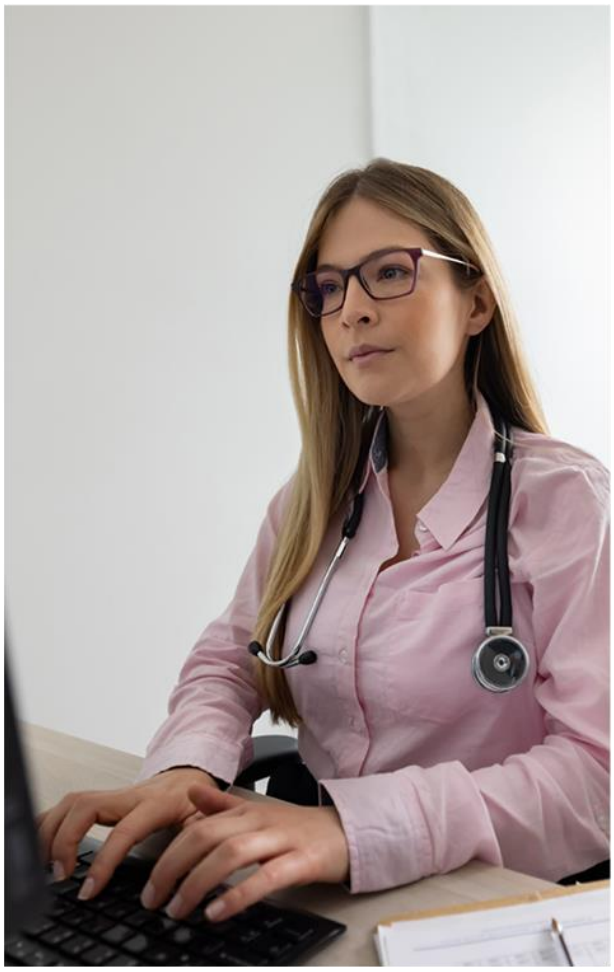
# Healthy Blue Provider Claim Payment Dispute and Appeals Process

## Medicaid



Provider Services: **844-594-5072**
**provider.healthybluenc.com**

BlueCross BlueShield of North Carolina | HealthyBlue

NCHB-CD-065113-24

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# Blue Cross and Blue Shield of North Carolina

# *Healthy Blue Provider Claim Payment Dispute and Appeals Process*

**https://provider.healthybluenc.com**


NCHB-CD-065113-24 September 2024

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## Overview

The **Provider Claim Payment Dispute** process is the process of disputing the denial, in whole or in part, of payment for services included on a clean claim.

This process consists of a [two-step] process:

- Claims Payment Reconsideration
- Claims Payment Appeal

Once completed, these steps are followed by a Regulatory Complaint process if the provider remains unsatisfied with the payment reconsideration or appeal findings. Providers are encouraged to continue to submit their concerns for denied [second step] Claims Payment Appeals to their assigned Provider Account Manager for review.

## Definitions:

- **Claims Payment Reconsideration**: Provider's request to investigate the outcome of a claim decision. The investigation of a reconsideration may result in a change to claim payment.

- **Claims Payment Appeal**: Provider's disagreement with a claim payment or a reconsideration decision. The investigation of a Claims Payment Appeal may result in a change to a claim payment.

- **Concurrent Reviews**: Utilization review to determine extensions of previously approved ongoing inpatient care.

- **Concurrent Review Appeals – Submitted**: A request for an extension of ongoing inpatient care is denied. An expedited appeal may be requested. This is a member appeal and will require member consent.

- **Medical Necessity Appeal**: Medical necessity appeals apply to authorization requests that were denied prior to the service or authorization for concurrent requests, made during an inpatient hospital confinement. They may be classified as pre-service or post-service. If a prior authorization (PA) was denied and not appealed and the claim is submitted, the claim will be denied for no authorization.

- **Pre-Service (Prospective) Review**: A Utilization review that is conducted on a health care service (or supply) that requires prior authorization prior to its delivery to the member.

- **Pre-Service Administrative Denial**: A determination based on noncompliance with a contractual arrangement. This decision was not based on medical necessity.

