

Horizon Healthcare Dental Services, Inc. Claim Appeal Process

Horizon Healthcare Dental Services, Inc. (HHDS) offers a Claim Appeal process to all Participating Dentists who wish to appeal Claim Payment Determinations related to services rendered to members/covered persons who are insured under all DPO, Traditional and PPO products that Horizon Healthcare Dental Services, Inc. administers in the state of New Jersey (with the exception of Horizon Mercy).

It is not available for claims for services furnished to persons covered under any ASO/Self-Insured Accounts that are administered by HHDS. However, a claim decision that is based on a utilization management determination, where the services in question are reviewed against specified guidelines for dental necessity or appropriateness in order to determine coverage under the benefits plan, shall not be considered a Claim Payment Determination and may not be appealed under this process. Such decisions are considered Adverse Utilization Management Determinations, which may be appealed by a provider, with the consent of and on behalf of a member/covered person, under HHDS's Member Appeals process.

A Claim Appeal under this process is a written request made by a Participating Provider asking for a formal review of a HHDS Claim Payment Determination following the procedure described below.

When a Participating Provider wishes to formally dispute a matter relating to the payment of claims or is dissatisfied with a Claim Payment Determination made by HHDS, he/she may file a Claim Appeal as described herein.

Examples of Claim Appeals include, but are not limited to:

- A Participating Provider writes HHDS appealing a Claim Payment Determination, which partially paid the amount billed or denied payment in full.
- A Participating Provider writes HHDS appealing a Claim Payment Determination involving a claim payment recovery, recoupment, deduction, capitation payment or adjustment, overpayment, a payment made in error or an inaccuracy in payment.
- A Participating Provider writes HHDS appealing a Claim Payment Determination involving member/covered person contract benefit issues, provider contract rates or requirements or HHDS administrative policies or procedures.

All Claim Appeals must be in writing and must be received by HHDS within one hundred eighty (180) days or the later of:

- a) The date HHDS's EOB was issued describing the Claim Payment Determination,
- b) The date of HHDS's electronic claims payment advice,
- c) The date of HHDS's notification to the Participating Provider of its decision on the specific claims-related Inquiry or Complaint, so long as the Inquiry or Complaint was commenced by the Participating Provider within one hundred eighty (180) days of the original Claim Payment Determination, or
- d) The date the Participating Provider can reasonably demonstrate being first notified of the specific dispute being appealed.

The Participating Provider must submit all of the following information when filing a Claim Appeal relating to a Claim Payment Determination:

- Name and address of the Participating Provider and the group practice's name, if applicable;
- Professional Participating Provider's Taxpayer Identification Number or an Institutional Provider's Medicare Provider Number, as applicable;

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- The Member/Covered Person's name and dental membership Identification Number;
- The date(s) of service, the service(s) rendered and charges billed for the specific claim in question;
- A letter or other written notice, clearly denoted as a Participating Provider Claim Appeal, which includes a description regarding the claim in question;
- A copy of any and all prior Explanation of Benefits forms (EOBs), or completed Form 579 inquiry forms (for institutional providers), issued by HHDS supporting its Claim Payment Determination;
- The specific basis or rationale for the Claim Appeal;
- The specific remedy or relief sought and if the amount due on the claim is questioned, the specific amount the Participating Provider believes is due and the basis, rationale and supporting documentation for such view;
- Other documentation that supports the rationale for Claim Appeal, if necessary. Examples of documentation that may be required or submitted include payment vouchers, claims records, prior correspondence, printouts of electronic claims systems transactions and any other documentation necessary to adequately support the rationale for the Claim Appeal.

If the Claim Appeal does not involve a Claim Payment Determination, the Participating Provider should supply a detailed description of the subject matter of the appeal along with copies of all supporting documentation relevant to the Claim Appeal, including all applicable items previously listed here.

HHDS processes each claim it receives on an individual, claim-by-claim basis. Because each claim involves its own set of facts, circumstances and benefits contract, all Claim Appeals involving Claim Payment Determinations must be submitted individually and involve only one Claim Payment Determination. Multiple claims, involving more than one patient and date of service, may not be combined into one Claim Appeal submission.

An HHDS employee who serves as a Participating Provider Claim Appeal Reviewer shall review all Claim Appeals. All Claim Appeal Reviewers are personnel of HHDS who are not responsible on a day-to-day basis for the payment of claims. The Claim Appeal Reviewer shall review all submitted documentation and confer with all necessary HHDS departments given the nature of the Claim Appeal. The Claim Appeal Reviewer shall communicate the results of the review, in writing, to the Participating Provider within ten (10) business days of the date of HHDS's receipt of the Claim Appeal request. The written decision shall include the following information:

- The names, titles and qualifying credentials of the persons participating in the internal review.
- A statement of the Participating Provider's basis for the Claim Appeal.
- The decision of the Claim Appeal Reviewer along with a detailed explanation of the contractual and/or dental basis for the decision.
- A description of the evidence or documentation that supports the decision, and
- If the decision is adverse to the Participating Provider, a description of the method to obtain an external review of the decision via the external Alternative Dispute Resolution (ADR) mechanism described below.

HHDS has established nonbinding external ADR mechanisms that involve arbitration, and in some cases, mediation, for Participating Providers who remain dissatisfied following their pursuit of an appeal through the internal Claim Appeal process.

To file a Claim Appeal, a Participating Provider must mail the above information to HHDS at the following address:

HHDS Participating Provider Appeals Unit
P.O. Box 1710
Three Penn Plaza East
Newark, NJ 07101-2200

