HOW TO BE SUCCESSFUL

CLAIM REVIEWS & APPEALS

Priority Health

It's important to us that you're satisfied with the way a claim is handled. This information is intended to support you through the claim dispute process to make sure your questions / concerns are resolved in a timely manner – and you're paid accurately and fairly for the care you've provided to our members.

	CLAIM REVIEW	CLAIM APPEAL
WHAT IS IT?	When you submit an **informal claim review**, you're asking us to reconsider our decision on a claim. This may include comprehensive claim reviews, coding / clinical edit questions, third-party liability, coordination of benefits and more.	When you make a **claim appeal**, you're asking us to change our informal claim review decision. You can submit a claim appeal to dispute payment issues, clinical edits and claim denials. We offer one level of post-claim appeals.
WHEN CAN YOU USE IT?	You must wait **at least 45 days after submitting a claim** to submit an informal claim review.	You may submit an appeal **within 180 days** of the claim denial and **after an informal claim review decision** is made.
HOW DO YOU DO IT?	All plans follow the same informal claim review submission process. **Find it here.**	Find instructions for **commercial and Medicaid appeals submission**. Find instructions for **Medicare appeals submission**.
WHEN WILL YOU HEAR BACK?	Within **15 calendar days*** of submission	Within **45 calendar days*** of submission (except for code review appeals at **60 calendar days***)

** Timeframes assume the correct dropdown option is selected in prism. Choosing the incorrect dropdown option will delay your response.*

WHAT MAKES A GOOD APPEAL?

1. **Start with the basics.** Who are you appealing for? What are you appealing? What do you want us to review? What about our informal claim review decision do you disagree with?

2. **Be specific.** Include information on what was denied and the cited reason for the denial (i.e., disputed code, fee schedules and any documentation or justification to support your appeal).

3. **Be thorough.** Be sure to include plenty of detail. Complete and accurate information is key. Include the following:

   - **Medical authorization appeals**: Office notes, radiology and lab / pathology reports, operative notes, etc.
   - **Coding / administrative appeals**: Documentation or attachment from CMS guidelines, CPT / HCPCS guidelines, ICD-10 guidelines, AMA, standard clinical practices and recommendations from medical societies, Priority Health policy, contract language, etc.

Note: If the above isn't included in your appeal, it will be considered invalid and closed without review.

FAQ

What if you just have a question about how a claim was processed?
If you have a claim number, look at the claim details under Medical Claims in **prism** first. Here you'll be able to find the most up-to-date billing information, claim status, any denial information including clinical edits that may have been applied, and more.

If you're unable to find the answer to your question in **prism**, you can send your question to our teams through one of the following **prism** features:

1. **Claims Inquiry** – After pulling up the claim in question in **prism**, click *Contact Us About This Claim* and complete the required fields. Note there are several options* to select from when determining what your message is about.

2. **General Requests** – If you don't have a claim number (i.e., your question is general in nature or you're inquiring about a claim that was front-end rejected), click *General Requests* in the main **prism** menu and then *New Request*. Select the most appropriate request type*, complete the required fields, attach any supporting documentation and click *Submit*.

** Each option routes your inquiry to a different Priority Health team for processing. Be sure to select the most appropriate option for timely processing.*

FAQ CONTINUED

What happens if we receive a claim appeal before a review has been completed?

We'll close the appeal and instruct the provider to submit a review, with the appropriate instructions to do so. Once the review is complete, the provider will have the opportunity to submit an appeal if desired, within the 180 day-window from the original claim denial.

What sort of documentation can you submit with your appeals?

We DO accept:

- ✓ Contract language / fee schedule for payment dispute
- ✓ CMS LCD / NCCI / OCE, etc.
- ✓ Medicare / Medicaid pricing
- ✓ Proof of timely filing, etc.

We DON'T accept*:

- X Remittance advice
- X A copy of a claim
- X A system print out
- X Medical records**

** We'll close the inquiry if we receive these types of documentation.*
*** Exception: we accept medical records with medical necessity appeals (i.e., your claim denied due to no authorization on file) or when specifically requested.*

What about reviews for multiple claims?

Here's how to send us an inquiry about multiple members' claims:

- **More than 10 members' claims**: If the same issues is affecting more than 10 members' claims, use the Claims Inquiry tool in **prism** described on page 2 to send is one example. Be sure to state in your message what the issue is and that it's happening to multiple members' claims. We'll investigate and contact you if we need more examples.
- **Less than 10 members' claims**: If the same issue is affecting less than 10 members' claims, use the Claims Inquiry tool in **prism** described on page 2 to send us an inquiry for each claim you're requesting we review, along with an explanation of the issue.
- **Different issues for each member**: Follow the instructions for *less than 10 members' claims* above.