- **Post-Service (Retrospective) Review**: A utilization review conducted after the healthcare service (or supply) has been provided to the member.

- **Peer-to-Peer/Informal Reconsideration**: Discussion between the provider and a health plan medical director. If a peer-to-peer does not resolve the issue to the provider's satisfaction, then the provider may submit an appeal of the corresponding PA denial. Original appeal time frame submissions will apply.

- **Regulatory Complaint**: General term for the Ombudsman for Medicaid process.

- **Urgent Care Review**: Request to expedite decision for medical care or services where application of the timeframe for making routine or non-life-threatening care determinations:
  - Could seriously jeopardize the life or health of the member's ability to regain maximum function, based on a prudent layperson's judgment, or
  - Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
  - In the opinion of a practitioner who is a licensed or certified professional providing medical care or behavioral healthcare services with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without care or treatment that is the subject of the request.

## Timeframes for Disputes and Appeals:

- **Claim Payment Dispute**: [60 days] from the date on the Explanation of Payment (EOP). If the reconsideration findings do not result in a payment, then the provider will have [30 days] to submit a Claims Payment Appeal.

- **Pre-Service/Utilization Management (UM) Administrative Denial**: [60 days] from the date of the Notice of Adverse Benefits Denial notification (provider may appeal on behalf of Member).

- **Post-Service Medical Necessity Appeal**: [90 days] from the date of the Notice of Adverse Benefits Denial notification or the date of the submitted claim, whichever comes first.

- **Pre-Service Medical Necessity Appeal**: [60 days] from the date of the Notice of Adverse Benefits Denial notification (provider may appeal on behalf of member).

## Provider Dispute Options

**1. Claim Payment Dispute**

If, after working through the Blue Line, you remain in disagreement over a [zero or partial] claim payment, or in lieu of this process, you may submit a Claims Payment Dispute.
A Claims Payment Dispute may be submitted for multiple reasons, some examples are listed below.

**Claims Payment Dispute Reason(s):**

- Contractual payment issues
- Inappropriate or unapproved referrals initiated by providers
- Retrospective review
- Disagreements over reduced or [zero-paid] claims
- Other health insurance denial issues
- Claim code editing issues
- Duplicate claim issues
- Experimental/investigational procedure issues
- Claim data issues

- Step 1: File a reconsideration with the Payment Dispute Unit.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) must receive your dispute within **[60 days] from the date of the EOP** for Healthy Blue members. Blue Cross NC will send a determination letter within [30 business days] of receiving the dispute. If you are dissatisfied with the outcome of the first step, you may follow up with the second step of submitting a request for a Claims Payment Appeal. This can be done electronically through Availity, if the option is available, or it can be accomplished by sending a written communication to the address provided below.

- Step 2: Submit a Claims Payment Appeal in writing and mail the request to:
  [Blue Cross NC | Healthy Blue Payment Dispute Unit
  P.O. Box 61599 Virginia Beach, VA 23466-1599]

**Blue Cross NC must receive your request for a Healthy Blue Claims Payment Appeal within [30 days] of receipt of the Reconsideration determination letter.**

**2. Claim Payment Dispute with Request for Post-Service Medical Review**

Claim dispute related to a denied claim because of the provider's failure to obtain an approved prior authorization for services. Providers may submit a Claims Payment Appeal (with medical records attached) via the provider website using the Availity Essentials secure provider portal at [**https://www.availity.com**].

A provider must exhaust the internal appeals process before seeking recourse under any other process permitted by contract or law. A written explanation of the Good Cause reason for not obtaining the prior authorization is required. If Good Cause is not provided, the claim will not receive a post-service review, and any previous Notice of Adverse Benefit Decision will be upheld. This will result in the continued denial of claim payment.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) will resolve appeals and provide a written resolution letter within [30 days] of receiving the appeal request. If a provider is not satisfied with the first-level decision, they may submit a second-level appeal within [30 calendar days] of receiving the Appeal Resolution letter.

