CareCentrix℠

P R O V I D E R

N E W S F L A S H

January 2001

RE: Appeals Procedure Change

Effective: February 1, 2001

In an effort to process claims and claims appeals more efficiently, CareCentrix is centralizing the Appeals function to the National Claims Center. This change will be implemented effective February 1, 2001. Prior to February 1 claims appeals had been sent to the Provider Relations Departments at each Regional Care Center. Please follow-up with each PR Dept. for appeals submitted prior to February 1, 2001. The revised "Appealing a Denied Claim Process" is attached. **In order to help with the processing of appeals please follow the following procedures.**

1. Complete a CareCentrix Claim Appeal Form for each claim being appealed. (attached)
    - Clearly check the Appeal Level 1-3.
    - Check reason for appeal, i.e. Denial (Code-Description)
    - Make sure Provider and Patient information is complete and accurate.
2. Provide a copy of the Claim, EOP, and Service Authorization Form.
3. Provide additional attachments as appropriate.
4. Please print or type information for accurate interpretation for appeal.

If there is more than one claim attached to the appeal cover sheet, please indicate the number of claims on the form.

Submit Appeals by mail to:

CareCentrix

National Claims Center
Attention: Appeals Department
111 Founders Plaza, Suite # 801
East Hartford, CT 06108

APPEALING A DENIED CLAIM PROCESS

CHECKING REIMBURSEMENT STATUS

Questions regarding the status of claims should first be directed to the CareCentrix National Claims Center (NCC) Customer Service Dept. The NCC is open Monday through Friday between the hours of 9:00 a.m. and 5:00 p.m. Eastern Standard Time and can be reached at 800-411-2305 ext. 2321

Our goal is to pay our providers within forty-five (45) days of receipt of a properly completed claim. Please do not make status calls or payment inquiries until forty-five (45) days after you reasonably expect the claim to be received by the CareCentrix National Claims Center.

REIMBURSEMENT GRIEVANCE AND APPEALS PROCESS

If you receive a payment that is different than expected, you should call the National Claims Center for the claim in question. A claims examiner will research the claim and related payment and will either answer your question or will forward you to the appropriate claims manager. The Claims Manager will research your claim and question and respond to you as soon as possible.

Decisions made by CareCentrix regarding reimbursement may be appealed. You are entitled to have the senior management of CareCentrix re-examine a decision made by the Care Management, HME or the Claims Processing Departments of CareCentrix by using the process defined below.

You may submit an appeal form and summary explaining your appeal regarding the level of reimbursement for services rendered, along with the requested action, to the National Claims Center. **When other insurance companies and/or Third Party Administrators are involved in your appeal, the burden for research with these entities is on the provider of service. It is suggested that CareCentrix Providers mail formal appeals by certified, return-receipt mail.**

Appeal written summary to accompany the appeal form should include as necessary:

- The patient's name and address.
- The date(s) of service, which you are appealing.
- The type(s) of service(s) provided.
- The itemized dollar amount for each service you are appealing.
- A copy of the original claim, CareCentrix authorization and CareCentrix EOP.

First Level Appeal

The written appeal must be made within thirty (30) days of receipt of reimbursement for services and/or Explanation of Payment (EOP). Upon receipt of the written appeal / form and summary, the National Claims Center Appeals Dept. will review the details of the request for reimbursement and render a written decision to you within thirty (30) days of receipt of the appeal.

Second Level Appeal

Within fifteen (15) days of your receipt of the decision by the National Claims Center Appeals Dept., you may initiate a second appeal in writing to the National Claims Center. Upon receipt of this second level appeal, the NCC Manager will forward the second appeal to the CareCentrix Appeals Committee for review. The Committee will render a decision in writing to the provider within thirty (30) days of receipt of the second appeal.

Third Level Appeal

Within ten (10) days of your receipt of the decision by the Appeals Committee, you may initiate a third level appeal in writing to the National Claims Center. Upon receipt of this third level appeal, the NCC Manager will forward the third level appeal to CareCentrix Senior Management for review. CareCentrix Senior Management will render a written decision within ten (10) days of receipt of the appeal. All decisions made by CareCentrix Senior Management are final.

CareCentrix Providers may not bill a patient or that patient's insurance company (if the insurance company is a CareCentrix client) for a balance remaining after a decision has been made on a CareCentrix Provider appeal.

CARECENTRIX
CLAIM APPEAL FORM

Provider Information

(Provider Name)	(Date)
(Street Address: Billing Center)	(Contact Name)
(City) (State) (Zip)	(Provider Phone #)

Patient Information

(Patient Name)	(Patient #)	(Invoice #)
(Date of Service)		(Claim #)

Appeal Level Designation (place check in appropriate level)

Level I	Level II	Level III

(PLEASE CHECK REASON FOR APPEAL: DENIAL CODE-DESCRIPTION)

- ☐ 23: No authorization for service
- ☐ 13: Billed units exceed authorized units
- ☐ 24: Billed amount exceed authorized amount
- ☐ 12: Date of service outside authorized range
- ☐ 22: Duplicate, previously paid
- ☐ 3: Service and/or UOM on the claim are not recognized
- ☐ 32: Overlapping dates of service, previously paid
- ☐ 33: Provide us with documentation or medical necessity
- ☐ 34: Provide us with payment/denial from primary payer
- ☐ 14: Claim was not filed within the timely filing limits allotted time frame
- ☐ 5: Service has substituted and the provider is not allowed to substitute services
- ☐ 7: Required carrier authorization number is missing
- ☐ 1: Patient on claim could not be matched with an active CareCentrix Member
- ☐ 37: Total amount of provided units exceeds clinical limit
- ☐ Denial Reason not Provided on Explanation of Payment (EOP)
- ☐ Other: _____

PLEASE PROVIDE THE NECESSARY ATTACHMENTS:

____ Service Authorization/Electronic Transmission
____ CareCentrix Explanation of Payment (EOP)
____ Historical Transaction Register
____ Proof of Timely Filing
____ Other: _____

____ Claims 98 Print Screen(s)
____ Intake 98 Print Screen(s)
____ Copy of Claim (HCFA 1500)

DESCRIPTION:

Reviewed By: _____
Phone #: _____
Date Completed: _____