Policy Name	New Mexico Provider Payment Dispute Process
Policy Number	1493A.01
Department	Complaints and Appeals
Subcategory	Payment Dispute 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):
_X_ Superior Vision Benefit Management
_X_ Superior Vision Services
___ Superior Vision of New Jersey, Inc.
___ Block Vision of Texas, Inc. d/b/a Superior Vision of Texas
_X_ Davis Vision
(Collectively referred to as 'Versant Health' or 'the Company')

DEFINITIONS:	
Term	**Definition**
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.
Payment Dispute	A formal, written request to review claim payments or denial of payment determinations.

PURPOSE:

To afford providers (participating and non-participating) with an internal payment dispute process for requests for review of payment and denial of payment determinations other than those based upon utilization management determinations.

SCOPE:

All participating and non-participating provider disputes associated with commercial plans in New Mexico.

POLICY:

The Company affords providers (contracted and non-contracted) a two-level payment dispute process after which the determination will be final; however, additional levels of appeal may apply in accordance with any state or federal regulation where applicable. The dispute process requires

direct communication between any provider and the Company and does not require any action by an enrollee.

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:

- Claim payment amount or timing (non-par may also grieve)
- Claim submission requirements or compliance;
- Surprise billing reimbursement amount, rate, or timing (non-par may also grieve)

Non-payment associated disputes are addressed in **policy # 1492A.XX-New Mexico Provider Administrative Dispute Resolution Process**.

Intake of all provider payment 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
- 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 requirements when filing a payment dispute, which should include, but not limited to:

- Member, Claim identifiers;
- Date of service;
- Dispute rationale; and
- Expected resolution.

Providers are made aware of the process via the Company's website, Provider Manual, and appeal rights included with adverse payment determinations.

An acknowledgement letter will be sent to the provider within five (**5**) calendar 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.

The Company will complete its review for both first and second level dispute requests, make a determination and provide written Notice of Determination. 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.

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

- The issue and detailed reasons/rationale for the determination, including any provision used in making the determination, when applicable (if the Company were unable to make a determination due to insufficient information presented or available to reach a determination, The Company will include a written statement that a determination could not be made and the allowable time to resolve the complaint has expired).

- 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 determination.
- (Level 2 only) A statement that the notice is a final determination. This will also include any additional external appeal or complaint rights as per applicable regulation.

Any documents, records or other information used in an initial determination or subsequent dispute review process are available to the provider upon request and free of charge.

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:

N/A

RELATED POLICIES AND PROCEDURES	
Policy Number	**Policy Name**
1492A.XX	New Mexico Provider Administrative Dispute Resolution Process

REVISION HISTORY:		
Date	***Revision***	***Version***
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]