

Provider Appeals – Name and Process Change

January 31, 2020

Our aim at Neighborhood Health Plan of Rhode Island (Neighborhood) is to make doing business with us easier. A careful review of provider claim payment appeal requests has revealed the need for increased education and guidance for providers on Neighborhood claim processes and the forms required for efficient handling and outcomes.

To that end, “Provider Claim Dispute” will replace the former “Provider Appeal Request” process as it relates to claim payment denials *only*. This update does not affect the process or nomenclature for appeals submitted by providers on behalf of members and the associated regulatory timeframes and rules for those appeals.

The existing “Provider Appeal Request Form” will be updated and replaced with a form that allows for both **Provider Claim Disputes** and **Provider-Initiated Appeals**. It will be available for use by April 1, 2020 and posted on our [website](#) to aid providers in following proper processes.

Provider Claim Disputes (*formerly Provider Appeal Requests*) are provider-initiated requests for further review of a claim denial after the Neighborhood claims process has been followed (if required). In order to efficiently and accurately address provider claim concerns, providers should utilize the [Claim Form Finder](#) to determine the appropriate form to submit for further action/review from Neighborhood.

The Neighborhood [Claim Form Finder](#) outlines the Claims Department processes providers must follow for:

- Corrected / Voided Claim Submissions,
- Reconsideration Requests, and/or
- Adjustment Requests

The **Provider Claim Dispute** process and form should be followed and submitted for the following reasons/circumstances:

- A Claims Reconsideration denial letter states the next step is to file a Provider Claim Dispute (formerly referred to as *appeal*)
- A provider disagrees with the Claims Department’s decision following processing of an Adjustment Request for a Timely Filing Denial
- A claim denies for No Authorization because the provider’s office did not follow the retro-authorization requirements outlined in the Provider Manual

Providers should submit a **Provider-Initiated Appeal** (on the Provider Dispute Form, referenced above) in the following situations* (**this is not an all-inclusive list*):

- A provider has received a denial from Neighborhood's Utilization Management or Pharmacy Department
- A provider is submitting a benefit appeal on behalf of a member when requesting coverage of a non-covered medication or service due to medical necessity
- A provider believes they received incomplete/inaccurate information from Neighborhood's Provider Services or our delegated entities before rendering a service resulting in a claim denial
- When a claim denies due to preauthorization previously denied by Neighborhood's Utilization Management department

In addition to the updated name of the process for Provider Claim Disputes, Neighborhood is aligning with industry standards in changing the timeframe allowed for providers to submit claim disputes. Effective April 1, 2020, Provider Claim Disputes must be submitted within 60 days following a claim denial or Claims Department decision (whichever is appropriate, given the scenarios above). Any provider claim payment dispute received by Neighborhood's Grievances and Appeals Unit after the 60 days will be rejected as 'over the time limit' (unless a provider's contract with Neighborhood states otherwise). Rejected provider claim disputes are not eligible for appeal.

**If you have questions regarding any of the above, please call
Neighborhood Provider Services at 1-800-963-1001.**