In the Colorado Access Provider Manual, you will find information about:

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Provider-Carrier Disputes

A **Provider-Carrier Dispute** is an administrative, payment, or other dispute between a Participating Provider and Colorado Access that **does not** involve Utilization Review analysis, a member appeal of any kind, including a denial of benefits for services that are not medically necessary or covered by the applicable benefits program, credentialing, a claim validation audit, or routine provider inquiries that Colorado Access resolves in a timely fashion through existing informal processes.

If a Participating Provider or provider representative is making an appeal on a member's behalf, please see our website at coaccess.com/members/services/appeals/ and/or the section titled "Appeals" in the Health First Colorado Member Handbook on the Health First Colorado website for this separate process. To submit an appeal on a member's behalf, you will need to provide Colorado Access with permission (as the Designated Client Representative) from by completing a signed Designated Client Representative form and submitting it along with your Member Appeal request as part of the Member Appeal process (instead of the Provider-Carrier Dispute process).

DEFINITIONS

Routine provider inquiries: Routine provider questions or requests for information that Colorado Access resolves in a timely fashion through existing informal processes. Examples of routine provider inquiries include, but are not limited to, billing questions, checking claims status, and requests for information on claim denials. Routine provider inquiries are not considered Provider-Carrier Disputes.

Participating Provider: A provider, either within or outside of Colorado that, under a contract with Colorado Access or with its contractor or subcontractor, has agreed to provide health care services to members with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly, from Colorado Access.

Provider Representative: A person designated by a Participating Provider in writing, including other Participating Providers or an association of Participating Providers, to represent the Participating Provider's interests during the Provider-Carrier Dispute process.

Utilization Review: A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques include, without limitation, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. Utilization Review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is a medically necessary service or is considered experimental or investigational in a given circumstance, and

reviews of a member's medical circumstances when necessary to determine if an exclusion applies in a given situation. Utilization Reviews are not considered Provider-Carrier Disputes.

SUBMISSION PROCESS

A Participating Provider or a Provider Representative may access the Provider-Carrier Dispute process to submit a written request for a resolution of a Provider-Carrier Dispute. In accordance with Division of Insurance regulations, we require Provider-Carrier Disputes to be submitted in writing. Information may be submitted in a brief letter in the Provider Portal, an email or, for claims appeals, on the Colorado Access Provider-Carrier Dispute form located on our website at coaccess.com/frequently-used-forms.

Provider-Carrier Disputes must be submitted within **60 calendar days** from the date of the incident on which the Provider-Carrier Dispute is based or the explanation of payment on which the claim in dispute appears. Furthermore, Providers may only submit one Provider-Carrier Dispute per each specific administrative, payment, or other dispute at issue.

- The *easiest method* is to use the **Provider Portal**. Once you have identified the claim, select 'File Claim Appeal.' A form will appear, and you attach supporting documentation, or;
- **Email** all necessary information to claimappeals@coaccess.com. You can find a claim appeal form at coaccess.com/wp-content/uploads/2023/06/01-06-102-0623E_Provider-Carrier-Dispute-Form-Fillable.pdf to make the process easier. or;
- **Mail** a letter or Provider-Carrier Dispute form with all necessary information to:

  Provider-Carrier Disputes
  P.O. Box 17189
  Denver, CO 80217-0189

Each request to resolve a Provider-Carrier Dispute must contain all of the following necessary information:

1. Each date of service, if applicable
2. Member name
3. Colorado Medicaid member number
4. Provider name
5. Provider tax identification number
6. Dollar amount in dispute, if applicable
7. Provider position statement explaining the nature of the dispute
8. Supporting documentation where necessary, e.g., medical records, proof of timely filing, etc.

PROCESSING TIMEFRAMES

Upon receipt of a Provider-Carrier Dispute and all necessary information, we will review, record, investigate, resolve, and provide appropriate and timely notifications in accordance with applicable state and federal rules and regulations.

- We will issue a written confirmation to the Participating Provider or their Provider Representative within 30 calendar days of receiving all necessary information for the Provider-Carrier Dispute. In the instance where the Provider-Carrier Dispute request is resolved within 30 calendar days, the written notification of the outcome will serve as written confirmation of receipt.
- When we do not receive all necessary information to make a determination, we will request any additional information needed within 30 calendar days of receipt of the Provider-Carrier Dispute request. The provider with have 30 calendar days from the date of the request for additional information to provide the requested additional information. If the provider does not respond within the 30 calendar day timeframe and provide the request additional information, we will close the request without further review. Further consideration of a closed Provider-Carrier Dispute must begin with a new request by the provider within applicable timeframes.
- We will resolve Provider-Carrier Disputes and issue written notification of the outcome within 45 calendar days of receipt of all necessary information, unless both parties agree to an extension.
- We may choose to use electronic means to send required notifications including email or fax.