**3. Post Service Medical Necessity Appeal**

An appeal related to an unfavorable medical necessity decision after a Notice of Adverse Benefit determination has been issued. Providers may submit an appeal via Availity.
Providers can also file in writing utilizing:

- Fax: [**844-429-9635**]
- Email: [ncmedicaidgrievances@nchealthyblue.com]
- Mail:

[Blue Cross NC | Healthy Blue
Appeals
Healthy Blue
P.O. Box 62429 Virginia Beach, VA 23466-2429]

**4. Pre-Service Appeal on behalf of member**

If you are appealing a medical necessity decision on behalf of a member, you have [60 days] to submit the appeal and you must obtain the member’s written permission, unless you are requesting an expedited appeal. There is only one level of review for provider medical necessity appeals.

**5. Pre-Service Administrative Denial Appeal on behalf of member**

If you are appealing an administrative denial on behalf of a member, you have [60 days] to submit the appeal and you must first obtain the member’s written permission. There is only one level of review for this type of appeal.

**6. Post-Service Medical Necessity Appeal**

An appeal related to an unfavorable medical necessity decision after a Notice of Adverse Benefit determination has been issued. Providers may submit an appeal via Availity.

Providers can also file in writing utilizing:

- Fax: [**844-429-9635**]
- Email: [ncmedicaidgrievances@nchealthyblue.com]
- Mail:

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## Methods for Prior Authorization and Peer-to-Peer Responses

Initial Notice of Adverse Benefit Determination (NABD) notifications are sent via fax to the fax number indicated by the submitter. If the NABD letter fax transmission fails, the NABD will be mailed to the provider. Peer-to-Peer responses are sent via fax to the number indicated by the submitter.

## Methods for Clinical Appeal Responses

**Standard appeal**: We will notify you of our decision within [30 calendar days] of receipt of your appeal. Appeal decisions are mailed and faxed upon request. Decisions are returned by fax to the fax number that appears on the original request unless otherwise requested.

**Expedited appeal:** If your requested service involves an emergent or life-threatening situation, you can request an expedited appeal. A decision will be made no later than [72 hours] after we receive your appeal request. If you submit an urgent request that does not qualify, the Appeals department will contact you to notify you that the request will be processed in the standard appeal time frame.

**Appeals extensions:** If Blue Cross NC needs more information to make either a standard or expedited decision about your appeal, we will:

- Notify you in writing regarding what information is needed. Please note: For expedited appeals, Blue Cross NC will contact you via telephone immediately and send written notice later.
- Explain why the delay is in your best interest.
- Make a decision no later than [14 calendar days] from the day Blue Cross NC has asked for more information.

If the member or member's representative needs more time to gather documents and information, then please feel free to ask Blue Cross NC to delay your case until you are ready.

## Special Authorization Scenarios

**Air Ambulance Prior Authorizations:**

- Blue Cross NC does not require a PA for scene-to-hospital air ambulance transfers.
- Blue Cross NC requires a PA for elective air ambulance transfers from hospital to hospital.
- For urgent, ground, hospital-to-hospital transfers Blue Cross NC does not require prior authorization; however, a post-service notification and medical necessity review are required.
- Although the review is completed post-service for urgent hospital-to-hospital transfers, the appeal timeframe will be [60 days], as that is the medical appeal timeframe notated in the NABD letter. This service does not fall under the typical PSCCR process and appeal timeframe.

