

Virginia long-term services and supports claim payment disputes quick reference guide

Virginia | HealthKeepers, Inc. | Anthem HealthKeepers Plus Medicaid products

This quick reference guide (QRG) outlines the steps to resolve Virginia long-term services and supports (LTSS) claim payment disputes.

Quick support contacts:

- <https://anthem.com/va/provider> > Resources
- Payment Appeal application at <https://www.Availity.com>
- **800-901-0020**
- Payment Appeals Unit: P.O. Box 65199, Virginia Beach, VA 23466-1599
- Virginia Department of Medical Assistance Services (DMAS) Appeals Division:
600 E. Broad St., Richmond, VA 23219

Claim payment dispute process overview

If you disagree with the outcome of a claim, you may begin the Anthem HealthKeepers Plus provider payment dispute process. A claim payment dispute occurs when the claim is finalized, but you disagree with the outcome. You will not be penalized for filing a claim payment dispute, and no action is required by the member.

What is not a claim payment dispute?

Claim inquiry: A question about a claim, but not a request to change a claim payment.

Claims correspondence: When we request more information to finalize a claim, such as medical records, itemized bills, or other insurance information.

Medical necessity appeals: A pre-service appeal for a denied service; for these, a claim has not yet been submitted.

Four-step escalation path

1. Claim payment reconsideration (one allowed per claim).
2. Claim payment appeal (one allowed).
3. Virginia LTSS PRN review if still dissatisfied.
4. Regulatory appeal through Virginia Department of Medical Assistance Services (DMAS) after the first three steps are exhausted.

Step	Stage	What it means
One	Claim payment reconsideration	Initial request for investigation into the outcome of a finalized claim. Most issues are resolved here. Only one reconsideration is allowed per claim.
Two	Claim payment appeal	Additional review if you disagree with the reconsideration outcome. Only one claim payment appeal is allowed.
Three	Provider relations network (Virginia LTSS PRN)	If you remain dissatisfied with the appeal decision, contact Virginia LTSS PRN for a review.
Four	Regulatory appeal	Virginia Department of Medical Assistance Services (DMAS) supports an external review process if you have exhausted all three steps in our payment dispute process but still disagree with the outcome.

A claim payment dispute may be submitted for multiple reasons, including:

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.

- Timely filing issues.*

*We will consider reimbursement of a claim denied for failure to meet the timely filing requirements if you can: 1) provide documentation that the claim was submitted within the timely filing requirements, or 2) demonstrate good cause exists.

Claim payment reconsideration

The first step in our claim payment dispute process is the reconsideration. It is your initial request to investigate the outcome of a finalized claim.

Please note that we cannot process a reconsideration without a finalized claim on file.

Reconsideration requests are accepted in writing, verbally, and through the secure provider website within 365 calendar days from the date on the EOP. Reconsiderations filed more than 365 days from the EOP will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, include as much detail as possible to explain why you believe the claim was not paid as expected. If clinical expertise is required, the appropriate clinical professionals will review it.

If you believe a finalized claim was processed incorrectly, begin with the claim payment reconsideration process.

Reconsideration timeline

We will make every effort to resolve the reconsideration within 30 calendar days of receipt. If additional information is needed, the determination date may be extended by 30 calendar days. A written extension letter will be mailed before the initial 30-day period expires.

The reconsideration determination letter will include:

- A statement of the provider's reconsideration request.
- A statement of what action HealthKeepers, Inc. intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.
- An explanation of the provider's right to request a claim payment appeal within 15 months of the date of service or 180 calendar days of the date you are notified of the reconsideration decision.
- An address to submit the claim payment appeal.

If the decision results in a claim adjustment, the payment and EOP will be sent separately.

Claim payment appeal

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal.

Please note that we cannot process a claim payment appeal without a reconsideration on file.

Claim payment appeals are accepted through the provider website or in writing within 15 months of the date of service, or 180 calendar days of the date you are notified of the reconsideration decision.

Claim payment appeals received more than 15 months from the date of service or 180 calendar days from the reconsideration decision notice will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, include as much information as possible to explain why you believe the reconsideration determination was incorrect. If clinical expertise is required, the appeal will be reviewed by our appropriate clinical professionals.

Appeal timeframe

We will make every effort to resolve the claim payment appeal within 60 calendar days of receipt. If additional information is required, the determination date may be extended by 60 calendar days. A written extension letter will be mailed before the initial 60-day period expires.

The appeal determination letter will include:

- A statement of the provider's claim payment appeal request.
- A statement of what action HealthKeepers, Inc. intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.

If the decision results in a claim adjustment, the payment and EOP will be sent separately.

How to submit a claim payment dispute	
Submission method	Instructions
Verbally (reconsiderations only)	Call Provider Services at 800-901-0020 .
Online (reconsiderations and appeals)	Use the secure Payment Appeal application at https://www.Availity.com . Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgment. You do not need to attach a Claim Information/Adjustment Request 151 Form for Medicaid Claims or a claim payment appeal form when using Availity Essentials.
Written (reconsiderations and appeals)	Mail all required documentation, including the Claim Information/Adjustment Request 151 Form for Medicaid Claims, to: HealthKeepers, Inc. Payment Appeals Unit, P.O. Box 61599, Virginia Beach, VA 23466-1599.

