Martin's Point

# Provider Claims Dispute Overview

The **Martin's Point Provider Claims Dispute Form** is for post-service disputes arising from denied US Family Health Plan (USFHP) or Generations Advantage (GA) claims. The Provider Claims Dispute Overview supports completion of the dispute process but does not replace official policies. Martin's Point policies and Provider Manual take precedence and govern this process. The claims dispute process is separate from and does not replace Martin's Point's Appeal process. To learn more please visit **martinspoint.org/ProviderClaimsDispute**.

## Provider Dispute

A Provider Claims Dispute is a formal request asking the health plan to review a claim or service line due to a denial, a reduced payment, or other concerns related to how the claim was processed. When submitting a dispute, providers must select the appropriate review type (described below) to ensure the request is routed to the correct Martin's Point team for timely evaluation.

**When to use this form:** Use this form only for post-service disputes where you believe a claim was denied improperly or processed incorrectly and no changes to the claim are needed.

**Do not use this form for Corrected Claims:** Submit a Corrected Claim when updating codes, modifiers, dates of service, charges, or other claim details. See: **martinspoint.org/CorrectedClaims**

**Do not use this form for Pre-Service Requests:** For Pre-Service requests, see **martinspoint.org/UtilizationManagement**.

**Do not use this form for USFHP Retro Authorization requests,** which must be submitted via ProAuth.

## Corrected Claims vs Disputes

**Do not file a dispute when the issue can be resolved with a corrected claim; corrected claims are the proper channel.**

**Submit a Corrected Claim When:**

- You need to fix an error or omission on the original claim, such as wrong diagnosis, missing modifier, or incorrect date of service.
- The claim was denied due to a billing error that you can correct.
- You're making changes to coding, units, charges, or other claim details.

**Submit a Dispute Request When:**

- You believe the claim was processed incorrectly or denied incorrectly and no changes to the claim are needed.
- You disagree with the denial reason (e.g., medical necessity, authorization, bundling.)

## Need Assistance?

If you have questions about the claim submission process, please contact Provider Inquiry at 1-888-732-7364 or visit our website: **martinspoint.org/For-Providers/Provider-Manual/Claims**.

# Filing Deadline & Dispute Timeframes

Providers must submit claims and disputes within specific timeframes based on participation status, the nature of the request (denial, underpayment, audit), and the level of review. Failure to adhere to these timeframes will result in a claim denial.

| Stage | Participating Providers | **Martin's Point Audit Vendors** (including EXL, Optum IBR, Optum DRG) |
|---|---|---|
| **Initial Claim Filing** | **120 days** from date of service (unless otherwise stated in Provider Agreement) | **120 days** from date of service (unless otherwise stated in agreement) |
| **1st Level Dispute** | **120 days** from original claim remittance (unless otherwise stated in Provider Agreement) | **30 days** from date of an Audit Vendor findings letter |
| **2nd Level Dispute** | **30 days** from Plan's 1st level response | **60 days** from Audit Vendor's response to 1st Level Dispute |

# Submission Method

Provider claims disputes for Generations Advantage and US Family Health Plan must be submitted **by mail** to the Claims Department at PO Box 11410, Portland, ME 04104; disputes are not accepted via phone or eFax at this time.

# Provider Claims Dispute – Review Types

Use the table below to select the appropriate review type based on the nature of your request. Selecting the correct review type determines what documentation you should submit with your dispute form, which helps ensure timely and accurate processing.

| Dispute Review Types | Provider Action / Required Documentation |
|---|---|
| **Code Review**<br>For claims denials based on codes submitted.<br>*Denial Examples: The primary service associated with this procedure has been denied due to submission of an outdated or vague diagnosis code, missing modifier, unlisted codes, or mismatched codes with a patient's gender or age.* | **Submit Dispute Form**<br>Include rationale and supporting documentation with relevant medical records (as necessary) to explain and validate the submitted code. *(Please do not send the entire medical record)* |
| **Denied Authorization**<br>For claims denials due to invalid or denied prior authorization for the service or date(s) of service (DOS). *Denial Examples: Authorization not valid for date of service (DOS), Prior Authorization denied.* | **Submit Dispute Form**<br>Include relevant documented rationale explaining why services were rendered following a denied prior authorization request. *(Please do not send medical records; Plan reserves the right to seek additional records to demonstrate medical necessity, if applicable)*<br>**Do not use this form for Pre-Service Requests:**<br>For Pre-Service requests, see UM. |

| Dispute Review Types | Provider Action / Required Documentation |
|---|---|
| **Failure to Obtain Authorization Due to Emergency or Urgently Needed Services (GA Only*)**<br>For claims denials for failure to obtain authorization, where the provider can demonstrate that the services rendered were "Emergency and Urgently Needed Services" exempt from prior authorization requirements under 42 CFR § 422.113 and applicable CMS rules. *Denial Example: No authorization on file.* ****US Family Health Plan Claims Only: Disputes for failure to obtain auth will be treated as Retro Authorization requests, if timely, and must be submitted via ProAuth.*** | **Submit Dispute Form**<br>Include relevant records demonstrating that the services rendered without prior authorization were emergency or urgently needed services, as set forth in 42 CFR § 422.113, and were medically necessary. *(Please attach reason for why prior authorization was not obtained and send applicable medical records).* |
| **Coordination of Benefits Review**<br>For denials due to coordination of benefits issues, such as missing or incomplete primary EOB or conflicts with other health insurance coverage. *Denial Examples: OHI must process claim first, resubmit with primary EOB, EOB does not match claim* | **If Missing Information:** Send **Corrected Claim** with Primary EOB attached, or include other missing information, **do not submit Dispute Form.**<br><br>**If 'EOB does not match':** Submit Dispute Form, include rationale. |
| **Timely Filing Review**<br>Claim/line denied for being submitted after the plans allowable filing deadline. This may happen if the original claim wasn't received, a denial was issued for a previously submitted claim, or a delay occurred due to coordination. *Denial Examples: Claim submitted beyond timely filing limit, filing deadline exceeded* | **Submit Dispute Form**<br>Include relevant proof of timely submission such as clearing house reports, EOB from other payers, rejection letters, any other necessary information. |
| **Benefit Limitations or Non-Covered Services**<br>For denials resulting from plan coverage rules, such as services that are excluded from benefits or that exceed defined benefit limits. *Denial Examples: Service is not a covered benefit, Benefit limit exceeded, Excluded cosmetic procedure* | **Submit Dispute Form**<br>Include documentation showing why the service should be covered, such as relevant policy references, or other rationale. |
| **Contractual or Pricing Review**<br>For payment amounts that may not match provider agreement, or incorrect takeback / recoupments. *Examples: Paid below contracted rate, unexpected takeback of payment Modifier reduced payment incorrectly* | **Submit Dispute Form**<br>Include contract or fee schedule and a detailed explanation of the payment issue. Attach relevant remits showing the discrepancy, if possible. |
| **Duplicate Review**<br>Claim/line denials identified as duplicate submissions. *Denial Examples: Duplicate claim* | **If Incorrectly Identified as Duplicate:**<br>Submit Dispute Form, include documentation showing why the service should be covered, such as relevant clinical notes, policy references, or other rationale. |
| **Other / Case-by-Case Review**<br>Use this category for disputes that don't fall into any of the categories above and may need special handling or clarification. | **Submit Dispute Form**<br>Include relevant information and supporting documentation. |