



Administrative Policy

Provider Administrative Claim Appeals

Policy Number: O.5.019

Version Number: 5

Version Effective Date: March 1, 2021

Impacted Products

- All Products**
- NH Medicaid
- NH Medicare Advantage
- MA MassHealth ACO
- MA MassHealth MCO
- MA Qualified Health Plans/Employer Choice Direct
- MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The purpose of this policy is to explain the process providers must follow for submitting provider administrative claim appeals to dispute payments. It also explains how WellSense Health Plan processes administrative claim appeals submitted by providers

All providers have the right to ask the Plan to review a claim they feel was wrongly denied or paid insufficiently for administrative reasons and request that the claim be paid or the payment increased. Such a request **must** always be submitted in writing by the provider and is called a provider administrative claim appeal. With a provider administrative claim appeal, the provider asks the Plan to review a claim as it was processed. Providers are encouraged to submit all documentation that supports their provider administrative claim appeal.

The following types of provider administrative claim appeals are IN SCOPE for this process:

- Level of Compensation/Reimbursement
- Timely Filing of Claims
- Retroactive Eligibility
- Lack of Prior Authorization/Inpatient Notification Denials
- Non-Covered and/or Unlisted Code Denials
- Other Party Liability (OPL)/Third Party Liability (TPL)/Coordination of Benefits (COB)

- Provider Audit and Special Investigation Unit (SIU) Appeals
- Duplicate Claim Appeals

The following are considered Claim Issues and are OUT-OF-SCOPE for this process and must be sent to the appropriate departments:

- Claim Adjustments
- Corrected Claims
- Claim Resubmissions
- Claims Involving OPL/TPL/COB*

*Note: Claims issues involving OPL/TPL/COB are not necessarily appeals involving OPL/TPL/COB claims. Providers are responsible for sending their requests to the appropriate address via the required method(s).

Definitions

Appeal resubmission: Appeal resubmitted to the Plan after being initially rejected because it did not include the required information. These follow the same appeal filing timeframes.

Claim denial: Plan's refusal to approve or pay for services, in whole or in part, that the provider believes should be covered by the Plan.

Explanation of Benefits (EOB): A statement that provides details about a claim that has been processed and explains what portion is being paid to the health care provider and what portion of the payment, if any, is member responsibility.

Facets: The Plan's electronic claims, eligibility, and contact documentation system.

Medical Claims Auditor (MCA): Medical coding specialist responsible for reviewing appeals for claims with medical coding or clinical editing issues; formerly known as the Clinical Nurse Reviewer (CNR).

Medical Claims Review Nurse: Plan staff person responsible for reviewing provider administrative claims appeals that require application of clinical coverage criteria.

Medical necessity OR medically necessary decision: Determination made by a Medical Claims Review Nurse or a Plan Physician Reviewer as to whether or not clinical services meet criteria for authorization.

Other party liability (OPL) also known as Third party liability (TPL) and Coordination of Benefits (COB): Department that processes claims partially paid by another insurance company.

Physician Reviewer: Plan staff medical doctor who performs clinical reviews of requests for services, supplies and medications.

Provider: Appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that may or may not have an agreement with the Plan for the delivery of covered services.

Plan: WellSense Health Plan (formerly Boston Medical Center HealthNet Plan)

Provider administrative claim appeal: Written request made by a provider to the Plan to review a claim the provider believes was wrongly denied or paid insufficiently for administrative reasons, and to pay the claim or adjust the payment.

Provider appeals coordinator (PAC): Plan employee responsible for processing provider administrative claims appeals.

Provider Audit/Special Investigation Unit (SIU): Plan department that examines claims data to detect aberrant billing patterns and investigates these patterns as well as referrals made to combat fraud, waste and abuse (FWA).

Remittance advice (RA): Facets-generated notice posted as a PDF that a provider can access through the Plan's provider web portal; shows details of payments and explains why adjustments or retractions have been made to the provider's account(s).

Request date: The date the Plan receives an appeal; the "received date" stamped on the appeal.