**Newborn Authorizations**

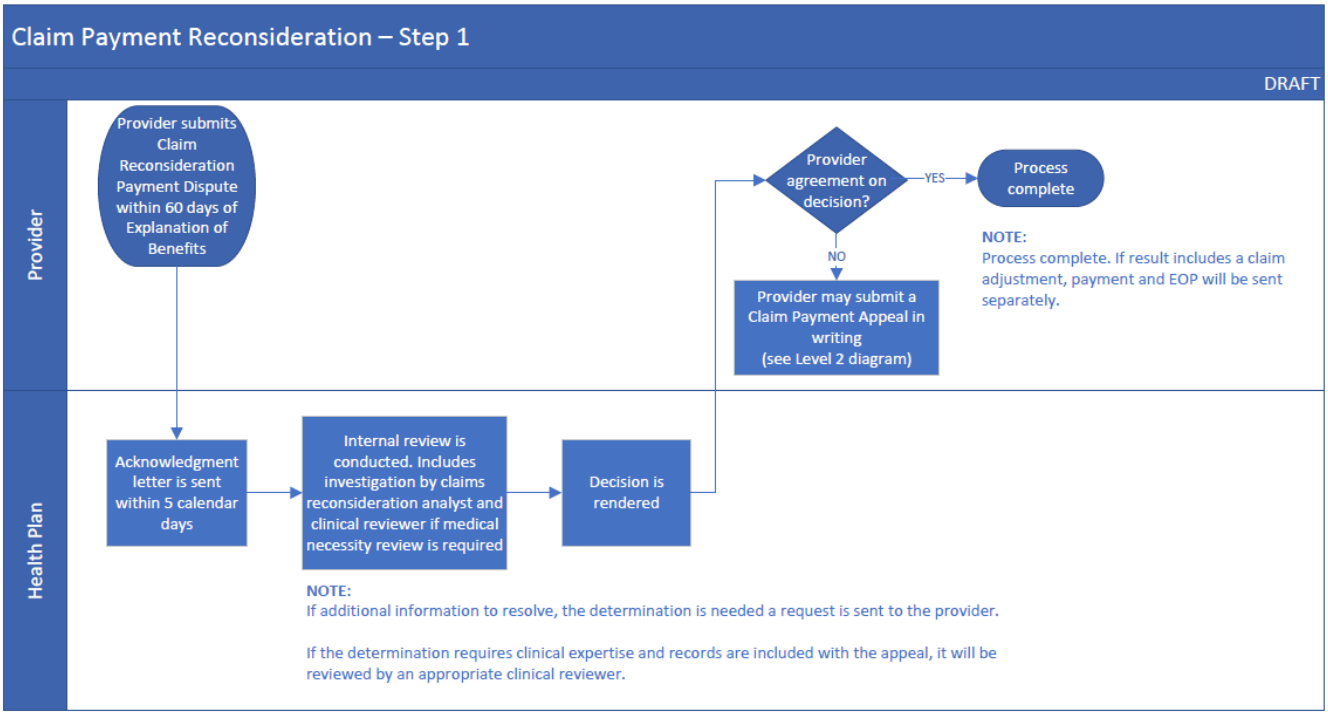
If the newborn's mother is insured under Blue Cross NC, the provider should, within [one (1)] business day of the newborn's birth, notify Blue Cross NC of the baby's birth and request a prior authorization if the newborn will need to be admitted to the neonatal intensive care unit (NICU). **Note:** Blue Cross NC will create a temporary ID for the newborn.

