POLICY:

Both contracted and non-contracted providers of services to Total Health Care members, have the right to submit an appeal to resolve issues or disputes in a timely and reasonable manner. Providers must follow established procedures and processes. Appeals can be related to claims, credentialing/recredentialing, or adverse benefit determinations (denials).

APPEALS:

1. Claims Appeals

   Providers who do not receive payment within required 45 day time frame have the right to request an appeal to Total Health Care.

   If a provider believes that he/she has not received a payment to which he/she is entitled, an appeal may be submitted to Total Health Care within 180 days from the original date of denial. The appeal may be oral or written. Total Health Care must process the appeal within 30 days.

MEDICAID ONLY DISPUTES FOR NON-CONTRACTED PROVIDERS:

1. If the appeal decision is not acceptable to you as a non-contracted hospital and you have signed the Hospital Access Agreement, you may request Rapid Dispute Resolution. Upon receipt of the request, Total Health Care will follow the Rapid Dispute Resolution Guidelines in the Medicaid Provider Manual.

2. If the appeal decision regarding a claim for a Medicaid member is not acceptable to you as a provider, you have the right to participate in a binding arbitration process specific to Medicaid members. The Department of Community Health will provide a listing of neutral arbitrators who resolve billing disputes that Total Health Care will use to resolve the issue.

   • To submit an appeal either write to Total Health Care or call:

   Medical Director: 313-871-7801

   Provider Relations Department: 844-THC-DOCS

2. Credentialing/Recredentialing Decision Appeals

- As a provider, you may not agree with a credentialing or recredentialing decision rendered by the Credentialing Committee of Total Health Care. You have the right to appeal a denial decision. This process is outlined in detail in the Credentialing and Recredentialing Section of the Provider Manual**.**

3. Adverse Benefit Determination (denials, authorizations)

- If an authorization or request for inpatient, continued stay, or other care for a member is denied, you as the provider have a right to appeal the denial. Providers have the right to submit appeals on their behalf or on behalf of a member. Appeals may be submitted orally or in writing. It is important that you submit your request in a timely manner to avoid any unnecessary problems for the member.

- Providers have 180 days from the denial date to file for an appeal. Expedited appeals are available for circumstances when waiting would be expected to jeopardize the Well-being of the member.

- Appeals should include the necessary medical documentation for the inpatient, continued stay, or other care that you are requesting. Total Health Care will review your appeal and render a decision within 30 days of receipt of the oral or written appeal for services that have not been received; with decision will be rendered within 30 days for services already completed. Expedited appeals decisions will be rendered within 72 hours of receipt of the request for appeal.

  To submit an appeal either write to Total Health Care or call:

  Medical Director: 313-871-7801
  Provider Relations Department: 844-THC-DOCS

ARBITRATION:

4. Arbitration Option to Settle Medicaid Claims Disputes

If the appeal decision is not acceptable to you as a provider (contracted and non-contracted), you have the right to participate in a binding arbitration process with regard to Medicaid<u>membersonly</u>. The Department of Community Health will provide a listing of neutral arbitrators who resolve billing disputes that will be used by you and Total Health Care to resolve the issue.