Retraction of payment: Provider request for retraction of an entire claim payment (because, for example, they did not see the member or the service not performed.)

Timely filing limit (TFL): Time period from date of service within which the provider must file a claim, and the time periods from the claim's date of service and the date of the claim's denial within which a provider must file an appeal; time limits can differ depending on several provider-related factors.

Policy

General Rules

- Must be submitted via the provider portal on the website or via mail through the United States Postal Service

Paper appeals must include a **completed*** Universal Request for Claim Review Form which can be located on our website at: www.wellsense.org/providers/ma/documents-and-forms#docs-8

A completed Form is a form submitted with all required information, including but not limited to completion of all fields denoted with an asterisk () and the correct Review Type box. If using "Other" on the form, providers must document specific information pertaining to their request.

Appeals with incomplete forms will be dismissed. A dismissal letter will inform the submitting provider that they may resubmit their appeal with the completed form. The provider's request will not be processed unless/until a completed form is received with the original appeal within the original appeal timely filing timeframes. Once the appeal is received with a completed Universal Request for Claim Review Form, the effective date of receipt of the provider administrative claim appeal will be the date the resubmitted appeal and completed form is received at the Plan. If an appeal resubmission is not received by the Plan within the original timeframes to appeal, it will be denied by the Plan as untimely.

- Forms submitted must be legible. Appeals that contain a Universal Request for Claim Review Form that cannot be interpreted or are illegible will be dismissed as unable to process.
- All appeals must **be accompanied by a written narrative from the provider** explaining in full detail the discrepancy or the rationale for the appeal of the denial
 - Appeals that do not contain a written narrative detailing the request and rationale will be dismissed as unable to process.
- All appeals must include a copy of the claim(s) in question, the remittance advice, applicable OPL/TPL/COB documents (example: EOB from another carrier, PIP letter, etc.) and any Plan issued correspondence
- All appeals must include **all necessary** information the provider wishes to have considered during the review.
 - The Plan will not accept additional information for review after an appeal decision has been rendered by the Plan.
- Must be received by the Plan within the following timeframes*:
 - **MCO/ACO**: 150 calendar days from the original denial date and no later than 300 calendar days from the date of service.
 - **Qualified Health Plans (QHP)**: 90 calendar days from the original denial date and no later than 180 calendar days from the date of service.
 - **Senior Care Options (SCO)**: 150 calendar days from the original denial date and no later than 300 calendar days from the date of service.

Providers must complete the Universal Request for Claim Review Form accurately. Mislabeling of the form may result in misrouting of review requests and will likely delay the outcome.

*Providers should refer to their provider contracts to verify specified timeframe for submission. Provider Appeals received after the required timeframes will be dismissed as untimely.

Specific Rules based on Provider Administrative Appeal Type

In addition to the information provided above, providers should refer to the below for more specific information to be included with their provider administrative claim appeal.

Required data elements for administrative appeals

The following data elements must be present on the [Request for Claim Review Form](#) and must be legible:

- Provider name
- MA-assigned provider identification (ID) number/NPI
- Contact name
- Contact telephone number
- Member name
- Member ID number
- Claim number
- Date of service
- Procedure code being appealed
- Charge amount
- Total claim charges
- Denial code

Appeal submission Types

- All administrative appeals must include a completed Universal Request for Claim Review Form available on our website at wellsense.org
- Administrative appeals can also be submitted via the HealthTrio Provider Portal.
- if submitting via mail

Address for submitting Provider Appeals:

WellSense Health Plan
Attn: Provider Administrative Claim Appeals
P.O. Box 55282
Boston, MA 02205

Level of Compensation/Reimbursement Appeals

- Include a written narrative (explanation) of the requested change(s)
- Include the remittance advice and identify the claim we should review.
- Include all supporting documentation in the form of invoices, operative notes, office notes, or any necessary medical record information.

