Claim and Clinical Reconsideration Request Reference Guide

If you receive a clinical claim denial, you can submit a reconsideration request for a full medical necessity review. This reference guide explains the submission process of a claim reconsideration request form, as well as the information required.

The Claim/Clinical Reconsideration Request Submission Process

Please complete a claim reconsideration request form with your information. You can find the form at:

- UHCCommunityPlan.com > Health Care Professionals > Iowa > Provider Forms > Claim Reconsideration Form.

Once you've completed your form, please send it to:

- Online: You can submit your form using the claimsLink app on Link. To access claimsLink, sign in to Link by clicking on the Link button in the top right corner of UHCprovider.com.
- Mail: send with your claim and your supporting documentation to:
  UnitedHealthcare Community Plan
  Attn: Claims
  P.O. Box 5220
  Kingston, NY 12402-5220

To find out more about the reconsideration process, please see your Care Provider Administrative Guide at UHCCommunityPlan.com > For Health Professionals > Iowa > Provider Manual.

Required Documents for Claim/Clinical Reconsideration Requests

When submitting a reconsideration request, please include supporting documentation. Below are 10 types of requests and the information required for each type.

1. The claim was previously denied/closed for "No Authorization on File" or "Does Not Meet Medical Necessity."

Please include the following on the first page of the request:

- Patient name
- Patient's address
- Patient member
- Member ID number

Doc#: PCA-1-007750-08282017_09272017

- Provider name and address
- Reference and/or claim number

Please attach the following medical necessity documentation:

- Medical Records
- Lab Reports
- Radiology Reports
- Any other pertinent medical necessity documents

2. The claim was previously denied/closed as "Exceeds Timely Filing."

Timely Filing refers to the time limit for filing claims, which may be specified in your network contract or state mandate. Benefit plans decide the timely filing limits for non-participating care providers. When timely filing denials are upheld, it's usually due to incomplete or invalid documentation submitted with the claim reconsideration request**.**

To submit a reconsideration request after this denial, please include the following:

Submission requirements for electronic claims:

- Submit an electronic data interchange (EDI) acceptance report that shows UnitedHealthcare or one of its affiliates received, accepted and/or acknowledged the claim submission within the timely filing period.
- A submission report alone isn't considered proof of timely filing for electronic claims. You must also include an acceptance report.

Submission requirements for paper claims:

- Submit a screen shot from your accounting software that shows the date the claim was submitted. The screen shot must show the:
  - Correct patient name
  - Correct date of service
  - Submission date within the timely filing period

3. The claim was previously denied/closed for "Additional Information."

Please attach a copy of all information requested and include the following information on the first page of the request:

- Patient name
- Patient's address
- Patient member ID number
- Provider name and address
- Reference number

Include whatever additional information has been requested. Examples include:

- Medical notes
- Anesthesia time units
- Current Procedural Technology (CPT)or Healthcare Common Procedure Coding System (HCPCS)codes (missing, illegible, or deleted)
- Date of service

- Description of service
- Diagnosis code where the primary code is missing ,illegible or is the wrong number of digits
- Physician name
- Patient name
- Place of service (POS) code
- Care provider's Tax Identification Number (TIN)
- Semi-private room rate

4. The claim was previously denied/closed for Coordination of Benefits information.

When an employer or individual claim has been denied for this reason, please include the below information on your reconsideration form:

- **Primary Payer Paid Amount:** Include the primary paid amount for each service line on the 835 Electronic Remittance Advice (835) or EOB. Include the paid amount on institutional claims at the claim level.
- **Adjustment Group Code:** Include the other payer claim adjustment group code found on the 835 or the EOB. Common reasons for the other payer paying less than billed include deductible, co-insurance, copayment, contractual obligations and/or non-covered services.
- **Adjustment Reason Code:** Include the other payer claim adjustment reason code on the 835 or the EOB. Common reasons for the other payer paying less than billed include: deductible, co-insurance, copayment, contractual obligations and/or non-covered services.
- **Adjustment Amount:** Include the other payer adjustment monetary amount.
- **Preference:** Submit professional claims at the line level as allowed by the primary payer. Institutional claims should be submitted at the claims or line level. The service level and claim level should be balanced. UnitedHealthcare follows 837pHealth Care Claim Encounter – Professional (837p)and 837i Health Care Claim Encounter -Institutional (837i) guidelines.