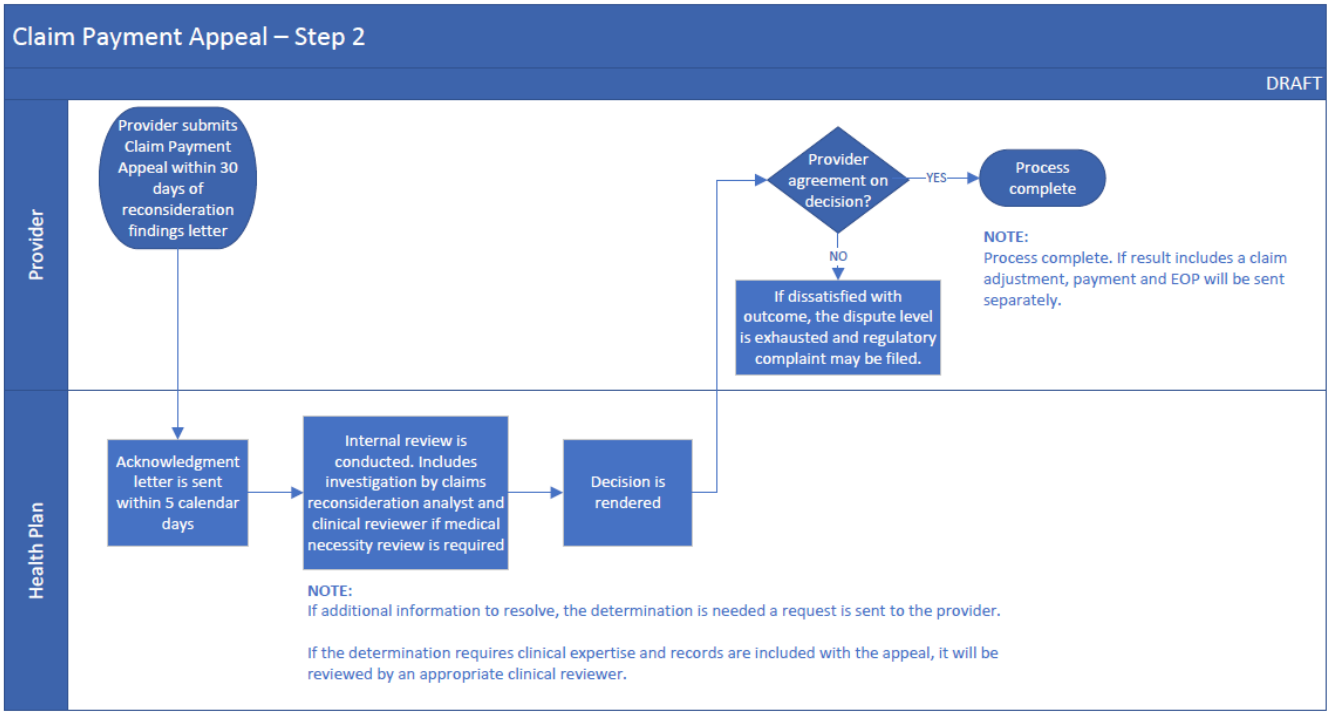
**Retro Authorization Due to Retro Eligibility**

Providers can submit the claim with a letter and copies of clinicals for review. Specify in the letter that notification was not submitted due to retro eligibility, and they are requesting a medical necessity review.