Timely Filing Claims Appeals

The timely filing timeframes for claim submissions to the Plan are as follows*:

- **MCO/ACO**: 150 calendar days
- **Qualified Health Plans (QHP)**: 90 calendar days
- **Senior Care Options (SCO)**: 150 calendar days

*Providers should refer to their provider contracts to verify specified timeframe for submission.

An appeal submitted due to a claim denial for violating the filing limit must include at least one of the following:

- If the initial claim submission is after the filing limit and the circumstances for the late submission is beyond the provider's control, providers may appeal by sending a letter documenting the reason(s) why the claim could not be submitted within the contracted filing limit. Providers must include the original claim form and send the appeal within the timeframe specified, as outlined in filing an administrative appeal in the Provider Appeals section of the Provider Manual.
- If the member did not identify him/herself as a Plan member, supply proof to the Plan that the member or another payer had been billed within the applicable Plan timely filing limit.

Appeals of claims denied for untimely filing must also include documented proof of timely submission, such as:

- Proof showing date the member was billed by the provider when accurate insurance information was not presented at time of service(s).
- Copy of RA from another insurer if the member did not provide proof of current eligibility with the Plan
- Copy of RA from the primary insurer that shows timely submission from the date that carrier processed the claim.
- Copy of personal injury protection (PIP) letter within the applicable timely filing timeframes noted above. For example, day one is the date of the PIP letter.
- Copy of Worker's Compensation denial within the applicable timely filing timeframes noted above. For example, day one is the date of the denial notification.

Retroactive Eligibility Appeals

- Must include a typed letter of medical necessity explaining why the service(s) was/were necessary.
- Must include a copy of the claim at issue (e.g. RA)
- Must include all clinical and administrative documentation pertaining to the issue.
- Must include print out of proof of eligibility on date of service(s) in question, such as: eligibility verification system (EVS), OR
- Proof that eligibility was not in the system at the time of service but has now been added retroactively.

Lack of Prior Authorization/Inpatient Notification Appeals

- All appeals must include a written member and service(s) specific typed narrative (explanation) detailing the request and any extenuating circumstance that prevented the provider from contacting the Plan for prior authorization, extending an existing authorization to cover the date(s) of service for a member's treatment or notifying the Plan timely of a member's admission.
- All appeals must include a copy of the claim at issue and RA
- All appeals must include all clinical and administrative documentation pertaining to the issue, service(s) rendered and/or inpatient admission/stay.
- All appeals for untimely notification of admission must include proof of successful fax transmittal to the Plan or proof notification was sent to another insurer timely when member failed to provide accurate insurance information before or during inpatient stay. (E.g. Face Sheet with clear date/time of notification and date/time receipt of notification from the other insurer that member was not eligible on their Plan).

Non-Covered Code Denials and Clinical Code Edit Appeals

Non-Covered Code Denial and Clinical Code Edit Appeals will be forwarded to the Plan's Medical Claims Auditor for review who will coordinate with the appropriate Plan department for final determination.

- Must include a typed letter of medical necessity explaining why the service(s) was/were necessary.
- Must include a copy of the claim at issue (e.g. RA)
- Must include all clinical and administrative documentation pertaining to the issue.

Other Party Liability (OPL)/Third Party Liability (TPL)/Coordination of Benefits (COB) Appeals

If the Plan is the secondary plan, providers must follow the primary carrier's rules, including prior authorization and inpatient notification. All provider administrative OPL/TPL/COB appeals must be exhausted with the primary carrier prior to appealing to the Plan.

- Must include documentation of the exhausted appeal(s) with the primary insurer
- Must include a copy of the claim at issue (e.g. RA)

- Must include a typed letter of medical necessity explaining why the service(s) was/were necessary
- Must include all clinical and administrative documentation pertaining to the issue

Provider Audit and Special Investigation (SIU) Appeals

All appeals for final Provider Audit and SIU findings should be sent to the attention of the Director of Provider Audit and Special Investigations.

- Must include a typed letter explaining in full detail the discrepancy or the rationale for the appeal of the denial
- Must include a copy of the claim at issue (e.g. RA)
- Must include all clinical and administrative documentation pertaining to the issue.

