Sentara® Health Plans

Overview of the Appeal, Reconsideration, and Contestment Processes

Table of Contents

Purpose of the Guide

This guide is designed to give providers a high-level overview of the appeal, reconsideration, and contestment processes to successfully conduct business with Sentara Health Plans.

Note: The Sentara Health Plans **Provider Manual**—a more extensive resource—is your trusted source for the health plan's policies and procedures.

General Information and Filing Requirements – Rendering and/or Billing Provider

The preferred method for claim submission to Sentara Health Plans is electronic claim submission. Claims can be submitted through Availity or any clearinghouse that can connect through Availity.

All claims must be submitted within the guidelines of the product (see the timely filing section in the provider manual), or they will be denied as a late claim submission.

Claims submitted must be for participating providers within the practice. Submit paper claims on the standard CMS 1500 form for professional providers or UB-04 form for facilities. All claims must be "clean claims."

To process a claim, Sentara Health Plans requires a valid W-9 for the provider's tax identification number (TIN) on file with Sentara Health Plans. Claims submitted without a W-9 may be administratively denied by Sentara Health Plans. Sentara Health Plans may require that any claim submitted without a valid W-9 on file be resubmitted to be processed.

All claims submitted to Sentara Health Plans must include individual and group practice national provider identifier (NPI) numbers and taxonomy codes. Claims received without an NPI number and taxonomy code will be rejected or denied.

Appeal Process Overview

What is an Appeal?

An appeal is a formal request to reconsider and change a previous adverse decision on a prior authorization request. This process occurs before a claim is submitted for payment.

Authorization Denied

- Occurs before a claim is submitted for payment.

Submit Appeal Request

- Member or appointed representative (includes provider) submit pre-service appeal within appropriate timeframe and using acceptable methods based on the line of business.
- Indicate "Expedited Appeal" on form when criteria is met.

Case Review

- All necessary documentation must be available.

Decision

- Standard OR expedited within three days.

Written Notice

- Member and authorized representative notified.
- Standard and expedited.
- Process complete.

TOC

Appeals Submission Methods and Timelines Overview

Government guidelines vary and timelines will vary based on the line of business (product)

Commercial

- File within 180 days of denial
- Submit by Fax, mail or email
- Decision timelines:
  - Standard appeals resolve within 30 calendar days of receipt
  - Expedited appeals resolve within 72 hours of receipt
  - Cancer related pain medication resolve within 24 hours

Medicare

- Within 65 days from the date on the Adverse Benefit Letter
- Submit by fax, mail, hand delivery, email, call Medicare member services, call Medicare Appeals and Grievances department
- Decision timelines:
  - Standard appeals resolve within 30 calendar days
  - Part B appeals resolve within 7 business days
  - Expedited resolve within 72 hours

Medicaid

- File within 60 days from the date on the Adverse Benefit Letter (member's consent required)
- Submit by fax, mail, hand delivery, email, or call Medicaid member services
  - Acknowledgment within 5 calendar days of submission for standard appeals
  - Decision timelines:
    - Standard appeals resolve within 30 calendar days
    - Expedited appeals resolve within 72 hours

Please view the procedure for details about FAMIS and State Fair Hearing and External Reviews.

For more information about the appeals procedure for commercial, Medicare and Medicaid, please visit the **website**.

How to Submit Your Appeal

Commercial

Fax: 1-877-240-4212

Mail:
Sentara Health Plans Commercial Appeals and Grievances
PO Box 66189
Virginia Beach, VA 23466

Email: commappeals@sentara.com

Medicare

Fax: 1-800-289-4970

Mail:
Sentara Medicare Appeals and Grievances
PO Box 62876
Virginia Beach, VA 23466

Hand Delivery:
1300 Sentara Park
Virginia Beach, VA 23464

Email: medicareappeals@sentara.com

Phone Support:

- **Medicare Member Services Phone: 1-800-927-6048**
- **Medicare Appeals and Grievances Department Phone: 1-855-813-0349**

Medicaid

Fax: 1-866-472-3920

Mail:
Sentara Medicaid Appeals and Grievances
P.O. Box 62876
Virginia Beach, VA 23466

