

15 Resolution of Provider Disputes

This section identifies the policies and procedures for dispute resolution that providers have a contractual obligation to follow. Following is a list of operational issues that may be identified as areas of concern for providers participating with BCBSNM:

- Disputes regarding claims
- Determination of medical necessity
- Contract issues, including contractual language, reimbursement, termination, and credentialing/quality issues
- Quality-of-care issues
- Potential cases of fraud

The subsections below further define the five BCBSNM classifications of provider disputes:

- Claims reimbursement
- Claims bundling and medical disputes
- Contractual and operational disputes
- Provider terminations
- Medical appeals on behalf of the member

If after following the procedures set forth below, the issue is not resolved, or if you have a question regarding the procedure, contact the Network Management Department to speak with the Network Contract Representative or Network Provider Representative for your geographic region. See the telephone directory at the beginning of this manual or go to [Contact Us](#) on the provider home page at www.bcbsnm.com.

15.1 Claims Reimbursement Disputes

15.1.1 Initial submission of a claim

Claims will be returned at initial submission if they are missing vital information for provider identification or if member information cannot be identified. These claims are sent back via the “reject” report for electronically submitted claims or physically returned with the missing information noted. Your contract stipulates that claims returned for any additional information must be returned to BCBSNM within 30 days of receipt. If these claims are not resubmitted, you risk being denied for timely filing if discovered late (180 or more days). When these claims are returned, they are considered to be the initial submission of the claims.

The most common reasons for rejection of claims or a request for additional information are:

- Member’s group coding is incorrect or not present (if you file electronically, this is automatically researched and filled in)
- Provider tax ID, addresses, etc., do not match the provider NPI given
- No CPT or diagnosis codes

If within 30 days from the date of service, you have not received an accounting of the claim, please do not resubmit the claim. BCBSNM provides self-service options utilizing the internet to request claim status on previously submitted claims. For more information regarding the available on-line tools visit [Availity](#). There is also an automated interactive voice response system ([IVR](#)) available to verify claim status.

Obtaining claim status prior to re-filing saves administrative costs by eliminating duplicate handling of previously submitted claims. If you wish to follow up by phone, please dial the following numbers:

- Provider Service Unit: **1-888-349-3706**
- Federal Health Plan Unit: **1-800-245-1609**

15.1.2 Appeals

Should the provider dispute the payment of a claim for any reason, e.g., the claim was denied, paid at an incorrect benefit level, or reimbursed incorrectly; the provider has the following appeal procedure options:

If the operational dispute concerns:

Timely Filing of Claim

Section 8, **Claims** describes the process for claims submission. The timely filing document defines the requirements and the documents considered acceptable as proof of timely filing.

Claims

Initial telephone inquiry is generally made with a Customer Advocate (CA) in the Provider Service Unit (PSU) or Federal Health Plan Unit associated with the member's benefit plan. Contact can be regarding the member's benefits, eligibility, or the status of a claim. If it is a question regarding the claim reimbursement [as shown on the Provider Claims Summary (PCS)], the CA will research the claim to determine if the claim has been paid correctly. If a payment error was made, the claim is processed as an adjustment.

If the provider office has examined the PCS and determined that the claim was processed in error, it may be appealed directly by using the [Provider Request for Claim Review](#) form following this section. Please follow the directions on the form and identify the issue as clearly as possible.

Note: Claims are not reviewed for any reason after one year from the date of service.

Level of Reimbursement

If the provider's concern is that the payment of the claim was insufficient for the level of service provided, for consideration of add-on codes, or other claims reimbursement issues, the provider will contact Customer Service. If the issue is not resolved to the provider's satisfaction, the provider may contact the Network Contract Representative for the geographic region where the provider resides. The contract representative then

consults with representatives of the Medical Review Unit (MRU), who may refer the question to the Medical Director to evaluate the provider's claim for additional reimbursement. If the complexity of the procedure warrants increased payment as determined by the Medical Director, a request for adjustment is submitted to the appropriate unit.