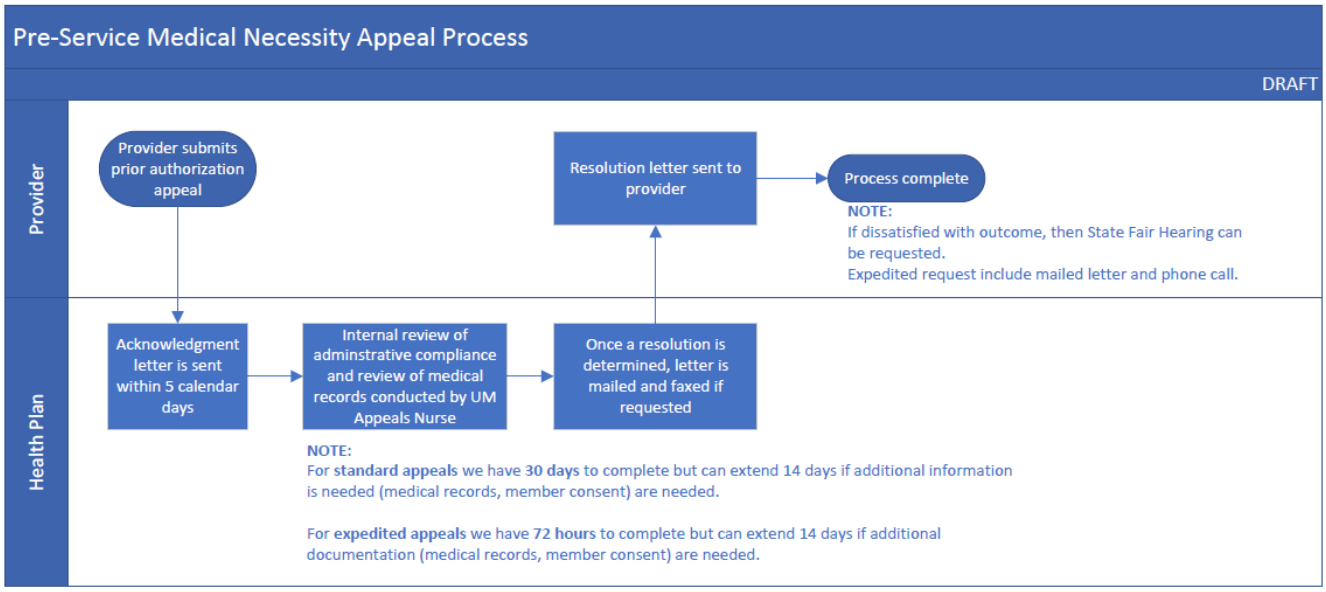
# Appeals and Disputes Workflows

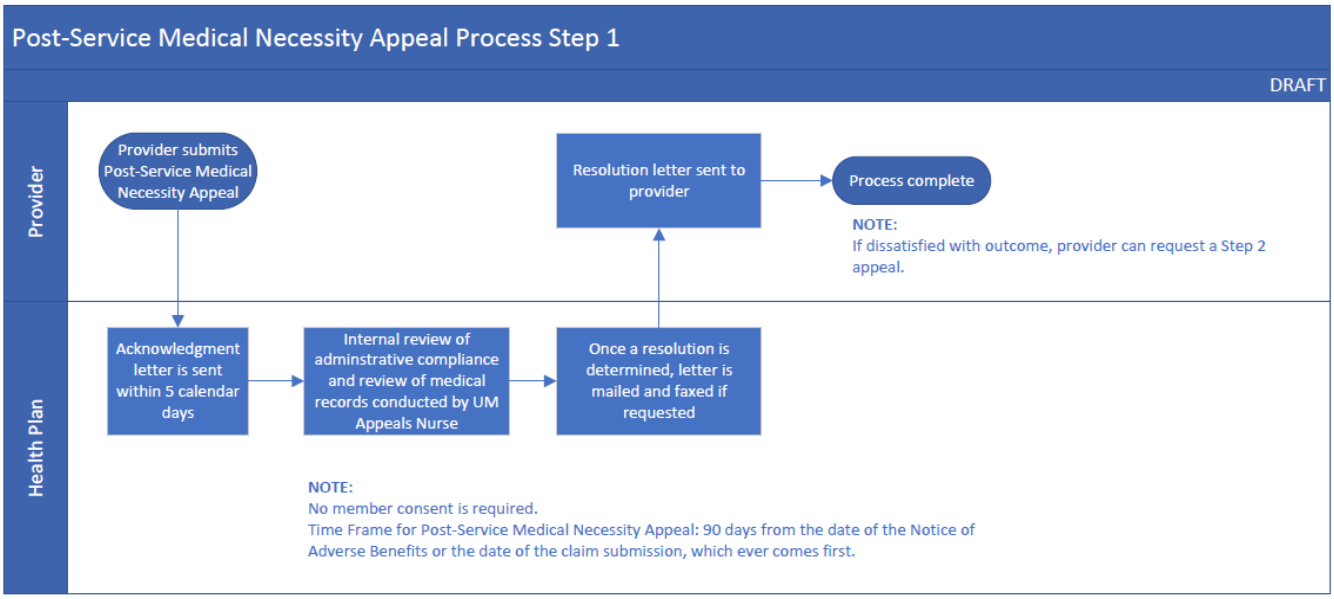
## Appendix A: Claim Payment Reconsiderations

