Health First
Health Plans

6450 US Highway 1
Rockledge, Florida 32955
myHFHP.org

Disputes Process

A provider dispute is a provider's written notice challenging, appealing or requesting reconsideration of a claim (or a bundled group of similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract disputes or disputing a request for reimbursement of an overpayment of a claim.

A corrected claim should never be submitted as a dispute. We do not accept disputes via fax. The preferred method of submitting a dispute is utilizing the provider portal at myHFHP.org/login. Online dispute form option. Providers may submit on paper by sending them to the following address:

Health First Health Plans
Attn: Claims Dispute Unit
6450 US Highway 1
Rockledge, FL 32955

In order for a dispute or reopening to be valid and eligible for reconsideration, the documentation should contain the following elements:

- Member Name
- Member ID Number
- Provider Name
- Provider Address
- Date of Service
- Claim Number and Line item at issue
- Medical documentation if applicable to establish medical necessity
- Signature of provider or authorized representative
- A request for a reconsideration, including rationale for payment (A duplicate claim or Remittance Advice submitted without a specific request for review and the reason for it will be returned)

Commercial Dispute Processing Guidelines:

- All provider disputes must be submitted within ***6 months*** from the date of original determination.
- If the dispute is resolved fully in the provider's favor, the claim will be adjusted accordingly and a new Remittance Advice will be generated. A letter will not be generated. The provider will receive an Explanation of Benefits.
- If the dispute is not resolved fully in the provider's favor or the initial denial a letter stating this will be sent to the provider reflecting the original decision was upheld, provider is entitled to a second level dispute.
- In order for a dispute or reopening to be valid and eligible for reconsideration the documentation should contain the following elements:
    - Copy of initial uphold denial letter and/or service reference number b.
    - Copy of EOB
    - Copy of the disputed claim
    - Narrative clearly identifying purpose of second level dispute
    - New or additional supporting documentation to establish medical necessity
- If the dispute is not resolved fully in the provider's favor, and the first and second levels of disputes are upheld, a letter will be sent to the disputing party advising of the reason(s) for the adverse decision and any further recourse that is available.

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- The provider has the right to file a Claim Dispute with the State of Florida. This program, known as the **Statewide Provider and Health Plan Claim Dispute Resolution Program**, is overseen by the Agency for Health Care Administration (AHCA) and conducted by MAXIMUS Federal Services.
- The process can be utilized up to 12 months after a final determination by the Health Plan if dollar thresholds are met. Costs for the review will be paid by the non-prevailing party.

Medicare Reopening Guidelines:

- All written requests for reopening must be submitted within ***1 year*** from the date of original determination, or up to 4 years with good cause. Good cause is established when an obvious error was made in the original decision, or there is new and material evidence that was not available at the time of the original decision.
- If the dispute is resolved fully in the provider's favor, the claim will be adjusted accordingly and a new Remittance Advice will be generated.
- If the dispute is not resolved fully in the provider's favor and the first and second levels of dispute are upheld, a letter will be sent to the disputing provider advising of the reason(s) for the adverse decision and the provider's right to request *Independent Payment Dispute Resolution* through FCSO.
    - Providers may request review of an adverse dispute decision by filing a request for *Independent Payment Dispute Resolution* through FCSO with the required documentation including a copy of the Health Plan's unfavorable redetermination or, if available, evidence that the Health Plan did not respond to the dispute within 60 days.
    - FCSO will review the Dispute and notify the provider and the Health Plan of the decision.
    - If FCSO requests materials related to a Dispute from the Health Plan, the materials must be sent within seven (7) calendar days and received on or before the eighth (8) day.
    - All Medicare Advantage Provider Disputes that do not qualify under the definition of a reopening will be forwarded to a Member Advocate, who will apply the Medicare Appeal process in accordance with GA-05 Medicare Part C Reconsideration.
    - The provider's Explanation of Payment meets as approval of notice.

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