Resolution of a Claim

Once a determination of payment is made, the appropriate unit is contacted with a recommendation as to the final disposition of the claim. Most claim disputes are handled at the customer service level by the supervisor in coordination with the unit manager. For complex or high-dollar claims, the issue may be escalated to a director of the claims unit.

Change in Fee Schedule

If the situation requires a change in the fee schedule for all claims submitted by the provider, the request is reviewed by a Network Management committee consisting of:

- Network Management Contract Representative
- Network Management Unit Manager/Contracts Specialist
- Network Management Director
- Vice President of NM Business and Network Management

15.2 Determinations About Claims Bundling, Complex Procedures, etc.

Disputes about bundling, medical policy, etc., are sent to the Medical Review Unit (MRU) of the Health Services Department for resolution. If the decision is reversed after the review is completed by Health Services personnel, additional benefits will be paid through an adjustment. If the original decision is upheld, the Health Services Department will inform you by letter within 20 working days after receipt of all requested information.

Note: For information on medical appeals on behalf of members, see Subsection 15.5.

Effective November 21, 2008, Medical Doctors and Doctors of Osteopathy (MDs/DOs) may file a post-service provider appeal to resolve disputes limited to the application of coding and payment rules and methodology related to ClaimCheck, bundling, and modifiers. Blue Cross and Blue Shield of New Mexico's internal appeal process must be exhausted before an external appeal will be considered. The provider appeals are conducted by an independent review organization, MES Solutions.

An appeal can be submitted online, by fax, or by mail. The guidelines for submitting an appeal and the applicable fees can be found at [MES Solutions](#).

15.3 Contractual and Operational Disputes

The Customer Service Unit receives all provider correspondence regarding contractual language or reimbursement disputes. This correspondence is imaged and sent to the Network Management Department for review by the contract representative for each provider's geographic region. The contract representative will reply within 20 working days of receiving all information required for resolution. Depending on the nature of the complaint (i.e., contract language, fee schedule change, etc.), the request may be reviewed by a committee consisting of:

- Network Management Contract Representative
- Network Management Unit Manager/Contracts Specialist
- Network Management Director
- Vice President of NM Business and Network Management

The preceding information identifies the general categories of dispute presented by providers. It also lists individuals responsible for resolution of the various types of operational disputes. We encourage contracted providers to discuss any concerns they may have regarding BCBSNM operations. Correspondence received in Customer Service from providers regarding operational disputes is routed to the appropriate division for review.

15.4 Provider Terminations

BCBSNM affords any provider terminated from our network the right to appeal the termination decision in accordance with the New Mexico Managed Health Care Plan Rule and the New Mexico Patient Protection Act. Appeal rights do not apply to a provider-initiated resignation from the network, a mutually agreed upon dissolution of a contractual relationship, expirations or non-renewals of fixed-term contracts, or contract default.

15.4.1 Determination of Termination

A provider may be terminated by BCBSNM as a result of business needs; contractual issues; failure to meet standards or performance expectations related to credentialing, recredentialing, utilization management, quality assurance, quality improvement, or fraud and abuse issues; or any other internal review process. Each of these internal processes includes avenues for addressing issues prior to termination, when such avenues are appropriate.

15.4.2 Notification of Termination

When BCBSNM terminates a provider from the network, BCBSNM notifies the provider in writing at least 30 calendar days in advance of the effective date of the termination, *unless* BCBSNM determines there is imminent risk to the health and safety of its members, in accordance with the expedited termination process described below.

The notification correspondence describes the reason for termination and, if applicable, summarizes any previous corrective action that took place in an attempt to avoid the need for termination. This correspondence informs the provider of the effective date of the termination of each applicable contract the provider holds with BCBSNM. The correspondence also details the provider's rights regarding an appeal of the termination.