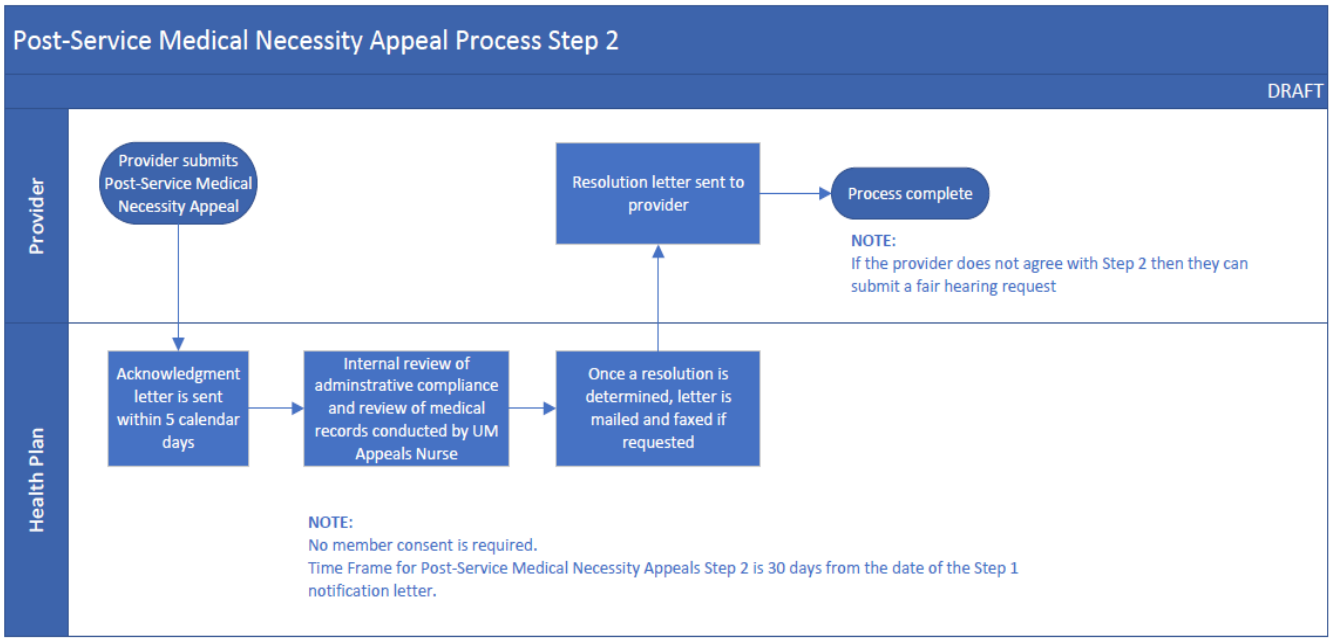


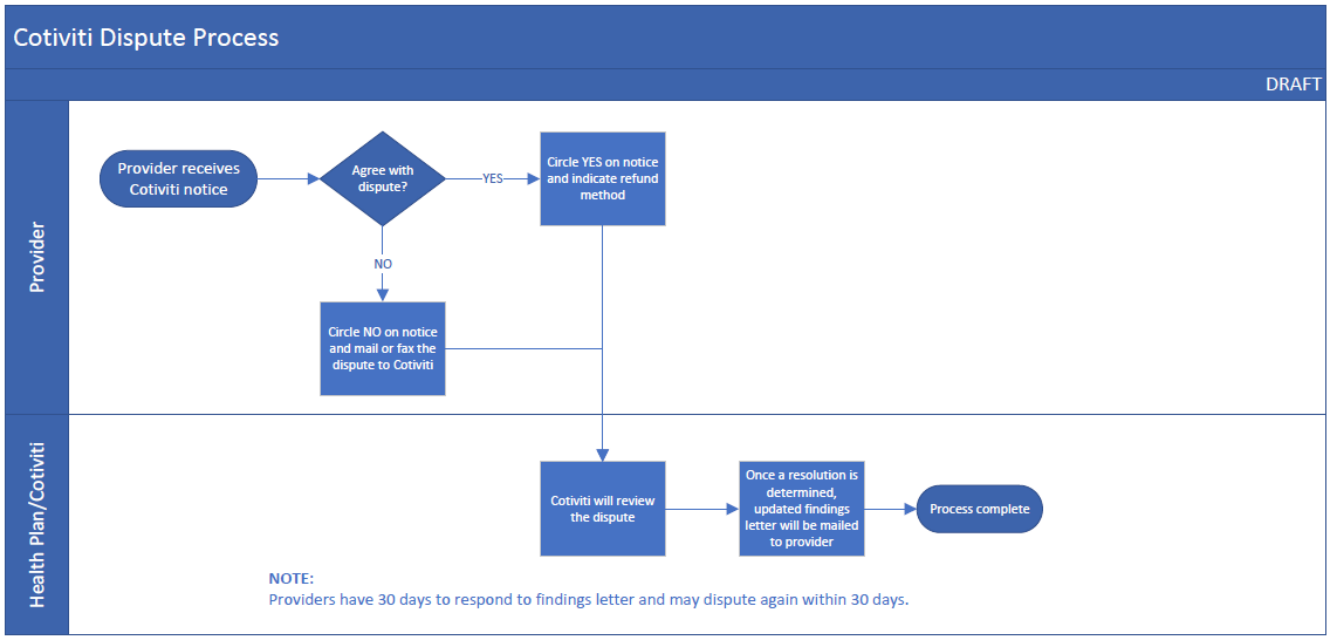
## Appendix B: Medical Necessity Appeals



