Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Provider Bulletin
November 2022

Provider manual excerpt — claim payment disputes

Below is an excerpt from the *Anthem HealthKeepers Plus Provider Manual* for your review. We appreciate your dedication to understanding the claims payment dispute process.

If you have any questions about this communication, call Anthem HealthKeepers Plus Provider Services at **800-901-0020**.

Claim Payment Disputes

Provider Claim Payment Dispute Process

If you disagree with the outcome of a claim, you may begin the Anthem HealthKeepers Plus provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized, but you disagree with the outcome.

Please be aware there are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we've defined them briefly here:

- Claim inquiry: a question about a claim but not a request to change a claim payment
- Claims correspondence: when HealthKeepers, Inc. requests further information to finalize a claim; typically includes medical records, itemized bills or information about other insurance a member may have
- Medical necessity appeals: a pre-service appeal for a denied service; for these, a claim has not yet been submitted

For more information on each of these, please refer to the appropriate section in this provider manual.

The Anthem HealthKeepers Plus provider payment dispute process consists of two internal steps and a third external step. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member.

1. **Claim payment reconsideration:** This is the first step in the Anthem HealthKeepers Plus provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step. Providers are only allowed **one** claim payment reconsideration per claim. If the provider disagrees with the outcome of the reconsideration, the provider should follow the process for claim payment appeal.
2. **Claim payment appeal:** This is the second step in the Anthem HealthKeepers Plus provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal. Providers are only allowed **one** claim payment appeal. If the provider disagrees with the outcome of the appeal, the provider can submit an appeal to the Department of Medical Assistance Services (DMAS).

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3. **Regulatory appeal:** DMAS supports an external review process if you have exhausted both steps in the Anthem HealthKeepers Plus payment dispute process but still disagree with the outcome.

A claim payment dispute may be submitted for multiple reason(s), 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 that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Claim Payment Reconsideration

The first step in the Anthem HealthKeepers Plus claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our secure provider website within 365 calendar days from the date on the *EOP* (see below for further details on how to submit). Reconsiderations filed more than 365 days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, the appropriate clinical Anthem HealthKeepers Plus professionals will review it.

HealthKeepers, Inc. requires providers to use our claims payment reconsideration process if you feel a claim was not processed correctly.

HealthKeepers, Inc. will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which 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, we cannot process a claim payment appeal without a reconsideration on file.**

We accept claim payment appeals through our 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 of the date of service or 180 calendar days of the date you are notified of the reconsideration decision will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate Anthem HealthKeepers Plus clinical professionals.

HealthKeepers, Inc. will make every effort to resolve the claim payment appeal within 60 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 60 additional calendar days. We will mail you a written extension letter before the expiration of the initial 60 calendar days.

We will send you our decision in a determination letter, which 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

We have several options to file a claim payment dispute:

- Verbally (for reconsiderations only): Call Provider Services at **1-800-901-0020**.
- Online (for reconsiderations and claim payment appeals): Use the secure Provider Availity Payment Appeal Tool at **availity.com**. Through Availity Essentials, you can upload supporting documentation and will receive immediate acknowledgement of your submission. 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 (for reconsiderations and claim payment appeals): Mail all required documentation (see below for more details), 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.* The *Claim Information/Adjustment Request 151 Form for Medicaid Claims* can be found on **www.anthem.com**. From the menu at the top of the page, select **Providers** and then select **Provider Overview**. Select the **Find Resources for Your State** button and select **Virginia**. Select **Answers@Anthem** (top menu), and pick **Provider Forms**. From this page, you can select the ***Claim Information/Adjustment Request 151 Form for Medicaid Claims***.

Submit written claim payment appeals via a written letter.

Required Documentation for Claims Payment Disputes

HealthKeepers, Inc. requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

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

State Appeal

If the claim payment appeal is denied, or a provider receives reduced reimbursement through the appeal process, he or she has exhausted the appeal rights. The final denial letter will state that the provider has exhausted HealthKeepers, Inc. appeal rights and that the next level of appeal is with the 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 third and 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:

DMAS Appeals Division
600 E. Broad St.
Richmond, VA 23219

Note: DMAS normal business hours 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 result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience program helps you with claim inquiries. Just call **800-901-0020** and select the *Claims* prompt within our voice portal. We will connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim Correspondence

Claim correspondence is different from a payment dispute. Correspondence is when HealthKeepers, Inc. requires more information to finalize a claim. Typically, HealthKeepers, Inc. makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, HealthKeepers, Inc. will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
Rejected Claim(s)	Use the EDI Hotline at **800-590-5745** when your claim was submitted electronically but was never paid or was rejected. We're available to assist you with setup questions and help resolve submission issues or electronic claims 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 on Original Submission	Submit your corrected claim to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to HealthKeepers, Inc. to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOB*.
Submission of Coordination of Benefits (COB)/Third-Party Liability (TPL) Information	Submit a copy of your *EOP* and the COB/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
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 refer to a situation in which an authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are different than 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 there is a need to modify a paid/finalized claim that was paid according to the information originally submitted, 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 claims corrections cannot be submitted on a *151 Claim Information/Adjustment Request* form.

Corrected claims may be submitted by mailing the proper claim form or on the provider website.

Written Corrected Claims

Mail written corrected claims to:

HealthKeepers, Inc.
P.O. Box 62404
Virginia Beach, VA 23466-2404

Electronic Corrected Claims

To file a corrected claim, go **availity.com** and:

1) Select **Claims & Payment/Professional Claim or Facility Claim**.
2) Fill in required fields (for details on claims inquiry, search "submitting claims" within Availity Help).
3) Select **Replacement of a prior claim** in the *Billing Frequency* field under the *Claim information* section of the Availity Essentials web claim form.

Note: When submitted, a corrected claim form must be indicated as such. On a *CMS-1500,* box 22 — Resubmission code and on a *CMS-1450* (*UB04),* box 4 — Bill type must be completed 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 (or the provider may physically stamp a claim as being a corrected claim).

For additional assistance, call Anthem HealthKeepers Plus Provider Services at **800-901-0020** Monday through Friday from 8 a.m. to 6 p.m. ET.

If you have any questions about this communication, call Anthem HealthKeepers Plus Provider Services at **800-901-0020**.