HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

Claim Reconsideration Requests Quick Reference Guide

A Claim Reconsideration request is typically the quickest way to address any concern you have with how we processed your claim. With a Claim Reconsideration request, we review whether a claim was paid correctly and confirm your contract is set up correctly in our system. Please allow 30 days from the received date of the claims reconsideration for review.

This reference tool provides instruction regarding the submission of a Claim Reconsideration Request and details the supporting information required for claim reconsiderations or to correct claims, and explains those processes.

There are several ways to submit a Claim Reconsideration Request.

1. **Paper:** Provide a description of the documentation being submitted along with all pertinent documentation. It is extremely important to include the Member Name and Member ID number as well as the provider name, address and TIN on the Claim Reconsideration form to prevent processing delays. Please use the Claim Reconsideration Request form to submit your request.

   This form can be downloaded from:

   www.myhpnonline.com or www.myshlonline.com

   Where to send Claim Reconsideration Requests:

   Health Plan of Nevada/Sierra Health and Life
   Attn: Claims Research
   PO Box 15645
   Las Vegas, NV 89114-5645

2. **Phone:** You can call Member Services to request an adjustment for a claim that does not require written documentation. For HPN members please call (702) 242-7300 or (800) 777-1840 and for SHL members please call (702) 242-7700 or (800) 888-2264.

3. **Claims Project:** If you have a request involving 20 or more paid or denied claims, please provide us with the following information in an Excel Spreadsheet. The project may be sent via secure email to pri@sierrahealth.com. An Excel template is also available for download on www.myhpnonline.com or www.myshlonline.com.

   At a minimum, please include the following information:

   i. Member First and Last Name
   ii. Member Date of Birth
   iii. Member ID Number
   iv. Claim Number
   v. Date of Service
   vi. Line of Business
   vii. Explanation of Underpayment and expected outcome

Please allow 30 days from date of receipt for all claim reconsiderations.

Claims Reconsideration Requests

Previously denied as "Exceeds Timely Filing"

Timely filing is the time limit for filing claims, which is specified in the network contract, a state mandate or a benefit plan. For a non-network provider, the benefit plan would decide the timely filing limits. When timely filing denials are upheld, it is usually due to incomplete or invalid documentation submitted with Claim Reconsideration Requests**.**

Submission requirements for electronic claims:

- Submit an electronic data interchange (EDI) acceptance report. This must show that Health Plan of Nevada, Sierra Health and Life or one of our affiliates received, accepted and/or acknowledged the claim submission.
- A submission report alone is not considered proof of timely filing for electronic claims. It must be accompanied by an acceptance report.
- The acceptance report must indicate the claim was either "accepted," "received" and/or "acknowledged" within the timely filing period.

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 member name
  - Correct date of service
  - Submission date of claim that is within the timely filing period

Previously denied 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 member ID number
- Provider name and address

Add the additional information requested. Examples include:

- Medical notes/records
- 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
- Provider's Tax Identification Number (TIN)
- Semi-private room rate
- Accident information

Previously denied for Coordination of Benefits information

Commercial Coordination of Benefits claim requirements

- Please attach the prime carriers Explanation of Benefits for proper claim adjudication

Medicaid Primary Coordination of Benefits Claims Requirements (Medicaid is the final payer in all coordination of benefits scenarios.)

Resubmission of a corrected claim

Consistent with Health Insurance Portability and Accountability Act (HIPAA) requirements, submit corrected claims in their entirety.

If a claim needs correction, please follow these guidelines:

- Make the necessary changes in your practice management system, so the corrections print on the amended claim.
- Attach the corrected claim (even line items that were previously paid correctly). Any partially- corrected request will be denied. Enter the words, "Corrected Claim" in the comments field on the claim form. Your practice management system help desk or your software vendor can provide specific instructions on where to enter this information in your system. If you do not have this feature, stamp or write "Corrected Claim" on the CMS 1500 form. Changes must be made in your practice management system and then printed on the claim form. You may not write on the claim itself.
- The resubmitted claim is compared to the original claim and all charges for that date of service. The provider and patient must be present on the claim, or we will send a letter advising that all charges for that day are required for reconsideration.
- Complete the reconsideration form as instructed and mark the box on Line 4 for Corrected Claims.
- Continue to the comments section and list the specific changes made and rationale or other supporting information.

Previously processed but rate applied incorrectly resulting in over/underpayment:

Network Providers - Please check your fee schedules prior to submitting a claim reconsideration request for this reason. Indicate the contract amount expected by code or case rate, compared to the amount received, as well as other factors related to the over- or under-payment. If you disagree with the fee schedule your claim was paid by, contact your Provider Relations advocate. You can reach the HPN/SHL Provider Advocates by calling (702) 242-7088 or (800)745-7065

Resubmission of "Prior Notification/Prior Authorization Information

Submit a prior authorization or referral number and other documents that support your request. Please also advise if the service was performed on an emergency basis and therefore notification was not possible.

Resubmission of a claim with bundled services

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 including any pertinent information on why the bundling is incorrect.

Carve Out

Provide detailed information on why claim was adjudicated incorrectly.

Other

Provide any additional information that supports your request.