Submit reconsiderations on the Claim Information/Adjustment Request 151 Form for Medicaid Claims.

Claim Information/Adjustment Request 151 Form for Medicaid Claims access information:

1. Go to <https://www.anthem.com/provider/individual-commercial/forms-and-guides>.
2. Select **Virginia**.
3. Select **Claims & Appeals**.
4. Search for Claim Information Adjustment Request 151 Form for Medicaid Claims.

Submit written claim payment appeals via a written letter.

Required documentation for claim payment disputes:

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and their Anthem HealthKeepers Plus or Cardinal Care Medicaid ID number
- A listing of disputed claims, including the Anthem HealthKeepers Plus claim number and date(s) of service
- All supporting statements and documentation

How to submit an email to Virginia LTSS Health Care Networks for claim payment dispute upheld review:

If you are dissatisfied with the outcome of a claim payment dispute determination, you may submit an email to Virginia LTSS Health Care Networks for review. **Please note that a reconsideration and a claim payment dispute must be on file.**

For nursing facility providers: VALTSSNFSupport@anthem.com

For LTSS providers, including but not limited to personal providers, service facilitators, hospice providers, environmental modifications, and adult day healthcare providers: VALTSSPR@anthem.com.

Virginia LTSS provider relations specialist and regions they support:

[VA_CCC_RegionalSupportTeams.pdf](#)

For doula providers: anthemdoulasupport@anthem.com

Include an Excel spreadsheet with the following headers:

Column A: Date inquiry submitted	Column B: Facility/provider name
Column C: NPI	Column D: TIN
Column E: Member name	Column F: Member ID
Column G: Claim number	Column H: Date of service
Column I: Billed charges	Column J: Paid amount
Column K: Expected payment amount	Column L: Type of claim issue
Column M: Provider comments	Column N: HealthKeepers, Inc. comments
Column O: Reconsideration number	Column P: Claim payment appeal number

State appeal

If the claim appeal is not wholly in the provider's favor, or a provider receives a reduced payment through the appeal process, the provider has exhausted appeal rights with HealthKeepers, Inc.

The final denial letter will state that the provider has exhausted appeal rights with HealthKeepers, Inc. and that the next level of appeal is with the Virginia Department of Medical Assistance Services (DMAS). It will also include the standard DMAS appeal rights, including the time period and address to file the appeal.

The appeal to DMAS is considered the final appeal.

Before appealing to DMAS, providers must first exhaust all appeal processes through HealthKeepers, Inc.

All DMAS provider appeals must be submitted in writing within 30 days of the second-level/resolution letter from HealthKeepers, Inc.

The state appeal must be submitted to Virginia Department of Medical Assistance Services (DMAS) Appeals Division, 600 E. Broad St., Richmond, VA 23219.

Note: Normal business hours for DMAS are 8 a.m. to 5 p.m.; if the appeal is submitted on the deadline day after 5 p.m., it will be considered untimely.

Claim inquiries

A question about a claim or claim payment is called an inquiry. Inquiries do not change claim payments, but the outcome of the inquiry may initiate the claim payment dispute process.

Once you receive the answer to your claim inquiry, you may choose to begin the claim payment dispute process.

The Provider Experience program helps with claim inquiries. Call **800-901-0020** and select the Claims prompt within the voice portal. You will be connected to a dedicated Provider Service Unit (PSU) that will provide the following:

- Availability of helpful, knowledgeable representatives to assist you.
- Increase first-contact issue resolution rates.
- Significantly improve the turnaround time of inquiry resolution.
- Increase outreach communication to keep you informed of inquiry status.
- Help determine the appropriate process to follow for resolving your claim issue.

Claim correspondence

Claim correspondence is different from a payment dispute. Correspondence occurs when we require more information to finalize a claim.

Typically, we request this information through the EOP. The claim or part of the claim may be denied temporarily because additional information is needed to process the claim. Once we receive the information, we will use it to finalize the claim.

Type of issue	What do I need to do?
Rejected claim(s)	Use the EDI Hotline at 800-590-5745 if your claim was submitted electronically but was not processed, rejected, or has not been paid. The hotline can assist with EDI enrollment and setup questions, claim submission issues, and troubleshooting electronic claim rejections.
EOP requests for supporting documentation (sterilization/hysterectomy/abortion consent forms, itemized bills, and invoices)	Submit a copy of your EOP and the supporting documentation to: Claims Correspondence, P.O. Box 61599, Virginia Beach, VA 23466-1599.
EOP requests for medical records	Submit a copy of your EOP and the medical records to: Claims Correspondence, P.O. Box 61599, Virginia Beach, VA 23466-1599.
Need to submit a corrected claim due to errors or changes in the original submission	Submit your corrected claim to Claims Correspondence, P.O. Box 61599, Virginia Beach, VA 23466-1599. Clearly identify the claim as a corrected claim. Handwritten changes or alterations to billing information will not be accepted. If the original claim was received within the required timely filing period, the corrected claim must be submitted within 365 days of the date of service. If a payment adjustment from the primary insurer requires updated Other Health Insurance (OHI) information, the timely filing period begins on the date of the most recent OHI Explanation of Benefits (EOB).
Submission of COB/TPL information	Submit a copy of your EOP and the COB/third-party liability (TPL) information to: Claims Correspondence, P.O. Box 61599, Virginia Beach, VA 23466-1599.