Email: memberappeals@sentara.com

Hand Delivery:
1300 Sentara Park
Virginia Beach, VA 23464

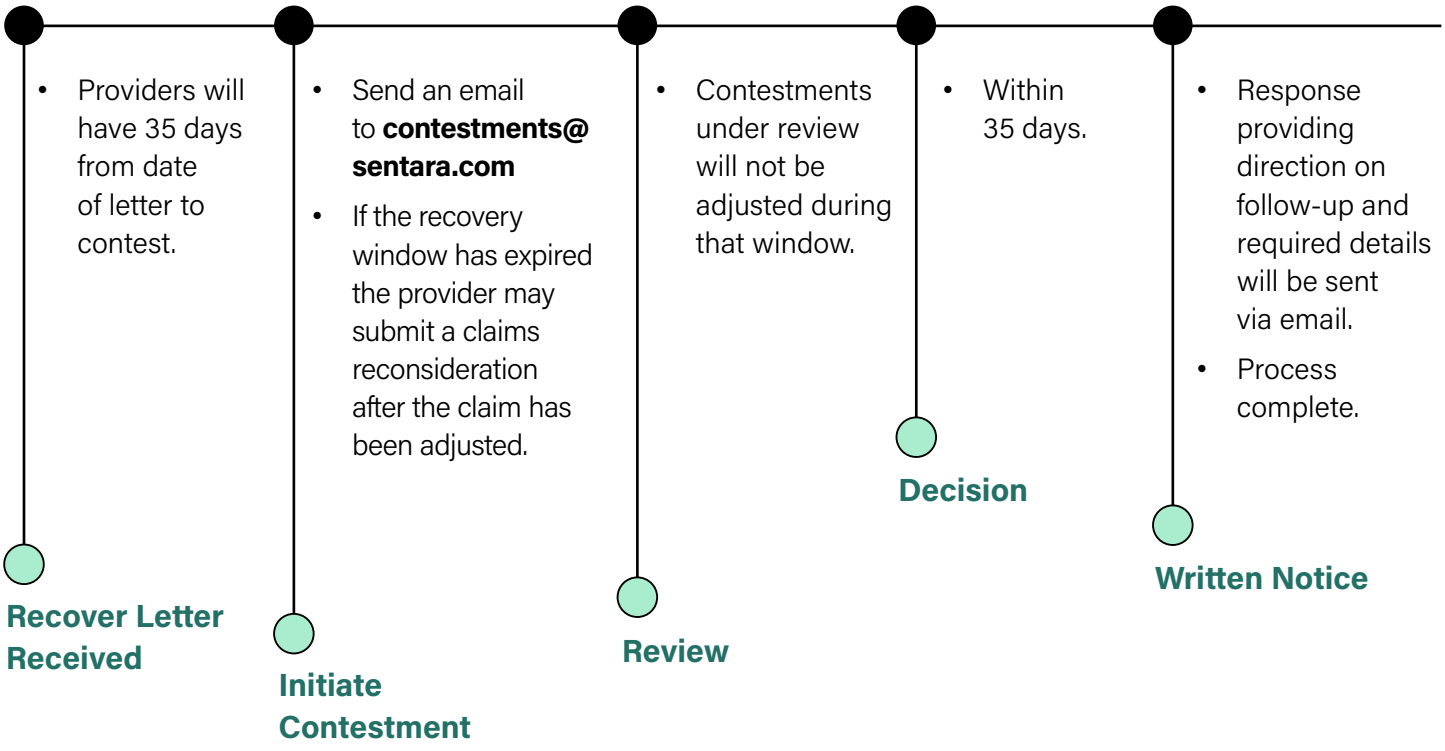
Phone: 1-844-434-2916

Contestment Process Overview

What is Contestment?

An industry term that refers to a dispute with supporting evidence that the health plan's claim recovery effort is erroneous. Contestment must occur prior to a claim adjustment.

Contestment Process



Corrected Claim Submission of a Previously Billed Claim

A corrected claim is a replacement of a previously submitted claim that requires changes or correction to the charges, clinical or procedures codes, dates of service, member information etc.

Corrected Claim Submission of a Previously Billed Claim UB-04 Claims

- Bill type is a key indicator to determine whether a claim has been previously submitted and processed.
- The first digit of the bill type indicates the type of facility.
- The second digit indicates the type of care provided.
- The third digit indicates the frequency of the bill.
- Billing type is important for interim billing or a replacement/resubmission bill.
- "Resubmission" should be indicated in block 80 or any other unoccupied block of the UB-04.

Corrected Claim Submission of a Previously Billed CMS-1500 Claims

- Claims submitted for correction require a "7" in box 22.
- Claims that need to be voided require an "8" in box 22.
- Enter the original claim number of the claim you are replacing in the right side of item 22.

Reconsideration Process Overview

What is a Reconsideration?

A claim reconsideration is defined as a written dispute for further consideration when a claim does not process as expected (paid or denied). Applies to an original, unmodified claim.

Reconsideration Process Overview

Claim does not process as expected

Applies to original, unmodified claim.

