

Administrative Simplification
Operational Guidelines

Simplification Area: Claims Processing

Topic: Provider follow-up on claims that have been processed

Objective: Quicker resolution of provider's questions and issues about claims that have been processed by the health plan

Synopsis:

A uniform set of procedures, across participating health plans, has been established for providers' follow-up on issues or questions about claims that have been processed.

These guidelines are intended to simplify the follow-up process for providers. Providers have the option of continuing to follow any current procedures that they have in place with the health plans.

If the provider's issue is still not resolved, their next step is to follow the appeals/grievance process issued by the respective health plan.

Background:

When a health plan completes their processing of a claim, they send a voucher to the provider which explains how the claim was processed and itemizes any payment amount. After reviewing the voucher, providers may have follow-up question/issues. Follow-up procedures are not clearly defined and are not always uniform across health plans. These differences add to the complexity and confusion in the follow-up process.

Useful definitions:

Claim Review – The health plan is being asked by the provider to review how a claim was processed. The provider will supply an explanation, along with any appropriate chart notes, in support of their request for claim review. The health plan will respond either by adjusting the remitted amount or with a denial or with greater explanation about why no adjustment is in order. (See more below.)

Appeal/Grievance – This is the escalated process step after Claim Review. The appeal/grievance process is available in the provider's contract and/or directly from the health plan. This guideline does not speak to the appeal/grievance process followed by each health plan.

Operational Guideline:

Health plans encourage providers to contact them by phone with questions about claim denials or about how a claim was paid. Phone conversations is the fastest way to get questions answered and issues resolved. Health plans will also respond to written questions or issues, but written correspondence is likely to take longer than a phone call.

Step 1: Before contacting the health plan, verify that the claim was coded and billed appropriately.

Step 2: Contact the appropriate health plan's provider customer services department.

Providers can find the contact information for the health plans by selecting Claims Support Services under Operational Questions in the Forum's Contact Directory located at <http://www.wahealthcareforum.org/healthplaninfo/contact/index.htm>

Health plans will attempt to answer general questions as quickly as possible, and usually on the same telephone call. Occasionally, the health plan representative may need to research a question by talking with other people in their organization. The health plan representative will call the provider back with the answer. Ideally, all questions will be answered within 48 hours, or the provider will be given a date by which the plan will call them back. In some cases, the provider may be asked to submit a corrected claim or to request a reconsideration of the claim. (These procedures are outlined later in this document.)

Alternative Step: If a provider would like to submit written correspondence requesting a claim review, Health Plans will review and respond to it. However, health plans encourage providers to address their questions/issues by phone. If corresponding by mail, then . . .

- Draft a letter, on your organization's letterhead, that requests a review of how the claim was adjudicated
- The letter should explain why you believe the adjudication of the claim merits a review.
- Include any materials, e.g. chart notes/ER notes, that you believe supports the request for review.
- Include the following information about the claim:
 - Claim Number
 - Dates of Service
 - Patient Name
 - Patient Date of Birth
 - Member's ID#/Subscriber ID#
 - Member/Subscriber Name

- Rendering Provider's Name

- Send the documentation to the appropriate location at the health plan. (Note that the correct location to send this information is often dependent on the specific product name.) Providers can find the address for the health plans by selecting Requests for Claims Review under Document Submissions in the Forum's Contact Directory located at <http://www.wahealthcareforum.org/healthplaninfo/contact/index.htm>

After receiving a written request for review (as described above), the health plan will review the request and will respond to it within **30** calendar days of receipt. (Regence will respond within **60** calendar days.) If the health plan cannot complete its research and response within that time period, the provider will be contacted and notified of the date by which they can expect a response.

If the health plan agrees with the provider's request, the claim will be readjudicated and a new voucher (Remittance Advice - R.A.) will be sent.

Otherwise the health plan will respond as described below...

Health Plan	Approach a	Approach b
Aetna	X	
Asuris Northwest Health	X	
Community Health Plan of Washington		
First Choice Health Administrators		X
Group Health Cooperative		X
Labor & Industries	X	
Health and Recovery Services Administration	X	
Molina Healthcare of Washington	X ^{*1}	X ^{*2}
PacifiCare	X	
Premera Blue Cross	X	
Regence BlueShield	X	
Uniform Medical Plan	X	

*1 - Uses Approach a for claims review inquiries

*2 - Uses Approach b for Denied Claims Review Requests

Approach a: Respond either with a form/check-off letter or using the payment voucher and indicating that the denial/current payment amount stands

Approach b: Respond with a written explanation of why the denial or level of payment was appropriate. The explanation will address the specific issues/questions that are raised in the provider's letter and will outline the health plan's rationale. The level of detail reflected in the response will indicate that the health plan has read, understood and considered the information contained in the provider's request.

A phone number will be given where the provider can contact a person who is familiar with their request for review and the health plan's response. Ideally, a contact person's name will also be provided.

If the explanation and actions outlined in the response do not satisfy the provider, their next step is to initiate the appeal/grievance process that is provided by the respective health plan.