Type of issue	What do I need to do?
Emergency room payment review	Submit a copy of your EOP and the medical records to: Claims Correspondence, P.O. Box 61599, Virginia Beach, VA 23466-1599.

Medical necessity appeals

Medical necessity appeals are situations in which authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are different from claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

Corrected claims

A claim is considered a corrected claim when there are data changes to the original submission. If a paid/finalized claim was paid according to the information originally submitted and data changes are needed, the corrections must be submitted on the applicable claim form.

Corrected claims must be received within 12 months of the adjudication of the original claim/date of the EOP. Requests for claim corrections cannot be submitted on a 151 Claim Information/Adjustment Request Form.

Corrected claims may be submitted by mailing the proper claim form or by using the Provider website.

Corrected claim method	Instructions
Written corrected claims	Mail to: HealthKeepers, Inc., P.O. Box 62404, Virginia Beach, VA 23466-2404.
Electronic corrected claims	To file a corrected claim, non-EVV claim, go to https://Availity.com and select Claims & Payment/Professional Claim or Facility Claim . Fill in the required fields. Select Replacement of a prior claim in the Billing Frequency field under the Claim information section of the Availity Essentials web claim form.
EVV note	EVV 151 claim adjustment requests need to go through Netsmart.

- When submitted, a corrected claim must be indicated as corrected.
- On a CMS-1500, complete box 22 — Resubmission code.

- On a CMS-1450 (UB-04), complete box 4 — Bill type by including the number 7, identifying the claim as a replacement to the previous submission.
- Providers should stamp or handwrite on the claim Corrected or Corrected Claim to indicate a correction was made to a previously submitted and adjudicated claim.
- For more information contact Provider Services at **800-901-0020**.

Claims overpayment recovery process

Refund notifications may be identified by two entities: The HealthKeepers, Inc. Cost Containment Unit (CCU) or the provider.

The CCU researches and notifies the provider of an overpayment and requests a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once we identify the overpayment, CCU will notify the provider. The provider may either submit a Refund Notification Form with the refund check or have the overpayment offset from future claim payments.

If a provider identifies the overpayment or returns a HealthKeepers, Inc. check, a completed Refund Notification Form specifying the reason for the return must be included. Claim information must be submitted with this form.

The Overpayment Refund Notification Form is available on the provider website at <https://anthem.com/va/provider> > Resources > Forms > Claims & Billing. Submission of the form helps CCU process and reconcile the overpayment in a timely manner.

If an Overpayment Refund Notification Form is unavailable, the provider may submit the refund check along with a letter.

The refund letter should include:

- Provider name/contact
- Contact number
- Provider ID
- Provider Tax ID
- Subscriber ID
- Member name
- Member account number
- Date of service
- Total billed charges
- Total check amount

- Claim number(s)
- Reason for refund or check return
- Received an overpayment notification letter
- Contract rate change
- Duplicate payment
- Incorrect member
- Incorrect provider
- Negative balance
- Other health insurance (OHI)/TPL
- Payment error
- Billed in error adjusted charge
- Other reason

When we must adjust previously paid claims to adhere to a new published rate, it will initiate a reconciliation of affected claims and determine the cumulative adjusted reimbursement amount based on the new rates.

If the result of this reconciliation is a net amount owed to HealthKeepers, Inc., recovery will begin through an offset against future claim payments.

These recoveries are not considered part of the overpayment recovery process described above or in the Provider Agreement.

For questions regarding the refund notification procedure, call **800-450-8753** and select the appropriate prompt.

Changes addressing overpayments have taken place with the passage of the Patient Protection and Affordable Care Act (PPACA), commonly known as the Affordable Care Act.

Cost containment overpayment disputes

The cost containment overpayment dispute process applies when we identify an overpayment or initiate a recoupment, and the provider disagrees with the overpayment determination.

We may identify the overpayments, or they may be self-identified by the provider. This process is separate from claim payment disputes.

Where to submit an overpayment dispute	Details
Mail	Cost Containment — Disputes, P.O. Box 62427, Virginia Beach, VA 23466-2437
CCU Inquiry	844-410-689 (CCU project/CCU dispute)
Fax	866-920-1874
Refund address if the provider agrees with the overpayment	Cost Containment, P.O. Box 933657, Atlanta, GA 31193-3657

Timeframes — what this means for you.

- Processing time for overpayment disputes is approximately 30 days from receipt.
- Federal law requires providers to report and return overpayments within 60 days of identification.
- Failure to comply may result in recoupment and potential penalties under the False Claims Act.