Provider Dispute Submission User Guide

Updated December 2020

CountyCare Provider Dispute System

- Providers have the right to submit a dispute.
- Providers submit a dispute through the CountyCare Provider Dispute System.
- Provider disputes may be submitted for any of the following reasons:
  - Payment/Claims (such as an unsatisfactory Claim Review resolution)
  - Contracting
  - Eligibility
  - Prior authorization
  - Provider enrollment
  - System issue
- All requests for disputes **must be received within 60 calendar days from the date of the Explanation of Payment (EOP).**
- Once all necessary information has been received from the provider, all dispute types will be researched and responded to within 30 calendar days from receipt of the dispute, with either a completed resolution OR a substantive response detailing actions and timeframe to resolve the dispute.

CountyCare HEALTH PLAN

How to Submit a Provider Dispute

- The Provider Dispute System is available all providers (contracted and non-contracted) through a portal link:
  https://countycareproviderdispute.jira.evolenthealth.com/

- Upon submission, a CountyCare tracking number will populate at the top of the dispute ticket. CountyCare tracking numbers lead with 03:
  - Format: 03-YYMMDD-xxxxx, Example: 03-191001-00001

- Provider Services and Provider representatives will not be able to submit disputes on behalf of providers. Providers must submit disputes directly into the Provider Dispute System.

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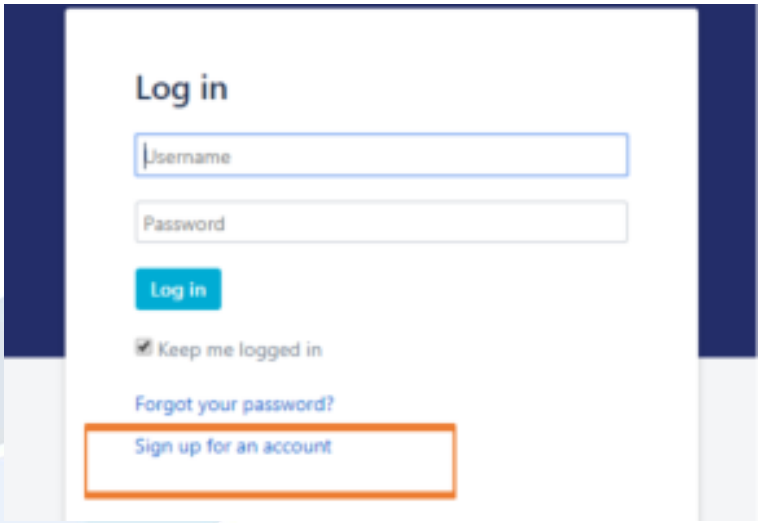
Creating An Account

1. Go to: www.countycareproviderdispute.jira.evolenthealth.com
2. Click “Sign Up for an Account”
3. Enter name, email, username, password and confirm password



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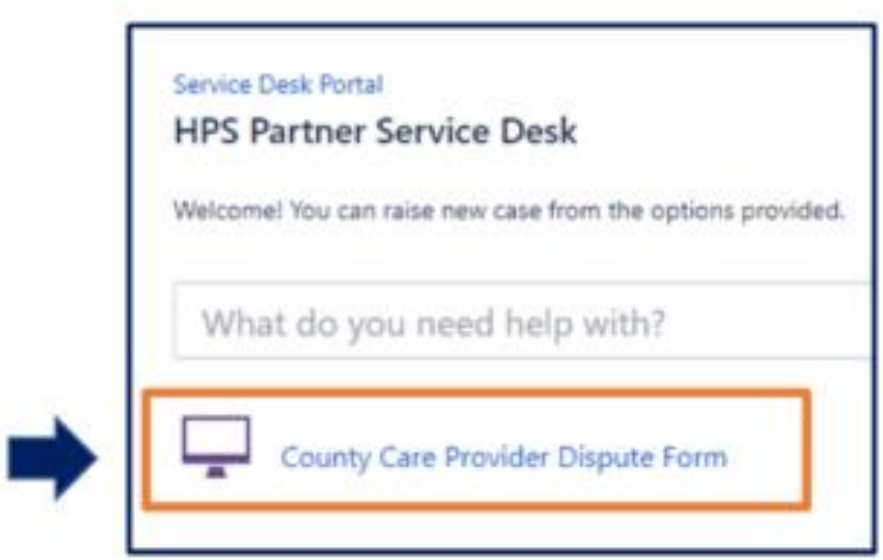
How to Submit a Provider Dispute

