Medicaid/CHIP Provider Complaints, Claim Payment Disputes and Appeals

The information below is a summary of each process. For full details, refer to the appropriate Amerigroup provider manual.

Provider complaints

Amerigroup accepts provider complaints verbally, by mail, fax and email. Verbal complaints may be submitted through Provider Services at 1-800-454-3730 or through local Provider Relations representatives. Written provider complaints should be mailed to the following address:

Amerigroup
P.O. Box 61789
Virginia Beach, VA 23466-1789

Written complaints can also be sent to the attention of the Provider Relations department of the local health plan or faxed to 1-844-664-7179. Complaints may also be sent by email to TXproviderrelations@amerigroup.com or via the provider website at https://providers.amerigroup.com/TX.

If a provider is not satisfied with the resolution of the complaint by Amerigroup, a complaint may be submitted to the Texas Health and Human Services Commission (HHSC) at HPM_Complaints@hhsc.state.tx.us or by mail to:

Texas Health and Human Services Commission
ATTN: Resolution Services
MCCO Research and Resolution
P.O. Box 149030, MC: 0210
Austin, TX 78714-9030

CHIP provider complaints can be sent to the Texas Department of Insurance at:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

Provider claim payment disputes

If you disagree with the outcome of a claim, you may use the Amerigroup provider claim payment dispute process. The simplest way to define a claim payment dispute is when a claim is finalized, but you disagree with the outcome.

The Amerigroup provider claim payment dispute process consists of two internal options. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member:

1. **Claim payment reconsideration:** This is a convenient option in the Amerigroup provider claim payment dispute process. The reconsideration is an initial request for an investigation into the outcome of the claim. Most issues are resolved with a claim payment reconsideration.

2. **Claim payment appeal:** This is an additional option in the Amerigroup provider claim payment dispute process. If you disagree with the outcome of a reconsideration or you choose not to ask for a reconsideration, you may request a claim payment appeal. **Please note:** If you did not ask for a claim payment reconsideration first, this will be the only internal appeal option available for your dispute.

Claim payment reconsideration
The first available option in the Amerigroup claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. **Please note:** We cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally or online through the Availity Portal at https://www.availity.com within 120 calendar days from the date on the *Explanation of Payment (EOP)*. See below for further details on how to submit. Reconsiderations filed more than 120 calendar days from the *EOP* will be considered untimely and denied unless good cause can be established. Amerigroup will resolve the claim payment reconsideration within 30 calendar days of receipt.

Claim payment appeal
If you are dissatisfied with the outcome of a reconsideration determination or wish to bypass the reconsideration process altogether, you may submit a claim payment appeal. We accept claim payment appeals online through the Availity Portal at https://www.availity.com or in writing within the later of:

- 30 calendar days from the date on the reconsideration determination letter, or
- 120 calendar days from the date of the original *EOP*

Claim payment appeals received later than these time frames will be considered untimely and upheld unless good cause can be established. Amerigroup will resolve the claim payment appeal within 30 calendar days of receipt.

How to submit a claim payment dispute
You have several options to file a claim payment dispute:

- Online (for reconsiderations and claim payment appeals): Use the secure Availity Provider Payment Appeal Tool at https://www.availity.com. Through the Availity Portal, you can upload supporting documentation and will receive immediate acknowledgement of your submission.
- Verbally (for reconsiderations only): Call Provider Services at 1-800-454-3730.
- Written (for reconsiderations and claim payment appeals): Mail all required documentation, including the *Provider Payment Dispute and Correspondence Submission Form*, to:

  Payment Dispute Unit
  Amerigroup
  P.O. Box 61599
  Virginia Beach, VA 23466-1599
- Fax (for reconsiderations and claim payment appeals) all required documentation to 1-844-756-4607.

Provider medical appeals
This type of appeal is available to providers with respect to a denial of services that have already been provided to the member and determined to be not medically necessary or appropriate. These appeals do not include member medical necessity appeals. Provider medical appeals should be submitted in writing to:

Appeals Team
Amerigroup
P.O. Box 61599
Virginia Beach, VA 23466-1599

A provider must file a medical appeal within 120 calendar days of the date of the denial letter or *EOP*. The results of the review will be communicated in a written decision to the provider within 30 calendar days of our receipt of the appeal.

If a provider is dissatisfied with the appeal resolution, he or she may file a second-level appeal. This must be a written appeal submitted within 30 calendar days of the date of the first-level determination letter. The case is handled by reviewers not involved in the first-level review. The results of the review are communicated in a written decision to the provider within 30 calendar days of receipt of the appeal.

Provider appeal process to HHSC (related to claim recoupment)
Upon notification of a claims payment recoupment, the first step is for the provider to recheck member eligibility to determine if a member eligibility change was made to fee-for-service (FFS) or to a different managed care organization (MCO) on the date of service:

1. **Member eligibility changed to FFS on the date of service**
   Providers may appeal claim payment recoupment by submitting the following information to HHSC:
   - A letter indicating that the appeal is related to a managed care disenrollment/recoupment, and that the provider is requesting an Exception Request.
   - **The *Explanation of Benefits (EOB)* showing the original payment —** Please note, this is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership to grant an authorization for the exact items that were approved by the plan.
   - **The *EOB* showing the recoupment and/or the plan's "demand" letter for recoupment —** If sending the demand letter, it must identify the client name, identification number, date(s) of service and recoupment amount. The information should match the payment *EOB*.
   - **Completed clean claim —** All paper claims must include both the valid NPI and TPI number. In cases where issuance of a prior authorization is needed, the provider will be contacted with the authorization number, and the provider will need to submit a corrected claim that contains the valid authorization number.

     Note: Label the request **Expedited Review Request** at the top of the letter to ensure the appeal request is reviewed prior to 18 months from the date of service.

Mail FFS-related appeal requests to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code: 91X
P.O. Box 204077
Austin, Texas 78720-4077

Prepare a new paper claim for each claim that was recouped and insert the new claims as attachments to the administrative appeal letter. Include documentation such as the original claim and the statement showing that the claims payment was recouped.

Submission of the new claims is not required before sending the administrative appeal letter. However, if a provider appeals prior to submitting the new claims, the provider must subsequently include the new claims with the administrative appeal.

HHSC Claims Administrator Contract Management only reviews appeals that are received within 18 months from the date of service. In accordance with *1 TAC § 354.1003*, providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management, and all claims must be finalized within 24 months from the date of service.

2. **Member eligibility changed from one MCO to another on the date of service**
   Providers may appeal claims payment recoupments and denials of services by submitting the following information to the appropriate MCO to which the member eligibility was changed on the date of service:
   - A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
   - **The *EOB* showing the original payment — The *EOB* showing the recoupment and/or the MCO's "demand" letter for recoupment** must identify the client name, identification number, date of service and recoupment amount. The information should match the payment *EOB*.

Documentation must identify the client name, identification number, date of service, recoupment amount and other claims information.

Note: Label the request **Expedited Review Request** at the top of the letter to ensure the appeal request is reviewed prior to 18 months from the date of service.

Submit appeals online at https://www.availity.com.

Mail FFS-related appeals to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code: 91X
P.O. Box 204077
Austin, Texas 78720-4077