17.6 Claim Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process

Claim Inquiries

Providers can view claims status on our website at www.healthfirst.org. Providers may also call Provider Services at **1-888-801-1660**, 24 hours a day, seven (7) days a week, to access claim status on a service line or service code basis instead of a claim's total.

As described below, Healthfirst provides a two (2)-level process for providers to appeal a claim denial or payment which the provider believes was incorrect or inaccurate. Please note that the provider appeal process described in this Section 17 does not apply to utilization management determinations concerning medical necessity. See Section 15 for information on medical necessity appeals.

Corrected Claims

Definitions

Rejected claim: A claim that was received by Healthfirst and determined to be unclean. The claim is never loaded to the adjudication system. The claim is returned to the provider along with the reason for the rejection.

Re-submission claim: Represents a claim that was rejected by Healthfirst. Once the provider makes the appropriate changes to the claim, the provider must re-submit the claim within timely filing guidelines for new claims. **Note: This re-submitted claim is always treated as a new claim.**

Accepted claim: A claim that was received by Healthfirst and passed all criteria. The claim was successfully loaded to the adjudication system. The system then makes a final determination of paid or denied.

Corrected claim: Represents a claim that was accepted by Healthfirst. The corrected claim has changed data elements that will potentially effect the payment of the claim.

EDI Corrected Claims:

When submitting an EDI "Corrected" Professional and/or Institutional claim to Healthfirst the following requirements must be met:

1) The claim type/frequency (CLM05-03) must be a 7.

   Ex. CLM*8084*96.98***11>B>7*Y*A*W*I*P~

2) The Healthfirst **original claim ID must be sent** in the REF*F8 segment in the 2300 loop. The Healthfirst claim ID is made up of a 2 digit branch code, 6 digit batch date, 3 digit batch sequence, and a 2 digit sequence ID. The Healthfirst claim ID can be found on the EOP and/or 835.

   Ex. REF*F8*010414153906 1~

Paper Corrected Claims:

When submitting a Paper "Corrected" Professional and/or Institutional claim to Healthfirst, the Providers should stamp or handwrite on the claim "CORRECTED" or "CORRECTED CLAIM" and **must include the**

original claim number being corrected.

Note: Corrected Claims submission must follow timely filing guidelines for new claims (Refer to Section 17.3 for timely filing rules).

Requests for Review and Reconsideration of a Claim

At times, a provider may be dissatisfied with a decision made by Healthfirst regarding a claim determination. Some of the common reasons include, but are not limited to:

incorrectly processed or denied claims;
the untimely submission of claims;
a failure to obtain prior authorization.

Providers who are dissatisfied with a claim determination made by Healthfirst must submit a **written** request for review and reconsideration with all supporting documentation to Healthfirst within **ninety** (90) calendar days from the paid date on the provider's Explanation of Payment (EOP). Written requests, including attachments, are accepted via the Healthfirst provider website at www.healthfirst.org or addressed to the following location:

Healthfirst Correspondence Unit

P.O. Box 958438,
Lake Mary, FL 32795-8438

All written requests for Review and Reconsideration via the provider website or P.O. Box 958438 should include the following information: a copy of the EOP, the claim, supporting documentation, and a written statement explaining why you disagree with Healthfirst's determination as to the amount or denial of payment.

Examples of information and supporting documentation that should be submitted with written requests for review and reconsideration include:

- A written statement explaining why you disagree with Healthfirst's claim determination.
- Provider's name, address, and telephone number.
- Provider's identification number.
- Member's name and Healthfirst identification number.
- Date(s) of service.
- Healthfirst claim number.
- A copy of the original claim or corrected claim, if applicable.
- A copy of the Healthfirst EOP.
- A copy of the EOP from another insurer or carrier (e.g., Medicare), along with supporting medical records to demonstrate medical necessity.
- Contract rate sheet to support payment rate or fee schedule.
- Evidence of eligibility verification (e.g., copy of Healthfirst member ID card).
- Evidence of timely filing:
    - RO59 Report (Insurance Carrier Rejection Report) or Emdeon Vision "Claim for Review"/"Claim Summary" Report;

- **Please note:** Healthfirst **does not** accept copies of certified mail or overnight mail receipts, or documentation from internal billing practice software as proof of timely filing.
- Copy of the approval number issued by Medical Management.

Healthfirst will investigate all written requests for Review and Reconsideration, and issue a written explanation stating that the claim has been either reprocessed or the initial denial has been upheld, within thirty (30) calendar days from the date of receipt of the provider's request for Review and Reconsideration.

Healthfirst will not review or reconsider claims determinations which are not appealed according to the procedures set forth above. If a provider submits a request for review and reconsideration after the ninety (90) calendar day time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services, irrespective of the merits of the underlying dispute, if the request for review and reconsideration is not timely filed. In such cases, providers may not bill members for services rendered.

All questions concerning requests for review and reconsideration should be directed to the Provider Services Unit at **1-888-801-1660.**

Claim Appeals Process

Providers who are dissatisfied with the outcome of the Review and Reconsideration may submit a **written** request for a formal appeal within **sixty (60) calendar days** from the date listed on the reconsideration determination letter.

Providers should submit all written requests for an appeal of a claim determination to the following location:

Healthfirst Provider Claim Appeals

P.O. Box 958431

Lake Mary, FL 32795-8431

Providers should provide a written statement explaining why they disagree with Healthfirst's decision regarding the review and reconsideration, a copy of that determination, and, if the provider submitted the request for Review and Reconsideration via the Healthfirst provider website, the specific Healthfirst tracking number. Providers should also specify the name, address, and telephone number of an individual who may be contacted regarding the appeal and include any additional relevant documentation to support the provider's position (see above for examples of documentation). Healthfirst will not accept appeals from providers that are not made in writing and that fail to address the reason for the appeal.

For appeals on payment rates, providers should specify in writing the basis for the dispute and enclose all relevant documentation, including, but not limited to, contract rate sheets or fee schedules.

Healthfirst will investigate all written requests for appeal and issue a written explanation stating that the claim has been either reprocessed or upheld, within thirty (30) calendar days from the date of receipt of the provider's request for appeal.

Healthfirst will not consider appeals that are not submitted according to the procedures set forth above. If a provider submits a request for appeal after the sixty (60) calendar day time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services, irrespective of the merits of the underlying dispute, if the request for appeal is not timely filed. In such cases, providers may not bill members for services rendered.

All questions concerning requests for review and reconsideration should be directed to the Provider Services Unit at 1-888-801-1660.