

Policy Name	New Mexico Provider Administrative Dispute Resolution Process
Policy Number	1492A.01
Department	Complaints and Appeals
Subcategory	Administrative Dispute Resolution Process
Original Issue Date	01/06/2023
Committee Approval Date	01/06/2023
Effective Date	01/01/2023

Company Entities Supported (Select All that Apply): <input checked="" type="checkbox"/> Superior Vision Benefit Management <input checked="" type="checkbox"/> Superior Vision Services <input type="checkbox"/> Superior Vision of New Jersey, Inc. <input type="checkbox"/> Block Vision of Texas, Inc. d/b/a Superior Vision of Texas <input checked="" type="checkbox"/> Davis Vision (Collectively referred to as 'Versant Health' or 'the Company')
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DEFINITIONS:	
Term	Definition
Administrative Dispute	Written expression of dissatisfaction other than a payment or medically necessary prior authorization determination. Also known as a complaint.
Day	Calendar day unless otherwise specified.
Non-Participating Provider	Provider that has not entered into an agreement with the organization to be part of a provider network
Participating Provider	Provider that has entered into an agreement with the organization to be part of the provider network

PURPOSE

To afford Commercial providers (contracted and non-contracted) with an internal process in which to address and resolve dissatisfaction complaints.

SCOPE

All participating and non-participating Commercial provider administrative disputes in New Mexico.

POLICY



The Company has established a two-level internal process by which a provider may request resolution to administrative challenges.

The Company will not retaliate or take any discriminatory action against any provider as a result of filing a dispute.

A written dispute from a participating or non-participating provider is considered a formal request for review. Providers may submit multiple disputes simultaneously and for a group of providers. A provider must file an initial dispute at least 90 days from the incident, either electronically or manually, following receipt of the initial claim determination or within fifteen (15) calendars following a first level adverse dispute determination to:

Versant Health
Complaints and Appeals Department
PO Box 791
Latham, NY 12110
Email: ProviderCA@versanthealth.com
Fax: 1-888-778-1008

Provider disputes handled within this policy include:

- Credentialing deadlines;
- Network adequacy, including participation determinations based on network composition;
- Network composition including provider qualifications;
- Utilization management practices;
- Provider contract construction or compliance;
- Patient care standards or access to care;
- Termination;
- Operation of the plan including compliance with any law enforceable by the superintendent, or of any directive of the superintendent; or
- Discrimination.

Payment associated disputes are addressed in **policy # 1493A.XX-New Mexico Provider Payment Dispute Resolution Process.**

Intake of all written provider administrative disputes are handled solely by the Company's Complaint and Appeals Department. The Company will ensure a review panel comprised of multiple members, at least one of whom is in a position of authority over the plan operations that are subject to the grievance decides the providers grievance. If the grievance is related to quality-of-care concerns, the panel must include a New Mexico licensed medical professional who practices in the general area of concern.

The review panel, at a minimum, will consist of the following leaders and staff from the following areas:

- Manager, Complaint and Appeals
- Quality Coordinator (Complaints and Appeals)
- Director, Provider Relations
- Director, Claims

- As needed participants
 - Medical/Clinical Director (Quality of Care)
 - Director, Credentialing
 - Director, Utilization Management
 - Additional Department Director's depending on grievance issue

All Director and above participants are considered to be subject matter experts and have the ability to make determinations for their respective departments. The Vice President, Quality, Complaints, and Appeals has the ultimate responsibility and oversight of the provider grievance process for the Company.

The Complaints and Appeals Manager, Quality Coordinator, Director, Provider Relations, and Director, Claims are standing members of the panel. As needed participants are added based on the following process/criteria:

- The Complaints and Appeal Quality Coordinator will review the dispute to determine primary issue(s) submitted by the provider and based on those findings participants from the appropriate department(s) within the Company will be requested to participate in the panel.
- All available information submitted by the provider and any additional information collected by the Quality Coordinator will be shared with the department representative. For example, a dispute related to the provider's participation status on the date of service will require the Director, Credentialing to participate in the panel meeting.

Providers are to supply the following minimum requirement when filing a dispute, which should include, but is not limited to:

- Provider Identifiers
- Member identifiers, if applicable
- Description of challenge and date of occurrence
- Expected resolution outcome

Providers are made aware of the process via The Company's website and Provider Manual.

Upon receipt of all necessary information, an administrative associate, or a clinical reviewer, as needed, who is qualified to render a decision and was not involved in prior determinations, will be assigned to review, and render a resolution.

An acknowledgement letter will be sent to the provider within five (**5**) days summarizing the challenge and providing clear direction regarding how a provider can submit additional information for review. The Company may require additional information within ten (**10**) days of the receipt and require providers to respond in ten (**10**) days. Extensions are allowable if they are documented and have agreement.

A determination will be made and written notification of resolution provided to the provider within forty-five (**45**) days of the later of receipt of the grievance, receipt of supplemental information requested resolve the grievance, or the due date for submission of any requested supplemental information.

This timeframe applies to both levels of internal review.

The Company provides written notice of resolution to the provider including, but not limited to:

- The issue and detailed reasons/rationale for the resolution, including any provision used in making the resolution, when applicable.
- A list of the titles and qualifications of the individuals participating in the review.
- Summary of the evidence relied upon to support the decision.
- Summary of any proposed remedial action.
- The name, address, and phone number of the assigned contact person.
- A statement advising the provider that any documents, records, or other information used in the determination may be requested free of charge.
- (Level 1 only) A statement advising the provider of the process for a second level of review of the level 1 outcome. This will also include any additional complaint rights as per applicable regulation.
- (Level 2 only) A statement that the notice is a final resolution and that the internal dispute process has been exhausted. This will also include any additional external appeal or complaint rights as per applicable regulation.

Provider Appeal

The state will conduct external reviews of provider grievances for those that are alleged violation of law, alleged noncompliance or termination based on providers alleged failure with law. External review will not occur unless the provider has exhausted the internal grievance process. Provider must file by thirty (30) days after the received grievance resolution.

All data related to dispute cases is retained in a designated C&A sub-system, which can produce reports to facilitate management oversight and compliance with all State, Federal, and accreditation requirements. C&A will maintain a log of disputes and resolutions for five (5) years. Tracking and trending of disputes are also presented at the Company’s Quality Improvement Committee meetings on at least a quarterly basis for tracking, trending, or intervention purposes.

DISCLAIMER, LIMITATIONS AND EXCLUSIONS

NA

RELATED POLICIES AND PROCEDURES	
Policy Number	Policy Name
1493A.XX	New Mexico Provider Payment Dispute Process

REVISION HISTORY		
<u>Date</u>	<u>Revision</u>	<u>Version</u>
12/01/2022	Initial Review- New policy	.01

Compliance Source(s)

New Mexico Office Of Superintendent of Insurance (OSI) [13.10.16.1 NMAC - Rp, 13.10.16.1 NMAC, 01/01/2023]