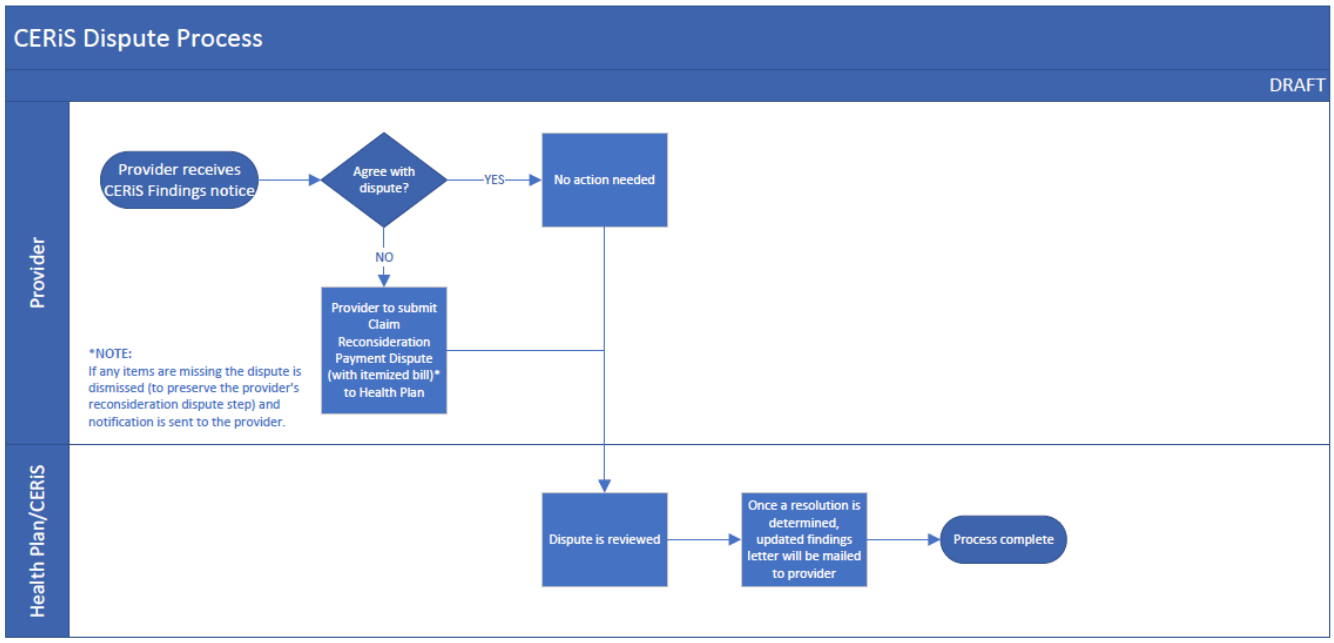






## Appendix C: Cotiviti Disputes




## Appendix D: CERIS Disputes


CERiS Dispute Process
DRAFT
Provider
Health Plan/CERiS
Provider receives CERiS Findings notice
Agree with dispute?
YES
No action needed
NO
Provider to submit Claim Reconsideration Payment Dispute (with itemized bill)* to Health Plan
*NOTE:
If any items are missing the dispute is dismissed (to preserve the provider's reconsideration dispute step) and notification is sent to the provider.
Dispute is reviewed
Once a resolution is determined, updated findings letter will be mailed to provider
Process complete