15.4.3 Provider Appeal Rights and Responsibilities

Notification of termination includes an explicit explanation of the provider's right to request, in writing, an appeal, which includes the right to a fair hearing if the termination is on a for-cause basis. The provider is informed how to submit the written request for appeal to BCBSNM. The provider is allowed 30 calendar days from the date of the letter to notify BCBSNM that he/she intends to appeal the termination. The provider is informed that he/she may submit a written appeal with any supporting documentation or may appear in person at a fair hearing if the termination is for cause. The provider is also informed that he/she may provide additional written information before or during the fair hearing, regardless of whether or not the provider attends the hearing. The provider is notified that he or she may ask questions of any BCBSNM representative at the fair hearing; that he/she has the right to representation, including but not limited to legal representation; of reasonable responsibilities that he or she must accept, including compliance with time frames, written notification of confirmation of attendance or nonattendance, and compliance with the rules of procedure established for the fair hearing, if a fair hearing is requested.

If BCBSNM determines in good faith and with reasonable belief that further care by the provider will result in imminent and significant harm to members, and then terminates the provider without advance written notice, the provider is notified that he/she may have an expedited hearing.

If a provider does not express in writing within the 15 calendar day time frame his or her desire to appeal the termination, the termination will take effect as described in the initial notification letter.

15.4.4 Fair Hearing

Providers terminated on a for-cause basis are afforded the opportunity to request in writing a fair hearing as part of their appeal rights. Providers may choose to exercise their appeal rights by providing written material and/or:

- By attending the fair hearing.
- By attending a fair hearing and having a representative attend a fair hearing.
- By having a representative attend a fair hearing in their place.

In all cases, "attending" a fair hearing is interpreted to include attendance in person, by teleconference, by videoconference, or by whatever method or technology that may exist that allows for real-time communication by which the provider may exercise his or her rights as described in this document.

After a fair hearing is requested in writing, the provider is informed of the rules of conduct and procedure of the hearing. To promote maximum information exchange, the hearings are held as informal proceedings that are not subject to civil rules of evidence.

The fair hearing is held as expeditiously as possible within 30 calendar days of BCBSNM's receipt of written notification of the provider's intent to appeal.

The fair hearing is facilitated by a senior management staff member. Other staff is assigned to the hearing as appropriate, based upon the nature of the reason for termination. BCBSNM legal counsel may attend the hearing.

At the fair hearing, the provider is afforded the opportunity to:

- Be informed of all information used in making the determination to the extent such access is permitted under state and federal law, regulation and rules, and BCBSNM policy.
- Present, in oral or written format, any information to the fair hearing officer or committee that the provider feels would support a reversal of the determination.
- Ask any questions of BCBSNM representatives on the committee.
- Answer questions posed by BCBSNM representatives on the committee.

The appeals process and fair hearing (if requested by the provider) leads to a determination of whether or not to uphold the termination. This determination is reviewed and approved by a senior vice president or official designee prior to being sent to the provider.

15.4.5 Notification of Final Determination

BCBSNM informs the provider in writing of the final determination within 15 days of the date of the fair hearing. If the termination is reversed, the provider is also notified of any limitations, stipulations, contingencies, or follow-up required. If the termination is upheld, the termination occurs as scheduled in the initial notification letter.

15.4.6 Expedited Terminations

If BCBSNM reasonably determines that a provider poses an imminent risk to the health or safety of members, BCBSNM may issue an expedited termination.

BCBSNM considers certain actions that are a matter of official record to be sufficient, on their face and *a priori*, for BCBSNM to conclude in good faith and with reasonable belief that there is an imminent and significant risk to the health and safety of members.

