental care guidelines used to render a determination
- The date that the appeal was resolved, with notification provided to the Appellant(s)
- The turnaround time from the day that the appeal was received to the date that the Appellant(s) was notified of the appeal decision; within 30 business days of receipt
- Any relevant Claim or Reconsideration guidelines used in processing

Definitions:

CSM: Customer Service Module; System module used to document provider and member call and appeal activity. CSM also houses member specific information such as eligibility, authorization records, and claim records.

ADM: Authorization Determination Module; System module used to electronically house authorization requests and determinations.

CAM: Claim Adjudication Module; System module used to electronically process, pay, and store claims for payment.

Follow-up: A tool in CSM used for the purpose of this policy, to communicate and document appeal activity.

Provider Dispute/Appeal: A request regarding a post service denial, made by a provider.

DRA: Dental Reimbursement Analyst; person charged with making claim payment decisions.

Timeframes for Appeals Resolution:

Provider Clinical Claim Appeal Reviews - completed within 30 calendar days from the date of receipt.

Provider Payment Disputes – completed within 15 business days. Should additional time be needed, a status update must be provided to the provider on the 15th business day and every 5th business days until the dispute is resolved.

Procedure

All incoming mail to the Appeals post office box is received and processed each business day. Verbal appeals are received via CSM follow-up as routed by the call center.

1. Mail opened is date stamped to indicate the date received. Verbal appeals are logged through the Enterprise system and automatic date stamps are applied to each confirmed call log.
2. The Appeals Specialist will read all incoming appeal requests and match the request for appeal to the corresponding denial stored in CSM.
3. The Appeals Specialist will review the initial denial letter for timely filing compliance of the appeal request. The appeal must be received no later than 365 calendar days from DOS or 60 calendar days from the date of the initial denial letter, whichever is greater, to be considered as a timely appeal submission.
4. If the request is found to be untimely, the appeal is denied for being "received beyond the timely filing limit".
    a. A letter is created and mailed to the Appellant explaining the timely filing denial.
    b. The denial letter and the written appeal (if applicable) are scanned to create an electronic copy of the documents.
    c. An appeal entry is made by the Appeals Specialist in CSM under the Appellant's permanent record to include the following information:
        i. A copy of the electronic documents created in Step 4-b
        ii. A brief summary of what was being appealed and why it is being denied
        iii. The claim number or authorization number containing the denial
    d. The Appeals Specialist will make a log entry recording the appeal activity on an external tracking log.
5. For timely filed appeals, the Appeals Specialist will create an acknowledgement letter (where required) for the Appellant. The member has the opportunity to submit written comments, documents or other information relating to the appeal.
6. The acknowledgement letter and any documentation received as a part of the appeal request are scanned to an electronic document. The original documentation is shredded and the acknowledgement letter is mailed within five (5) business days of receiving the appeal.
   If the appeal is accompanied by clinical information, the Appeals Specialist will review the authorization record in ADM and will determine what alternate Dental Consultant will review the appeal request.
7. The claim record in CAM is prepared by attaching a copy of the appeal documents to the original claim

record.

8. The Appeals Specialist will then assign the appeal to a Dental Consultant or Dental Reimbursement Analyst by creating and assigning a follow-up in CSM to include the following information:
    a. A copy of the electronic documents
    b. A brief summary of what is being appealed
    c. The claim number containing the denial, which serves as the unique appeal case identifier
    d. A due date for the Dental Consultant or Dental Reimbursement Analyst to complete their review by
    e. An attestation listed (if applicable) for the Dental Consultant to attest to that they are qualified to clinically review the services on appeal
        i. The attestation will have the specific name and credentials of the reviewer, as well as the unique appeal case identifier listed in the verbiage
        ii. The verbiage is as follows:

        (Unique identifier) I, (Dental Consultant Name, Credentials), attest that, to the best of my knowledge, I have a scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review, as well as current, relevant experience and/or knowledge to render a determination for the case under review. (Description of denied services)

9. The Dental Consultant or Dental Reimbursement Analyst will render a determination after reviewing all of the documentation presented.
10. If the request is again denied, the rationale used to make this determination will be documented in the CSM follow up by the reviewing Dental Consultant or Dental Reimbursement Analyst and the follow-up will then be reassigned back to the Appeal Specialist.
11. If the request is approved, the claim in CAM will be resubmitted to pay in the subsequent check run (within 30 calendar days from the date of written notice). The follow up will then be reassigned back to the Appeals Specialist
12. If the appeal is overturned, the claim remittance containing the resubmitted claim and payment, will serve as the written notification of appeal determination requirement.
13. The Appeals Specialist will create a denial notice in the event that the appeal is upheld, to include the rationale supplied by the Dental Consultant or Dental Reimbursement Analyst. The denial notice will be mailed and an electronic copy will be retained and added to the appeal record in the Enterprise system. Any appeal uphold will include further appeal rights for the member, as appropriate based upon regulatory standards.
14. The external appeal log will be updated to include the disposition of the appeal outcome, the resolution date, and the calculated turnaround time.
15. The CSM follow up will be resolved.