Changes Priority Health	BILLING POLICY No. 182
Technical Denials	
Date of origin: March 2026	Review dates: None yet recorded

DEFINITION

In accordance with CMS policies and procedures, and applicable state and federal regulations, Priority Health reserves the right to perform pre-payment and post-payment reviews to ensure payment integrity.

When a paid claim is identified as requiring medical record review, providers receive at least one request to submit medical records. These letters include a list of the requested medical records and instructions for submission and state the claim will be denied if they don't submit the requested records within the timeframes specified in the letters.

The goal of this policy is to increase payment accuracy by confirming that payments are only made for services supported by coverage, coding, and medical necessity requirements.

Technical Denial – A technical denial is a denial of the entire paid amount of a claim in instances when the care provided to a member cannot be substantiated due to a provider's non-response to Priority Health requests for medical records, itemized bills, documents, etc.

Pre-payment review – a claim review prior to payment to ensure complete documentation, validate coding and confirm medical necessity. In the meantime, the claim will be pended until the documentation is received or until the deadline for receipt of the documentation passes. If requested information has not been received within 30 calendar days unless otherwise specified, the claim will be denied.

Claim dispute – a request to reconsider a claim decision. Please see our provider manual page here for information on our dispute process and timeframes.

Post-pay request – a request for submission of documentation after the claim has been paid to validate coding accuracy and medical necessity to support compliance.

The reviews of the provider's medical record and/or other supporting documentation is to support claims with the following criteria:

- The service was medically necessary.
- The service was reasonable.
- The service was provided in the appropriate setting.
- The service was billed correctly.
- The service was coded accurately
- The service was covered by Priority Health

POLICY SPECIFIC INFORMATION

Record request: The provider will receive a request for medical records; it's important to comply with the allowed timeframe. In alignment with industry standards, we apply technical denials to claims selected for audit when we don't receive the requested medical records.

Lack of response: If the medical records aren't submitted by the deadline, we deny the paid claim to the provider's liability and take back the paid funds. The claim may show a denial code which indicates additional documents are required.

After a technical denial

Even after a technical denial is issued, you can submit the requested medical records to the requestor for consideration within 60 calendars days unless otherwise specified.

Final Decision: if the requested documentation is received after a technical denial has been issued but within the dispute period outlined per applicable contractual, state of federal guidelines, the records will be reviewed to make a final determination.

For funds recoupment, follow our corrections to overpayments process, or we'll recoup from future claims payments.

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
March 2026	New policy. Effective date 05/18/2026