Process

The Plan provides one level of thorough review for administrative appeals submitted with all necessary information within 30 calendar days from the date the appeal is received at the Plan. If an appeal is submitted without all required information, the Plan will dismiss the appeal as unable to process and providers will be notified by the Plan in writing. If a provider elects to perform an appeal resubmission of the administrative appeal with the required information, the original timeframes to submit appeals apply. If the additional information is received after the original timeframe to appeal expires, the Plan may dismiss the appeal as untimely.

Provider Administrative Claim Appeals Process

The Plan offers one level of review for provider administrative claim appeals.

Appeals are reviewed by Provider Appeals Coordinators (PACs) in the Plan's Service and Operations division. PACs determine whether to uphold or overturn the administrative decision made by the Plan, based on clearly defined administrative criteria. Notification of the outcome of a provider administrative claim appeal is sent to the provider once a decision has been made on the appeal.

There may be a number of cases where the PAC cannot make a decision based solely on defined administrative criteria. In these cases the PAC may:

- Forward the appeal directly to another department or individual if it is clear that the appeal should be evaluated by that department or individual (e.g., appeals involving OPL/TPL/COB, appeals that involve application of clinical criteria for medical necessity decisions or appeals related to medical coding or clinical edit issues).

The PAC tracks all appeals forwarded to another department to ensure timely processing.

Provider Administrative Medical Necessity Process

An administrative provider claim appeal may require a decision about whether the services were medically necessary or there was a medical reason that created extenuating circumstances preventing the provider from fulfilling one or more administrative requirements prior to rendering the service(s). All claims requiring application of clinical coverage criteria for a medical necessity review are forwarded by PACs to the Claims Review Nurse who will apply the appropriate clinical criteria. If the member meets the applicable clinical coverage criteria, the Claims Review Nurse will approve the provider claims appeal as medically necessary. If the member does not meet the applicable clinical criteria for coverage, the Claims Review Nurse will forward the provider administrative claims appeal to a Plan Physician Reviewer, MD for review and final determination. All such appeals are tracked to ensure timely processing.

Providers who have questions on their internal appeal(s) must contact the Plan's Customer Care/Provider Services department where a representative will be happy to assist with their inquiries.

Responsibility and Accountability

The Plan is responsible for:

- a) Managing the Plan administrative claims appeals processes.
- b) Maintaining records of all provider administrative claim appeals.
- c) Ensuring timely and thorough review and processing of provider administrative claim appeals.
- d) Reviewing and updating policy annually and notifying providers of updates and/or changes to the process.
- e) Providing notification of provider administrative claim appeal outcomes.
- f) Retaining provider administrative records for no shorter than ten (10) years.

Monitoring Compliance

The Plan will maintain records of all internal provider administrative claim appeals. Records will include but not be limited to the following information:

- Type and nature of Appeal
- Name of Provider
- Date received
- Member name(s) and Plan identification number(s)
- Supporting information received from provider
- Appeal outcome
- Date of decision
- What, if any, actions taken (such as effectuation date, if applicable)
- Name, title, credentials of appeal decision maker

Policy History

Original Approval Date	Original Effective Date and Version Number	Policy Owner	Original Policy Approved by
October 15, 2015	October 15, 2015 Version 1	Director of Claims, Member Enrollment and Provider Appeals	Vice President of Operations

Policy Revisions History			
Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
Date	Revisions	Date Version	Approver
February 1, 2019	Document updated.	February 1, 2019 Version 2	Manager of Operational Quality Assurance
December 1, 2019	Document rewritten to reflect new one-level appeal process.	March 1, 2020 Version 3	Service and Operations Management
December 15, 2020	Minimal updates to reflect provider portal submission option; procedural review	March 1, 2021 Version 4	Service and Operations Management
October 28, 2022	Updates to links, Plan name and template	October 28, 2022	Director of Claims, Member Enrollment & Provider Appeals

Next Review Date

October 2023

Other Applicable Policies

- N/A

References

- CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

Disclaimer Information:

N/A