1. Access the County Care Provider Dispute Form URL
2. Click on "CountyCare Provider Dispute Form."



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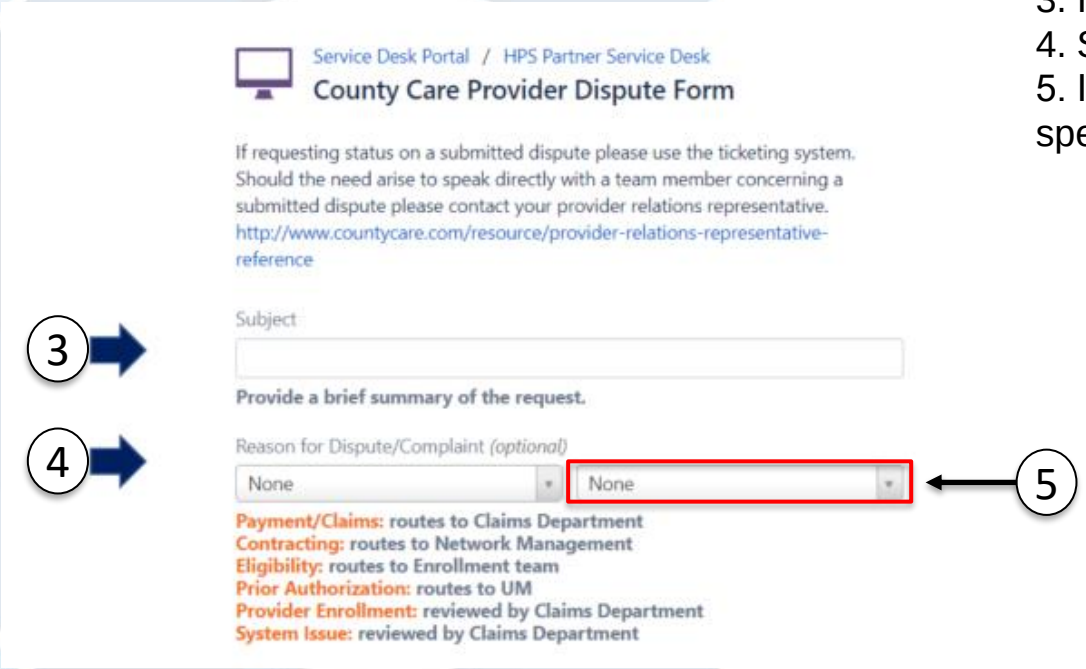
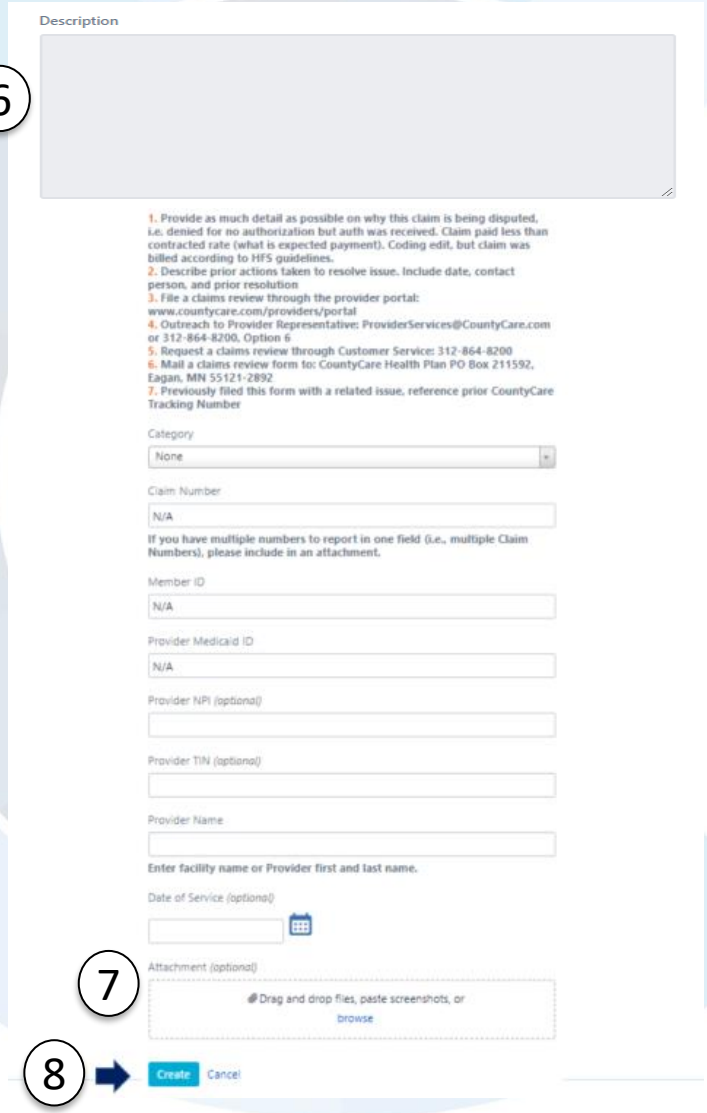
How to Submit a Provider Dispute



3. Input the subject of the dispute
4. Select a reason for the dispute
5. If “Payment/Claims” is selected, further specify in the second drop down:

- Claim was denied for no authorization, but authorization was obtained (see attachment for authorization).
- Claim was denied for no authorization, but no authorization is required for this service.
- Claim was denied for untimely filing in error (see attachment for proof of timely filing).
- Claim was denied as a duplicate.
- Claim was denied for member eligibility (see attachment of MEDI screenshot).
- Claim was paid for incorrect amount.
- Claim was processed as an out of network provider.
- Payment not received / delayed
- Other

How to Submit a Provider Dispute



6. Provide as much detail as possible in the “Description” box outlining other methods used to resolve the issue such as:
    - Reaching out to Provider Representative
    - Calling Customer Service
    - Submitting a Claim or Medical Necessity Review via Provider Portal or mail

7. Upload attachments, if applicable. If more than one claim is being disputed for the same reason, attach a spreadsheet containing all the claim numbers and detail.

