Priority Health

CLAIM DISPUTES

HOW TO BE SUCCESSFUL

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.

	LEVEL 1 CLAIM DISPUTE	LEVEL 2 CLAIM DISPUTE
WHAT IS IT?	When you submit an **Level 1 claim dispute,** 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?	**Only after** you've received an adjudication response to your claim submission.	You can submit a Level 2 claim dispute within **180 days** of the claim denial and **after a Level 1 claim dispute** decision has been made.
HOW DO YOU DO IT?	All plans follow the same informal claim review submission process. **Find it here.**	Instructions are the same for all contracted providers **found here**. Instructions for non-contracted Medicare providers are **here.**
WHEN WILL YOU HEAR BACK?	Within **15 calendar days*** of submission	Within **45 calendar days*** of submission for most disputes and **60 calendar days*** for clinical edit disputes.

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

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WHAT MAKES A GOOD DISPUTE?

1. **The criteria.** Was the claim processed incorrectly based on our policies? Did the decision deviate from our Billing & Coding policies and regulatory standards? This is the criteria needed to submit a good dispute.

2. **Be specific.** Include information on what was denied and the cited reason for the denial. Attach any policy or clinical guidelines applicable to the denial, and any regulatory, billing, coding guidelines or contract language.

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 dispute, 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.*