

11: Provider Dispute Procedures

11.1 Overview

It is Unison's goal to identify, eliminate, and prevent dissatisfaction of providers by making every effort to maintain open and intense lines of communication with providers. To ensure that provider disputes are resolved in a consistent manner, Unison operates internal provider dispute procedures.

If a Provider has a complaint or other problem regarding any aspect of Unison's operations, the provider may contact the Provider Services Department at 1.800.600.9007 to register a complaint and seek resolution.

If a matter cannot be resolved to the provider's satisfaction, the provider can exercise his/her dispute rights in writing within the timeframes specified below. Requests should include all details relevant to the dispute and attempts at resolution prior to filing.

11.2 Provider Disputes

Set forth below is a brief description of Unison's various dispute processes. Providers may obtain further information regarding specific situations by contacting our Provider Services Department.

Providers may dispute the following decisions by Unison:

1. Denial of a claim and request for payment authorization (failure to follow procedure).
2. Credentialing or Re-credentialing Denial.
3. Provider Contract Termination by Unison.

11.3 Dispute of Denied Claims and Payment Authorization

Claims and requests for payment authorization may be denied for failure to follow required procedures or Unison's UM/QI Plan, e.g., failure to obtain required prior authorization, or submit claims on time. While Unison encourages providers to seek informal resolution of claim disputes through our Provider Services Department, the formal dispute process must be initiated within forty-five (45) days of Unison's remittance advice. Disputes of denied claims must be submitted in writing to:

Unison Health Plan of Ohio, Inc.
Grievance/Appeal Coordinator
1001 Brinton Road
Pittsburgh, PA 15221

Providers should not re-submit denied claims or send disputes to the Claims Department.

Disputes must include all supporting documentation and specify all reasons why the provider believes Unison's original decision is in error. Disputes over payment will generally be decided within thirty (30) days of receipt thereof (the Provider may request an extension).

11.4 Appeals of Credentialing Decisions and Contract Termination Decisions

Providers may request review of Unison's credentialing decision or other professional review action. Professional review actions are peer review actions subject to all protections provided by law and are reviewed pursuant to Unison's Quality Improvement Provider Dispute process (as amended from time-to-time). Currently, such disputes are reviewed by a panel of Unison's participating providers. Providers have the right to (1) appear and participate in person; (2) submit evidence, written and verbal; and (3) be represented by an attorney in such proceedings. Providers seeking review of professional review actions should submit their dispute in writing via certified mail within thirty (30) days of the date of the Professional Review Action notice to:

Unison Health Plan of Ohio, Inc.
Medical Director
1001 Brinton Road
Pittsburgh, PA 15221

The provider will receive a hearing notice setting the time, date and place of the hearing and relating the provider's rights during the hearing process. A hearing will be held at least thirty (30) days from the date of the hearing notice.

Providers seeking reconsideration of credentialing decisions involving failure to meet baseline credentialing criteria may submit additional information for review by the plan's Credentialing Committee. Unison's Medical Director shall have sole discretion in determining whether the provider's credentialing application, along with the additional information, will be forwarded to the Credentialing Committee for reconsideration. Providers disputing contract termination decisions should, upon receipt of Unison's decision, immediately contact the Provider Services Department at 1.800.600.9007.

11.5 Arbitration

Providers may also be able to seek review of any dispute through the arbitration process, as set forth in the Provider Agreement, if applicable. Providers are generally required to exhaust all available internal dispute processes before seeking arbitration.

11.6 Provider Dispute Process Revisions

The provider dispute process described herein is subject to change, without notice, to accommodate revisions in applicable Federal and state law. If you have any questions, contact our Provider Services Department at 1.800.600.9007.

11.7 Member Appeals, Grievances and State Hearings

The Provider may reference the member handbook provided with this manual or contact Unison to request Unison's policies and procedures for more detailed information regarding the member dispute process.

11.7.1 Member Appeal Process

The member, or authorized representative with the written consent of the member, may file an appeal regarding a Unison action within ninety (90) days of the date of the action. An action is any reduction, suspension, termination, denial, or untimely delivery of a service or denial of payment for a service. The member may request that the authorized representative assist or represent them during the process and be present during the review. Member appeals are reviewed and resolved within fifteen (15) days of receipt.

Unison will review the member's appeal in an expedited manner if the member's treating provider certifies that the member's health will be harmed by deciding the appeal in the regular appeal timeframes. The certification must include the clinical rationale and member-specific facts to support the physician's opinion. The appeal will be reviewed and decided within three (3) working days of its receipt of the expedited appeal request.

11.7.2 Member Grievance Process

The member, or their authorized representative with written consent of the member, may file a grievance with Unison to express dissatisfaction with any aspect of Unison's or a provider's operation, provision of health care services, activities, or behaviors, other than an action, within ninety (90) calendar days of the date that the member became aware of the issue. Members will be notified of the outcome of Unison's review of grievances within the following time frames:

1. two (2) working days of receipt if the grievance is regarding access to Medicaid-covered services;
2. thirty (30) calendar days of receipt for non claims-related grievances; or
3. sixty (60) calendar days of receipt for claims-related grievances.

The member may have his/her grievance reviewed in an expedited manner if the member's treating provider certifies that the member's health will be harmed by deciding the grievance in the regular grievance timeframes. The certification must include the clinical rationale and member-specific facts to support the provider's opinion.

11.8 State Hearing Process

The member, or their authorized representative with the written consent of the member, may request a state hearing within ninety (90) calendar days of when the following occurs:

1. Unison denies a request for the authorization of a Medicaid-covered service, in whole or in part and simultaneously mails state hearing form JFS 04043.
2. Unison reduces, suspends or terminates a previously authorized service and simultaneously mails state hearing form JFS 04043.
3. Unison learns that a member has been billed by a provider due to Unison's denial of payment on appeal and mails state hearing form JFS 04046.

Providers cannot use the hearing process to address claims payment disputes over failure to follow Unison procedures. Providers may file appeals and grievances verbally or in writing.

11.9 Continuation of Services

The member may continue receiving services or items until a decision is made about his or her appeal or state hearing if the member is receiving the services that were denied, reduced or terminated, the authorization period has not expired, the request for appeal or state hearing is hand-delivered or postmarked within ten (10) days of the date of Unison's NOA denying, reducing or terminating the services or items and the member requests the extension of benefits.

The member may be liable for the cost of any continued benefits at the discretion of the Ohio Department of Job and Family Services.