Practitioner and Provider Appeals and Grievance Process

PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

All practitioners and providers have the right to file a formal grievance or appeal with Presbyterian. Practitioners and providers should submit their grievance or appeal to the Presbyterian Grievance and Appeals Coordinator within the time frames identified below.

Timely Filing Reminders

1. File claims correctly the first time or, if time allows, resubmit the claim through the Presbyterian Provider Care Unit to resolve an issue.
2. Contact your Presbyterian provider services coordinator for clarification on any denials or other actions relevant to the claim and for assistance with a possible resubmission of a claim with modifications.

Standard Appeal Process

1. Practitioners and providers have 12 months from the date of service to correct any defects in the initial claim submission and resubmit the claim for reprocessing.
2. Practitioners and providers contracted with Presbyterian for Medicare lines of business must file an appeal regarding a claim denial with in 12 months from the date of service or the denial will be upheld.
    - Practitioners and providers contracted with Presbyterian for commerical and Medicaid lines of business must submit an appeal within 60 days from the date the denial was issued or the denial will be upheld.
3. When filing an appeal, the reasons for the reconsideration request must be documented and all supporting documentation must be attached for review.
    - If the appeal involves a claims denial andthe claim was previously submitted electronically, then please include a copy of the claim for review of your appeal.
    - If the appeal is related to a claim coding matter, then please include supporting medical records such as office notes and operative reports, if applicable.

Formal Grievance Process

A grievance may be filed orally or in writing, and it must:

1. State with particularity the factual and legal basis for the grievance, which typically includes a chronology of pertinent events and a statement that explains the reason(s) the practitioner or provider believes the action by Presbyterian was incorrect.
2. Include supporting documents, such as a copy of a claim, remittance, medical review sheet, medical records, correspondence, etc.
3. Identify the relief requested.

Grievances are reviewed in accordance with all federal and state regulatory guidelines and Presbyterian policies and procedures, and they are resolved within 30 calendar days.

Practitioner and Provider Appeals and Grievance Process

PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

Grievances for Interagency Benefits Advisory Committee (IBAC), Fully-Insured and Commercial Plans

Providers have the right to present oral or documentary evidence to a Presbyterian committee review panel responsible for the substantive area addressed by the concern. If the grievance raises a quality-of care concern, then the panel will include a New Mexico-licensed medical professional who practices in the general area of concern. Presbyterian will issue a decision to the provider pursuing a grievance within 45 calendar days after the committee has obtained all information concerning the provider's grievance. No person with a conflict of interest will participate in a decision to resolve a grievance. For a list of the applicable regulations, please see the applicable Appeal and Grievance Regulations at the following link: https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=wcmdev1000913.

Pharmacists and Pharmacies

1. Presbyterian manages all appeals and grievances related to coverage determinations and the formulary review process and resolves grievances within 30 calendar days.
2. OptumRx manages all appeals and grievances related to policies and procedures in accordance with participating pharmacy provider network agreements, including term definitions; contract information; processing claims; prescription bank identification number (BIN); compliance, fraud, waste and abuse (FWA); pharmacy network participation requirements; and Maximum Allowable Cost (MAC) appeals.

   For more information regarding OptumRX's appeals and grievances processes, please view the OptumRx Provider Manual at the following link: https://professionals.optumrx.com/resources/manuals-guides/provider-manual.html.

MAC Appeals Process

1. Pharmacists and pharmacies can submit MAC Appeal Requests by visiting the OptumRx website, which is available at the following link: https://professionals.optumrx.com/resources/manuals-guides/appeals-sub mission-guide.html.
2. Should a pharmacist or pharmacy disagree with any policy, decision or adverse action made by Presbyterian, they can contact the Provider Care Unit at (505) 923-5757 or toll-free at 1-888-923-5757. Pharmacists and pharmaices can also contact their Provider Network Operations (PNO) relationship executive. You can find your dedicated PNO relationship executive in our contact guide at the following link: www.phs.org/ContactGuide.

Prior Authorization Reminders

1. Certain specialized services and prescription drugs require a prior authorization or inpatient notification before they are rendered to patients and members.
2. For prior authorization information related to pharmacies, visit our Authorizations page at the following link: www.phs.org/providers/authorizations.