When a Medicare claim has been denied for this reason, please include the below information on your reconsideration form:

- **Adjustment Group Code:** Include the other payer claim adjustment group code on the 835 or the EOB. At the claim level, do not enter any amounts included at the line level. Common reasons for the other payer paying less than billed include deductible, co-insurance, copayment, contractual obligations and/or non-covered services.
- **Adjustment Reason Code:** Include the other payer claim adjustment reason code on the 835 or the EOB. At the claim level, do not enter any amounts included at the line level. Common reasons for the other payer paying less than billed include deductible, co-insurance, copayment, contractual obligations and/or non-covered services.
- **Adjustment Amount:** Include the other payer adjustment amount.
- **Medicare Paid Amount:** Include the other payer claim level and line level paid amounts when UnitedHealthcare is the secondary payer to Medicare.
- **Medicare Approved Amount:** Include the other payer claim level and line level allowed amounts when UnitedHealthcare is the secondary payer to Medicare.
- **Patient Responsibility Amount:** Include the patient’s responsibility amount from the 835 or the Medicare EOB.
- **Medicare Acceptance of Assignment:** Indicate whether the provider accepts the Medicare assignment.
- **Preference:** Submit professional claims at the line level if the primary payer provides the information, and submit institutional claims at either the line or claim level. The service level and claim level should be balanced. UnitedHealthcare follows 837pand 837i guidelines.

Benefits are not coordinated for Medicaid Primary, so Medicaid claims will not be denied for this reason.

5. The request is a resubmission of a corrected claim.

Health Care Financing Administration (HCFA): Corrected claims should be resubmitted in their entirety to meet Health Insurance Portability and Accountability Act (HIPAA) requirements. To do so, please follow these guidelines:

- Make any necessary changes in your practice management system, so the corrections will print on the amended claim. You may not write on the claim itself.
- Attach the entire corrected claim, including line items that were paid correctly. Partial requests will be denied. Enter the words "Corrected Claim" in the comments field on the claim form. If your practice management system help desk or your software vendor doesn't offer this feature, stamp or write "Corrected Claim" on the CMS 1500 form.
- The care provider and patient must be present on the claim, or all charges for that day will be required for reconsideration.
- After completing the reconsideration form, mark the box on Line 4 for Corrected Claims.
- In the Comments section, list the specific changes made and rationale or other supporting information you think would be helpful.

UB04: UB Type of Bill should be used to identify the type of bill submitted:

- XX5 Late Charges
- XX7 Corrected Claim
- XX8 Void/Cancel previous claim

6. The claim was previously processed with an incorrect rate, resulting in over/underpayment.

To resubmit, indicate the contract amount expected for the code or case rate, compared to the amount you received. Please also include any other factors related to the over or underpayment.

7. The claim was denied for "Prior Notification/Prior Authorization Information."

To resubmit, include a prior authorization number and other documents that support your request. If you spoke to a customer service representative and were told that notification was not required, please include the date, time and reference number of that call and the name of the representative you spoke to. Please also let us know if notification was not possible because the service was performed on an emergency basis.

8. The request is a resubmission of a bundled claim.

Review your claim for appropriate code billing, including modifiers. If the claim needs to be corrected, please submit a corrected claim. If a bundled claim is not paid correctly, submit a detailed explanation of why the bundling is incorrect.

9. The request is for a revised DRG / Cost Outlier payment due to MedReview determination. (Effective Sept. 1, 2015)

If you received a revised DRG/cost outlier payment from MedReview, you can submit a Challenge of initial determination to the address below. Your MedReview Determination Letter will include the instructions for Challenge Submission.

DRG Claims
Appeals Department at MedReview
Attention: Michele Smith
199 Water Street, 27th Floor
New York, NY 10038

Cost Outlier Claims
Appeals Department at MedReview Inc.
Attention: Mildred Lecoin
199 Water Street, 27th Floor
New York, NY 10038

If you don't agree with MedReview's Challenge Determination, you can file a claim reconsideration request with UnitedHealthcare Community Plan.

- For a claim reconsideration for a Medicaid member, visit UHCCommunityPlan.com > For Health Care Professionals > Iowa > Provider Forms > Claim Reconsideration Form.
- For more information, refer to your Provider Manual or call Provider Services at 888-650-3462.

10. You have another type of claim reconsideration request.

If your claim denial does not fall into one of the above categories, submit your request form with any additional supporting information.

Find Out More

You can find additional information on the reconsideration process or formal claims dispute rights in your Care Provider Administrative Guide. Please visit UHCCommunityPlan.com > For Health Care Professionals > Iowa > Provider Manual.

If we can answer any questions for you, please call Provider Services at 888-650-3462.