Identify correct form

Provider Reconsideration Form – medical claims

Behavioral Health Provider Reconsideration Form – behavioral health claims

Waiver of Liability Form – Medicare non-contracted providers (cannot bill member for denied services)

Submit

Follow submissions instructions on the top of the form

- Within 365 days of last DOS not applicable to Medicare non-contracted providers.
- Within 65 days
  - Claim denial date
  - Medicare non-contracted providers

Missing or incomplete information may result in the original decision being upheld

Response

Within 60 days

TOC

Claim Reconsideration Tiered Review Process - Filing Deadline

- **First-Level Reconsideration:** Must be submitted within 365 days from the last date of service. Reconsiderations are reviewed by the Sentara claims review team.
- **Second-Level Reconsideration:** Must be submitted within 60 days of the first-level claim reconsideration determination. Reconsiderations are reviewed by an alternate team member from the first level submission.
    - If the original claim decision is to be overturned, the claim will be reprocessed and updated remittance will be the notification to the provider that item processed with updated determination.
    - If the original decision stands, the provider will receive an uphold letter indicating reason(s) why and next steps to have claim further reconsidered.
    - Each subsequent submission has a 60-day follow-up period from the last remittance/ decision letter date when submitting a follow-up reconsideration.
        - Additional escalations must continue to be submitted using the **Provider Reconsideration Form or the Behavioral Health Provider Reconsideration Form**, noting the level of escalation (i.e., first or second level reconsideration).
        - After a second level reconsideration submission has been upheld, all reconsideration rights at Sentara Health Plans will be considered exhausted.
        - **Medicaid providers** have the right to submit an appeal to the Department of Medical Assistance Services (DMAS) for further review. Steps to complete this process will be listed in the uphold letter submitted to the provider.
- **Medicare Non-Contracted Providers:**
    - Must submit a reconsideration within 60 days of the claim denial date.
    - A signed Waiver of Liability Form is required. By signing, you agree to not bill the member for denied services.
    - *Note: Medicare non-contracted providers are only eligible for one level of reconsideration.*
- **Sentara Health Plans Response Time:** You will receive a response within 65 days of receipt of reconsideration. All providers are encouraged to contact provider services at **1-800-229-8822**, option 2, if a disputed claim is not responded to within 65 days of submission.

Claim Reconsideration Forms

- **Provider Reconsideration Form - For medical and behavioral health claims**
- **Waiver of Liability Statement**

Claims Mailing Addresses

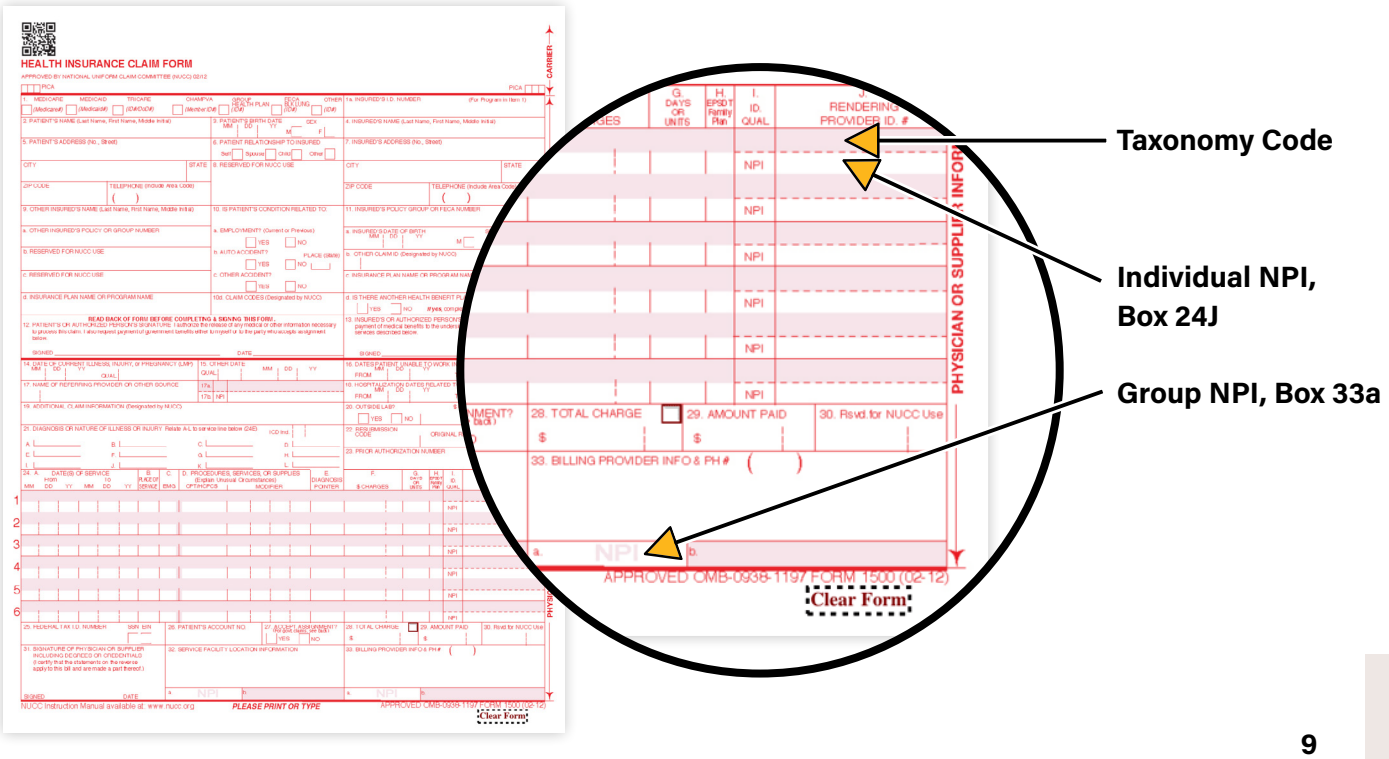
Mail Paper Claims, Corrected Paper Claims, and Reconsiderations

