DENVER HEALTH MEDICAL PLAN INC.™

PROVIDER RECONSIDERATION AND PROVIDER DISPUTE FAQS

WHAT HAPPENS WHEN I SUBMIT A REQUEST FOR RECONSIDERATION?

First things first:

- You have 60 business days from the date of the original Remittance advice to request a reconsideration
- DHMP will make every effort to respond to your request within 30 business days
- Your reconsideration must be submitted with a completed reconsideration form or it will be returned to you. DHMP uses this form to route your request to the appropriate department
- If you have received a decision on a claim and have an issue with what was approved in an authorization, DHMP will uphold its original claim decision. No clinical review is performed on claims after the original pre-service UM decision appeal process has passed

What happens next:

- DHMP will review your request to ensure that your claim was submitted timely, authorization and documentation guidelines were followed and the proper reimbursement was applied to your claim
- If your request is received outside of the reconsideration timely filing period of 60 business days, your request will not be considered for review. The following will appear on your remittance advice:
  - » RECONTF: Your request for reconsideration has been denied for timely filing
- If the above requirements were met and your claim didn't pay correctly, DHMP will overturn its original decision and reimburse the claim based on your provider agreement with DHMP. The following will appear on your remittance advice:
  - » RCONPAY: We have reviewed and agree with your reconsideration request. Claim has now been reprocessed for payment
- If any of the above requirements were not met. DHMP will maintain its original decision and the following will appear on your remittance advice:
  - » RECON: We have reviewed your reconsideration request and determined the claim has been processed correctly. If you disagree, please see the provider dispute instructions for next steps at denverhealthmedicalplan.org

WHAT CAN I DO IF I DON'T LIKE THE RESPONSE I RECEIVED FROM DHMP ON MY RECONSIDERATION REQUEST?

- The dispute process is the final step in DHMP's internal review process when a provider is not satisfied with our claims decision
- You have 30 calendar days from the date on the reconsideration remittance advice to complete and submit a dispute form and the appropriate supporting documents.
- For participating providers, DHMP will review and make a decision on your dispute within 45 calendar days
- For non-participating providers, DHMP will review and make a decision on your dispute within 90 calendar days
- Your dispute must be submitted with a completed dispute form or it will be returned to you. DHMP uses this form to route your request to the appropriate department
- No clinical review is performed on claims payment disputes