Provider claims payment disputes

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This article serves as a reminder to Anthem HealthKeepers Plus providers about policies and procedures regarding claims payment disputes. The following information is included in the *Anthem HealthKeepers Plus Provider Manual* found at https://mediproviders.anthem.com/va **>** Manuals, Directories, Training & More > Anthem HealthKeepers Plus Manuals, Directories, Training & Resources.

Provider reconsiderations (first-level appeals)

For questions regarding the outcome of a claim not related to additional authorized days or services, providers may request a reconsideration by calling Provider Services or submitting a *Claim Information/Adjustment Request 151 Form*. Examples of reconsiderations include claim processing errors or responses to additional information requested. HealthKeepers, Inc. will respond to all reconsideration requests within 60 calendar days.

- Reconsiderations will not be considered if received 12 or more months after the date of the claim adjudication or the *EOP*. There is no limit to the number of reconsiderations that can be submitted for the same claim within the 12-month period prior to submitting a formal (second-level) appeal; however, once a formal appeal is submitted, no additional reconsiderations can be submitted for that claim.

- Requests to review a finalized claim denied as not medically necessary or experimental/investigational must be submitted as a medical necessity appeal to be considered.

- Requests to review a finalized claim that may require additional authorized days or services must be submitted as a claims payment appeal (see below).

- Adjustments made to finalized claims must be submitted as corrected claims (see below).

Verbal reconsiderations

To submit a verbal reconsideration, call Provider Services at **1-800-901-0020** or Anthem CCC Plus Provider Services at **1-855-323-4687**, Monday to Friday, 8 a.m. to 6 p.m. ET.

Written reconsiderations

To submit a written reconsideration, use a blank *Claim Information/Adjustment Request 151 Form*, available online at https://mediproviders.anthem.com/va **>** Claims > Forms.

Once the form is complete, attach any necessary information and mail it to:

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

Electronic reconsiderations

To submit an electronic reconsideration, go to https://www.availity.com and:

- Select **Claims & Payment/Claims Status Inquiry**.
- Fill in the required fields — for details on claims inquiry, search claim inquiry within *Availity Help* — and navigate to the *Claims Detail* page.
- Go to the bottom of the claims detail and select **Request an appeal for this claim/Dispute the Claim**.
- Select **I Agree**.

If submitted within one year from the date of the *EOP*, the submission will be treated as a reconsideration. The provider can attach a *Claim Information/Adjustment Request 151 Form*, but it is not required. If the submission is within one year of the date of the *EOP* and the provider wishes for HealthKeepers, Inc. to treat the submission as an official appeal, the provider should indicate in the text box provided that the submission should be treated as an appeal and not a reconsideration.

For additional assistance, call Provider Services at **1-800-901-0020** or Anthem CCC Plus Provider Services at **1-855-323-4687**, Monday to Friday, 8 a.m. to 6 p.m. ET.

Claims payment appeals (second-level appeals)

A claims payment appeal may be requested when:

- A provider disagrees with the determination of a reconsideration.
- A provider is requesting additional days or services to be authorized for a paid claim.

An appeal request must be received within 15 months of the date of service or 180 calendar days of the date a provider is notified of the adverse coverage decision, whichever is later. A claims payment appeal must be submitted in writing or through the Availity Portal.

Written appeals

All claims payment appeals submitted in writing must clearly state that the provider is formally appealing the adverse decision. In order to ensure it is treated as a formal appeal, the provider must indicate that the appeal should not be treated as a reconsideration. Mail written appeal requests to:

HealthKeepers, Inc.
Payment Appeals Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

Electronic appeals

To submit an electronic appeal, go to https://www.availity.com and:

- Select **Claims & Payment/Claims Status Inquiry**.
- Fill in the required fields — for details on claims inquiry, search *claim inquiry* within *Availity Help* — and navigate to the *Claims Detail* page.
- Go to the bottom of the claims detail and select **Request an appeal for this claim/Dispute the Claim**.
- Select **I Agree**.

For additional assistance, call Provider Services at **1-800-901-0020** or Anthem CCC Plus Provider Services at **1-855-323-4687**, Monday to Friday, 8 a.m. to 6 p.m. ET.

Process and resolution

HealthKeepers, Inc. will respond to all claims payment appeal requests within 60 calendar days. To ensure a timely and appropriate resolution of the appeal, HealthKeepers, Inc. recommends providers:

- Include the word **appeal** in bold in the request.
- Include, if available, the patient's name, identification number, date(s) of service, claim number(s) and case number with HealthKeepers, Inc.
- Include the specific reason(s) for the appeal; giving a generic reason for the appeal will make it difficult to respond timely and appropriately.
- Include all relevant information, such as medical records or other supporting documentation, regardless of whether it was considered at the time the initial decision was made.

If the claim appeal is denied or a provider receives reduced reimbursement through the appeal process, their appeal rights have been exhausted. 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 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-level appeal.

Before appealing to DMAS, providers must first exhaust all appeal processes with HealthKeepers, Inc. All DMAS provider appeals must be submitted in writing within 30 days of the first-level resolution letter from HealthKeepers, Inc. The second-level 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. ET; DMAS will consider the appeal untimely if it is submitted on the deadline day after 5 p.m.

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