8. Click “Create” to submit.

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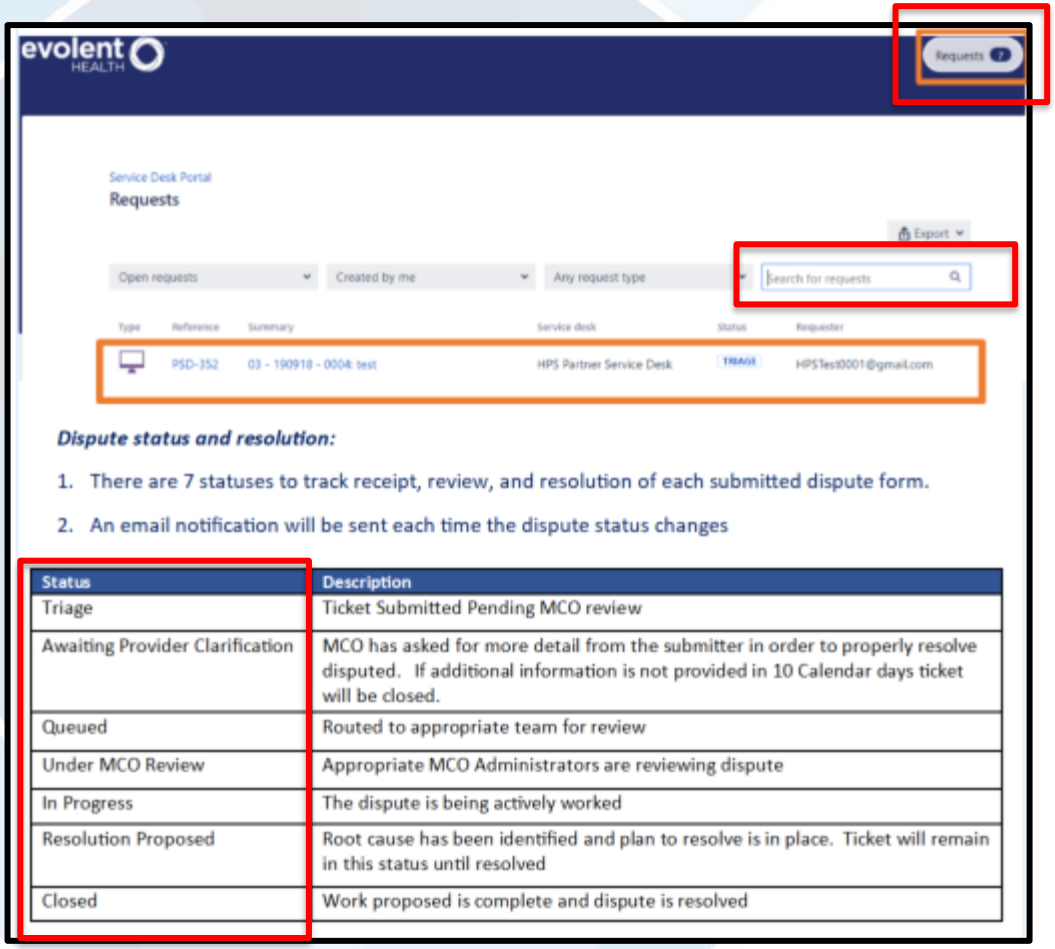
Viewing Submitted Disputes



Dispute status and resolution:

1. There are 7 statuses to track receipt, review, and resolution of each submitted dispute form.
2. An email notification will be sent each time the dispute status changes

Status	Description
Triage	Ticket Submitted Pending MCO review
Awaiting Provider Clarification	MCO has asked for more detail from the submitter in order to properly resolve disputed. If additional information is not provided in 10 Calendar days ticket will be closed.
Queued	Routed to appropriate team for review
Under MCO Review	Appropriate MCO Administrators are reviewing dispute
In Progress	The dispute is being actively worked
Resolution Proposed	Root cause has been identified and plan to resolve is in place. Ticket will remain in this status until resolved
Closed	Work proposed is complete and dispute is resolved

- Click on the “Requests” button at the top right-hand corner of screen.
- Filter and search functionality is available to help find previously submitted disputes
- Ticket statuses will indicate the current state of the dispute
  - <u>If more information is needed from the provider</u>, the status will change to “Awaiting Provider Clarification” and a notification email will be sent to the provider
- If at any time the status changes, an email notification will be sent to the provider stating the status has been changed

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Provider Dispute Resolution

- Once all necessary information has been received from the provider, the ticket status will be “In Progress.”
- From there, all disputes will be researched and responded to within 30 calendar days providing a completed resolution OR a substantive response detailing actions and timeframe to resolve the dispute.

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