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Health Plan Oversight: Contract Monitoring Branch
Managed Care Organization Dispute Form

Dispute Form Guide (Please read before submitting a dispute):
The dispute resolution process requires providers and/or members to use the Managed Care Organizations ("MCO") internal grievance/appeal process before submitting a dispute to the Kentucky Department for Medicaid Services ("KDMS"). This means providers and/or members must first follow and exhaust ALL processes provided by MCOs to resolve a dispute, including peer-to-peer, before submitting a complaint to KDMS.

Grievances/appeals submitted through the MCO process may be submitted to KDMS Dispute Resolution no sooner than 30 calendar days after submitting to the MCO's internal process. If KDMS determines a dispute was submitted sooner than 30 calendar days, the complaint will be immediately closed.

A Provider who has exhausted the MCO's internal appeal process shall have a right to a final Denial, in whole or in part, by the MCO to an external independent third party in accordance with applicable state laws and regulations, including Denials, in whole or in part, involving Emergency Services. The MCO shall provide written notification to the Provider of its right to file an appeal. A Provider shall have a right to Appeal a final decision by an external independent third party to the Cabinet for Health and Family Services Division of Administrative Hearings for a hearing in accordance with applicable state laws and regulation. If the Provider prevails, in whole or in part, the MCO shall comply with any Final Order within sixty (60) Days unless the Final Order designates a different timeframe.

Under the MCO internal grievance/appeal process, MCOs are required to assign the provider and/or member a tracking number for each dispute submitted. The provider and/or member must enter this MCO assigned tracking number in the MCO Dispute Form when completing a dispute. Disputes that are not complete when submitted, will be closed. Disputes that are complete, will be submitted to the MCO for timely review and response/resolution.

- *Providers must use the new standard Dispute/Claim-Issue template for submitting two (2) or more of the same or similar complaints/claims with the same MCO. Providers are limited to a maximum of 100 complaints/claims on a template. The template can be found here (link).*
- *Claims Payments: KDMS cannot act as a collection service. However, we do expect MCO's to take prompt action on a claim, and to fully investigate all pertinent facts concerning the claim.*

What you can expect from KDMS after your dispute is accepted:

- *Send you an electronic acknowledgment within three to five (3-5) business days of receipt of your dispute*
- *Start working with the respective MCO on your dispute*
- *Check in with you within ten (10) business days of acknowledgement of your dispute*
- *The KDMS specialists will determine if the complaint was substantiated and follow up with you to discuss the outcome.*

Section 1: Contact Information *[Complete ALL fields]*	
Contact Name	
Contact Business Name	
Contact Email	
Contact Fax Number	
Contact Phone Number	
Which MCO are you filing a dispute against?	☐ Aetna BH-KY ☐ Anthem BCBS ☐ Humana ☐ United HC ☐ Passport by Molina ☐ WellCare of KY
What is your reason for filing this dispute?	☐ Denied Claim ☐ Underpaid Claim ☐ Prior Authorization Denial ☐ Credentialing ☐ Eligibility ☐ Other: *Please specify in space below*
Were any of the following methods utilized to resolve your dispute directly with the MCO? *Include all assigned ticket/tracking numbers for any method utilized, and determinations received.*	☐ *Written / Oral Grievance* Date Filed: _____ Ticket/Tracking Number: _____ ***Has there been a determination?*** ☐ Yes – when? _____ ☐ No
	☐ *Appeal* Date Filed: _____ Ticket/Tracking Number: _____

	Has there been a determination? ☐ Yes – when? _____ ☐ No
	☐ *External Independent Third-Party Review* Date Filed: _____ Ticket/Tracking Number: _____ ***Has there been a determination?*** ☐ Yes – when? _____ ☐ No
	☐ *State Fair Administrative Hearing* Date Filed: _____ Ticket/Tracking Number: _____ ***Has there been a determination?*** ☐ Yes – when? _____ ☐ No
Provide Details of MCO Contact	Date:
	Method: ☐Phone ☐Email ☐ Letter
	MCO Representative Name:
	MCO Tracking Number:
Section 2: Provider Information *[Complete ALL fields]*	
Provider Name	
Provider NPI	
Provider Specialty	
Provider Tax Identification Number ("TIN")	
Provider Business Address	
Provider Business City, State, Zip Code	
Provider Email	
Section 3: Member Information *[Complete ALL fields]*	
Member Name	
MCO Member ID	
Member Phone Number (if applicable)	
Member Email (if applicable)	
Section 4: Description of Dispute *[Complete ALL fields]*	

Provide a detailed description of your dispute.	
Section 5: Claim Information *[Complete ALL fields if dispute is regarding claims]*	
Claim Number *If you are disputing one (1) claim, all fields must be complete in this section.* *If you are disputing two (2) or more of the same/similar claims issues, please complete and attach the Dispute/Claim-Issue template spreadsheet. Link here*	
Authorization Number (If applicable)	
Date of Service	
Date Claim Submitted to MCO	
What method was utilized to submit the claim?	☐Mail ☐Electronic
Has the MCO…	*Acknowledged Receipt of claim?* ☐ Yes – When? _____ ☐ No
	Denied receipt of claim? ☐ Yes – When? _____ ☐ No
	Made any payment? ☐ Yes – When? _____ ☐ No
	Recouped any amount on this claim? ☐ Yes – When? _____ ☐ No
	Denied the claim in writing? ☐ Yes – When? _____ ☐ No

Section 6: Desired Resolution *[Complete ALL fields]*	
Please provide a detailed description of the desired resolution.	

Section 6: Supporting Documentation *[Complete ALL fields]*	
Provider a list of attached supporting documents *(e.g., copies of the claim, EOB, prior authorization request, medical records, etc.)*	

Section 7: Dispute Certification

I certify that the information provided in this dispute resolution form is true and correct to the best of my knowledge. I understand that any false statements can result in penalties under state and federal law.

Signature_____ Date _____

<u>Please complete this information and submit by mail, email, or fax to:</u>

Mail:

Division of Health Plan Oversight
Contract Monitoring Branch
Department for Medicaid Services
275 E. Main Street 6C-C
Frankfort, KY 40621

Email: ProviderMCOInquiry@ky.gov