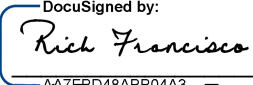




Procedure Title: Provider Claim Dispute Resolution	Procedure #: 03-014	<u>Review Dates</u>	
Category: Finance Subject: Provider Claim Dispute Resolution	Prepared by: Name: Brandy Carlson Title: Chief Financial Officer Approved by: DocuSigned by:  AA7CPD48ABR04A3 Rich Francisco, Executive Director Effective Date: 01/01/2002	07/23/2025	
		Last Revised Date: 03/25/2025	

I. PURPOSE

To establish and maintain consistent procedures for the resolution of provider claim disputes.

II. APPLICATION

All employees of HealthWest and all service providers contracted by this agency.

III. DEFINITIONS

- A. Provider: All outside vendors contracted through Network Management to provide services on behalf of the agency to the individuals served by HealthWest.
- B. Dispute: Differences between the agency and the providers with regard to the contractual billable services.
- C. EOB: An explanation of benefits.

IV. PROCEDURE

Appeals for Claims denied for timely filing are only considered when extenuating circumstances are present.

- A. The provider shall submit monthly invoices/claim(s) with any required supporting documentation within five (5) business days of the end of the month in which services were provided or within ~~five~~ ninety (90) business days of receipt of the EOB from the third-party payor when third party coordination of benefits is an issue.
- B. Within five (5) business days, Finance staff shall verify the billed services by verifying:
 - 1. The amounts billed are for individuals that are the financial obligation of HealthWest to pay;
 - 2. The services are/were authorized by the HealthWest Utilization Management Department for approved payment.
 - 3. The number of service units billed is within the number of authorized units;

4. The rates billed are in accordance with the contract in effect for that period of service.
- C. Claims Department (Finance) staff will review the provider invoice/claim(s) submitted electronically for any discrepancies [communicate via Latitude 43 to the provider of findings, when necessary](#). Form F009 can be used for communication of discrepancies for claims submitted outside of Latitude 43 (paper invoices/claim(s)).
- D. Claims Department (Finance) staff will complete the financial coding of the invoice/claim(s), once discrepancies are resolved. Claims Department (Finance) will then process and forward the Invoice and a copy of the F009 to Accounts Payable for payment processing.
- E. The County Central Finance Department will process and mail/release payment, within 14 business days.
- F. Upon receipt of those payments, the provider will review the remittance advice and if they wish to dispute the payment, they will follow the steps outlined below.
 1. Appeals are to be submitted to Claims email at Claims@Healthwest.net. Appeals must include reason for appeal, consumer identification, service provided, dates of service, batch number (if applicable), and any other relevant information or documents attached.
 2. Upon appeal review, HealthWest Claims Department will notify provider via email the result of the appeal. If the appeal result is not agreed upon, the provider can contact the Claims department program supervisor to resolve.
 3. After speaking with the Claims department Program Supervisor, if the issue is still unresolved, the Provider may request a review of the appeal by the Director of Finance. The request can be made via email or phone. HealthWest's Director of Finance will notify provider via email or phone with the date/ time of meeting and attendees. Meetings will most often be conducted via video platforms (Teams, Zoom). At the meeting—the Provider will give—the reasons why the Provider believes the claim issue is still not resolved. The meeting is the last recourse the Provider has, and the final decision regarding resolution of the invoice/claim(s) will be made at that time by the Director of Finance.
 4. When resolved, if payments is approved for the services in question, the payment will be made on the next provider check date.

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