Medical Claims
P.O. Box 8203
Kingston, NY 12402-8203

Behavioral Health Claims:
P.O. Box 8204
Kingston, NY 12402-8204

Avoiding Common Claim Submission Errors

1. Correct member name: The patient's name on the claim must match the patient's name as listed on the member ID card.
2. Correct date of birth.
3. Member ID number, including:
   - Member suffix: member number on claim must contain the correct two-digit suffix that identifies the patient
   - Complete member ID number
   - No asterisk or spaces
4. Providers offering multiple services and multiple provider setups must bill the appropriate NPI/ tax ID on the claim to eliminate assignment logic delays.
5. Rendering/Individual NPI should be listed in box 24J, "Rendering Provider ID #," in the bottom unshaded portion of the box labeled "NPI."
6. Taxonomy code should be listed in the top shaded portion of box 24J. Claims submitted without the correct taxonomy code will be rejected or denied.
7. Billing/Group NPI should be listed in box 33a, "Billing Provider Info & PH #."
8. Services requiring pre-authorization can be found on **sentarahealthplans.com/providers**. If unsure, contact provider services at **757-552-7474** or **1-800-229-8822**.
9. Coordination of Benefits, Sentara Health Plans as secondary carrier. Claims must be submitted with Explanations of Benefits (EOBs) attached and the identical information included on the original claim.
   - Providers may not bill one insurance carrier for one charge amount and Sentara Health Plans for a different charge amount.
   - If a claim is filed for a member whose primary insurance is not Sentara Health Plans, the provider must submit an EOB for the claims within 18 months of the date of service.
10. Nonpar provider. After the Coordination of Care period, providers must secure a dually executed contract to participate with Sentara Health Plans and service Sentara Health Plans members. For more information on joining the network, please visit our website.
11. Please note: Timely filing deadline on all claims is 365 days from the date of service. This includes any corrections, reconsiderations, and/or appeals.



TOC

When and How to Follow-up

Appeals: If a decision has not been communicated within the promised timeframe, contact the appeals team using the email or phone number listed on the form.

Reconsiderations: If a decision has not been communicated within the stated timeframe, please contact provider customer service at **1-800-229-8822**.

Close the Communication Loop

Departments such as Appeals and Grievances and Utlization Management rely on good contact information to communicate with you regarding approvals, denials, and requests for additional documentation. To better ensure we can close the communication loop, we have two simple, but important solutions:

1. Submit your requests using the correct appeal or reconsiderations form to ensure we have the address for which you want to receive correspondence. When we do not receive a form, we will select the address that we have on record.

2. Update your information annually, or more often, if necessary, to ensure that the address on record is correct. Having outdated contact information on record may result in delayed or missing correspondence. If you need to make changes to your information, please use the **Provider Update Form** to submit your updates.

Helpful Resources and Links

- Provider Services: **1-800-229-8822**
- Network Educator: **contactmyrep@sentara.com**
- **Authorization Forms**
- **Claim Reconsideration Form**
- **Frequent Service Contact**

Glossary

Appeal - An appeal is a formal request to reconsider and change a previous adverse decision on a prior authorization request.

Corrected claim – A 're-billed" or "corrected claim" is a claim being resubmitted by the provider to correct or change a previous submission for the same patient, date of service, and/or procedures.

Electronic claim – An electronic claim is any medical claim created entirely via digital means, without any paper or printing, usually within medical software that includes a medical practice management system (PMS).

Electronic funds transfer (EFT) - An electronic funds transfer is the electronic transfer of money between people, banks, and companies.

Reconsideration - A claim reconsideration is defined as a written dispute for further consideration when a claim does not process as expected (paid or denied). Applies to an original, unmodified claim.

Timely filing – Timely filing is the time frame within which healthcare providers or medical billing companies should submit claims to insurance companies for reimbursement. Sentara Health Plans policy: All claims are to be submitted within one year, 365 days of the date of service. This includes first-time submission claims and claims that have been previously paid or denied (reconsideration). Sentara Health Plans allows 18 months from the date of service to coordinate benefits.