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Originated Department	Clinical Operations

Provider Appeals and Disputes

Audience

Medical Management

Purpose

Medical policies provide general support for applying Mountain Health Co-Op member policy document coverage decisions, and the member-specific benefit plan document must be referenced. The terms of the member-specific Policy document may differ from the standard benefit plan based on this medical policy. If there is a conflict between a member-specific policy document and the Mountain Health Co-Op medical policy, the document supersedes this policy. Any person(s) applying this medical policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this medical policy, including the existence of any state or federal guidance. Mountain Health Co-Op medical policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to the satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health Co-Op reserves the sole discretionary right to modify all policies and guidelines at any time.

Definition

Dispute: An informal process for providers to raise awareness, concerns, and disputes of an adverse determination, such as payment terms, bundling, denial for no prior authorization, and claim edits. The Inquiry process is the first step in the claim dispute process.

Medical Provider Appeal: Review of an adverse benefit determination by the Plan or Issuer for services deemed not medically necessary, experimental, investigational, or cosmetic.

Policy/Procedure

To resolve most provider complaints through the informal dispute process, leaving the formal provider appeal process as the mechanism to resolve more complex disputes. By separating provider and member appeals, we allow the member appeal process to proceed expeditiously and provider disputes to be handled less formally when appropriate.

1. Appeals for Medical Services

1.1 Mountain Health Co-Op intends to resolve most provider complaints through the informal dispute process, leaving the formal provider appeal process as the mechanism to resolve more complex disputes. By separating provider and member appeals, we allow the member appeal process to proceed expeditiously and provider disputes to be handled less formally when appropriate.

1.2 The Provider Dispute and Appeal Process are administered through a manner in which a provider may inquire about the terms of the Provider Contract or appeal denials clinical in nature, such as medical necessity, investigational status, or contractual exclusion. Disputes and Formal Appeals are initiated through the online form at mountainhealth.coop

2. Provider Dispute

2.1 A Provider Dispute is an informal process for providers to raise awareness, concerns, and disputes about adverse determinations such as payment terms, bundling, denial for no prior authorization, and claim edits. It is the first step in the claim dispute process.

2.2 The Provider Dispute process does not apply to the following, which must proceed through the formal appeal process:

- a) Utilization management determinations (e.g., claims for services considered not medically necessary, experimental/ investigational, cosmetic);
- b) Pre-service/authorization/referral requirements;
- c) Benefit/eligibility determinations (e.g., claims for noncovered services);

2.3 Once a dispute is received, the party working on the dispute will research the issue and determine a course of action. If a determination is made in favor of the provider, the claim(s) in dispute will be routed adjustment. The provider will receive a revised explanation of payment (EOP). If a decision is made to favor the plan, the provider will be notified of the findings and justifications of the decision and additional education as needed. This communication may be made in writing or through phone calls. Documentation of the Provider Dispute and determination will be made for tracking purposes.

See the Table 1.0 timeline below for more details.

3. Provider Appeals

3.1 The Provider Appeal process applies to the following services

- a) Utilization management adverse determinations (e.g., claims for services considered not medically necessary, experimental/ investigational, cosmetic);
- b) Adverse determinations for Pre-service/authorization/referral requirements;
- c) Adverse Benefit/eligibility determinations (e.g., claims for noncovered services);

4. First Level Appeal Provider Appeal

4.1 Utilization management, preservice, and benefit determinations will be processed through the Formal Appeal process. To initiate a First-level Appeal, the provider must submit in writing the nature of the appeal and justification to overturn the initial determination. Copies of pertinent medical records and other forms of documentation that will aid in Mountain Health Co-Op's review should be included with the submission. The appeal must be submitted within the timeline described below. Each appeal will be determined within the guidelines in Table 1.0.

5. Second-Level Provider Appeal

5.1 Providers may proceed with a second-level appeal if they disagree with the Co-Op's determination from the first-level appeal. The Second level appeal must be in writing, including why the provider disagrees with the decision and provides new materials to support their position. The second-level appeal must be submitted within **30 calendar days** of the first-level determination. Additional medical records and other forms of documentation not previously submitted should accompany the second-level appeal. If no new documentation is supplied, the dispute will be dismissed.

6. Additional Appeal Options

6.1 In rare instances, upon mutual agreement, MHC and Providers may enter Arbitration or Mediation in an attempt to resolve outstanding items. Providers must initiate this additional appeal option in writing.

***Refer to RealRx Appeal policies for all Pharmacy Appeals**

Table 1.0

Dispute or Appeal Level	Time frame for submission from the date of Adverse Determination	MHC/TPA response timeframe from the date of receipt	Contacts
Provider Dispute – related to claims edits, pricing,	Within 180 calendar days of the adverse determination,	30 calendar days	Phone: 800-299-6080 Fax: 1-800-781-6260 Mail: Wipro HealthPlan Services PO Box 30311 Salt Lake City, UT 84130

First Level Provider Appeal – related to denials for medical necessity, investigational, contract exclusions	For Preservice Denials - Within 90 calendar days of the initial adverse determination For Post-Service Denials – Within 180 days of the initial adverse determination	Preservice 30 calendar days Post Service 60 Days Expedited 72hrs	Phone: 800-299-6080 Fax: 1-800-781-6260 Mail: Wipro HealthPlan Services PO Box 30311 Salt Lake City, UT 84130
Second Level Provider Appeal - related to denials for medical necessity, investigational, contract exclusions	Within 30 calendar days of the decision of the first-level determination	30 calendar days Post Service 60 Days Expedited 72hrs	Phone: 800-299-6080 Fax: 1-800-781-6260 Mail: Wipro HealthPlan Services PO Box 30311 Salt Lake City, UT 84130

Vendors
<ul style="list-style-type: none"> • HPS • Personify

References

Review/Revision/Approval History	
Date	Description
1/1/2024	New Policy
3/9/2026	Revised by Mountain Health CO-OP Policy Committee

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