

Health Plus Medical & Claims Payment Bulletin

Bulletin number: CL – B200

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Subject: Claim Appeals

Definitions:

- **Claim Appeal for Administrative Denials** – Administrative policy are guidelines use to determine a course of action in adjudicating the claim.

These are claims denied for reasons other than medical need, such as untimely filing, lack of authorization, member not eligible on date of service, and other organizational rules.

- **Medical (Clinical) Appeals** – are claims denied because the service and/or number of visits/units requested were found to be not medically needed.

These appeals are referred to Health services or Behavioral Health Services and will be decided by qualified clinical personnel.

- **Claim Resubmissions** – are claims that denied in part or in whole because information on the claim form was missing, incorrect, or additional information requested to process the claim was not received.
- **Reconsiderations** – are claims that were underpaid for reasons such as billing errors, entry/adjudication errors, or system setup errors.

Claim Requests and Appeal Submission:

Claim resubmissions, requests for reconsideration and/or appeals must be made in writing within 60 business days from the date of the initial determination.

Consistent with CMS guidelines, resubmission of claims with required or corrected information, or requests for adjustment due to claim processing errors are not appeals. The provider may submit a corrected or complete claim through the Claims Correspondence Unit.

- When resubmitting the claim form for adjustment, add the missing information, the claim ID# of the denied claim and indicate at the top of the claim form being submitted for adjustment “CORRECTED CLAIM”.

If not clearly marked, the paper claim may be denied as a duplicate claim.

- To appeal a claims action, submit a completed Provider Claim Dispute Request Form (available in the Provider Section of the Health Plus website www.healthplus-ny.org) or provide the following information to our Claims Correspondence Unit:

- Provider Name and Health Plus Provider Number
- Provider Billing Address
- Contact Person (Name, phone number and fax number)
- Member Name and Health Plus ID number (not Medicaid Number)
- Date of Service
- Health Plus Claim Number
- Amount Billed and Amount Paid
- Dispute Information (Provide clear rationale for your dispute and attach supporting documentation, if necessary)
- Provider or Authorized Representative Name, Title, and Signature with Date

- Use one form for each disputed claim. Please allow 30 days before checking the status of your appeal. Health Plus will decide on your medical appeal within 30 days and your non-medical appeal within 45 days of receipt and notify you in writing.
- Send the written appeal and all supporting documentation to:

Health Plus
Claims Correspondence Unit
241 37th Street, Suite 412
Brooklyn, NY 11232

- Health Plus will provide written acknowledgment of the appeal within fifteen (15) days of receipt of the appeal. All medical appeals will be resolved within thirty (30) days and all non-medical appeals within 45 days after the receipt of all necessary information.

Expedited action appeals will be resolved within two business days of receipt of necessary information and no later than three business days of the date of receipt of the action appeal.

Policies in this manual are intended to reflect standard Health Plus procedures. In instances where a provider's contract contains other policies which may be more or less restrictive than those in this manual, these contractual provisions will apply.

Date Approved:	5-16-06	Approved By:	<i>Clifford D. Markut, M.D., M.P.H.</i>
Date Approved:	5-22-06	Approved By:	<i>[Handwritten Signature]</i>