Depending on the specific details, these actions may include but are not limited to:

- Loss, restriction, sanction, or stipulation of professional license
- Loss, restriction, sanction, or stipulation of clinical privileges
- Legal findings of gross negligence
- Inclusion on a Medicare/Medicaid sanction report
- Indictment or conviction of a felony

- Conviction of a misdemeanor that substantially endangers the public, such as driving while intoxicated

When BCBSNM determines it must institute an expedited termination, the effective date of termination for an expedited termination **may** be less than 30 days from the date of notification. In cases where BCBSNM has determined in good faith and with reasonable belief that further care by the provider would result in imminent and significant harm to members, the provider is notified in writing of the termination; however, written **advance** notice of the termination **may** be waived.

If BCBSNM terminates a provider from the network without written advance notice because BCBSNM has determined in good faith and with reasonable belief that further care by the provider would result in imminent and significant harm to members, the provider is informed that he or she may request in writing an expedited fair hearing. This written request must be made within 15 calendar days of the notification of termination or it will be deemed that the provider has waived appeal rights. The date for an expedited fair hearing will be set to occur as soon as practicable, within 30 days of the provider's termination.

All other elements and conditions of the Provider Grievance of Terminations plan described above apply to expedited terminations, including written notification, explanation of the reason for termination, explanation of appeals and fair hearing rights and responsibilities, and notification of the final determination.

15.5 Appeal on Behalf of the Member for Medically Related Issues

The following section applies to “member/patient” appeals, where they are requesting assistance from their health care provider to appeal an adverse determination of medically related issues. The member/patient must provide authorization, as indicated by their signature and a statement to this fact. (See attached form, Provider Request for Appeal on Behalf of Member.)

Several regulatory bodies dictate the types and levels of appeals available to members. The member's group plan is the determining factor as to which regulatory requirements apply.

Department of Insurance Managed Health Care Regulations

This type of dispute includes denial of claims, referrals, or prior authorizations for medical necessity. Effective May 3, 2004, updated regulations were issued by the New Mexico Insurance Division mandating changes to the way BCBSNM addresses members' appeals and grievances for certain employee groups.

Note: Some denials are based on benefit limitations or exclusions, irrespective of perceived medical necessity.

Managed Health Care

When a member (or person allowed by regulation to act on the member's behalf, such as a treating physician) contests a determination that the member believes is adverse, the first level of review (previously called an appeal) is now referred to as the Initial Review of Adverse Determination by the Medical Director.

If the outcome of that review remains unchanged from the original determination, then a second level of review is available. This second level (previously called a grievance) involves a review panel/committee and is thus called the Internal Panel Review of Adverse Determination. The member and/or representative may attend the Internal Panel Review, or participate by teleconference.

For determinations related to clinical issues, an independent consultant physician who practices in a like specialty will participate in (and optionally may attend the proceedings of) the Internal Panel Review.

An expedited review (where the standard timeframe for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function), is available under certain circumstances. Please discuss this with the Member Services Department Customer Service Representative.

Department of Labor (DOL)-ERISA

Members who received their appeal rights under DOL-ERISA receive one level of appeal called the DOL-ERISA committee appeal. The member or his or her representative can provide additional information to the committee, but the member does not participate in the actual committee meeting. The request for an appeal must be received at BCBSNM within 180 days of the initial denial.

Not covered under Managed Health Care or DOL-ERISA regulations

Members who are not covered under either of the above regulatory bodies are entitled to one level of appeal that is a chart review and not a panel or committee review process. The member may submit additional information and the request must be received within 180 days of the original denial.

To assist you, the form for initiating a Provider Request for Appeal on Behalf of Member is located at the end of this Section. This form is also available on our website at bcbsnm.com. For additional information, please call the appropriate Customer Service area (use the phone number on the member's ID card).

15.6 Resolution of Other Provider Disputes, Complaints, and Appeals

For assistance with the resolution of any provider disputes, complaints or appeal processes not described above, please contact your [Network Management Contract Representative](#).

15.7 Attachments

- [Provider Request for Claim Review](#)
- [Provider Request for Appeal on Behalf of a Member](#)