Timely Filing Protocols and The Reconsideration Process

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Health Partners Plans HPP

Timely Filing Deadlines

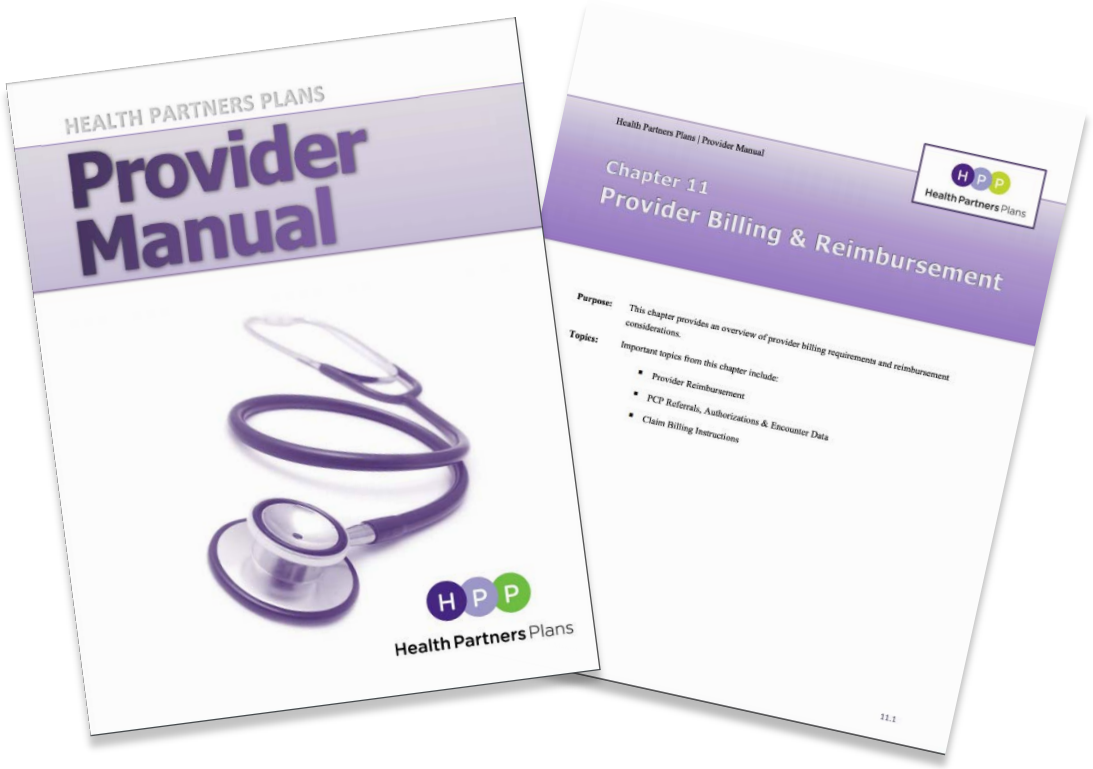
- Health Partners Plans (HPP) allows 180 calendar days from the date of service or discharge date to submit and have accepted a valid initial claim.

Claim Timely Filing Deadlines:

- **Initial Submissions:** 180-days from date of service or discharge date
- **Reconsiderations:** 180-days from the date of HPP's Explanation of Payment (EOP)
- **Coordination of Benefits:** 60-days from the date of other carriers EOP

Resources

- ✓ HPP Provider Manual 11.11
- ✓ Chapter 11 Provider Billing & Reimbursement



Timely Filing Protocols

A claim must be accepted as valid as proven by entry into the HPP claims processing system and assignment of a claim control number to be considered filed.

Timely Filing Protocols

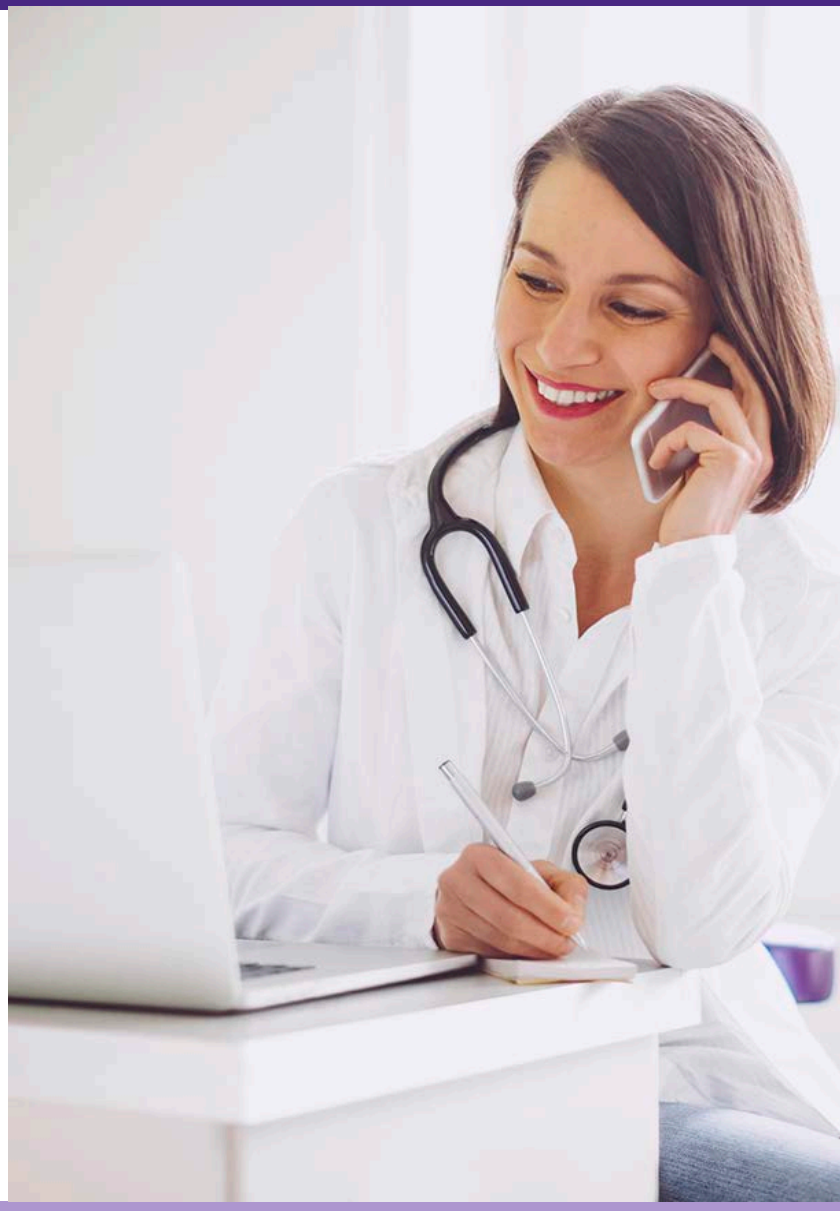
- Paper claim submissions that cannot be entered into the claim processing system because of an invalid member, provider or coding information are returned to the provider with a rejection notice (form letter or insert) explaining the reason for rejection.

Timely Filing Protocols

- Electronic claim submissions are rejected on electronic submission/error reports. The submission/error report(s) that a provider's office receives depends on the billing service and/or electronic interchange vendor used.

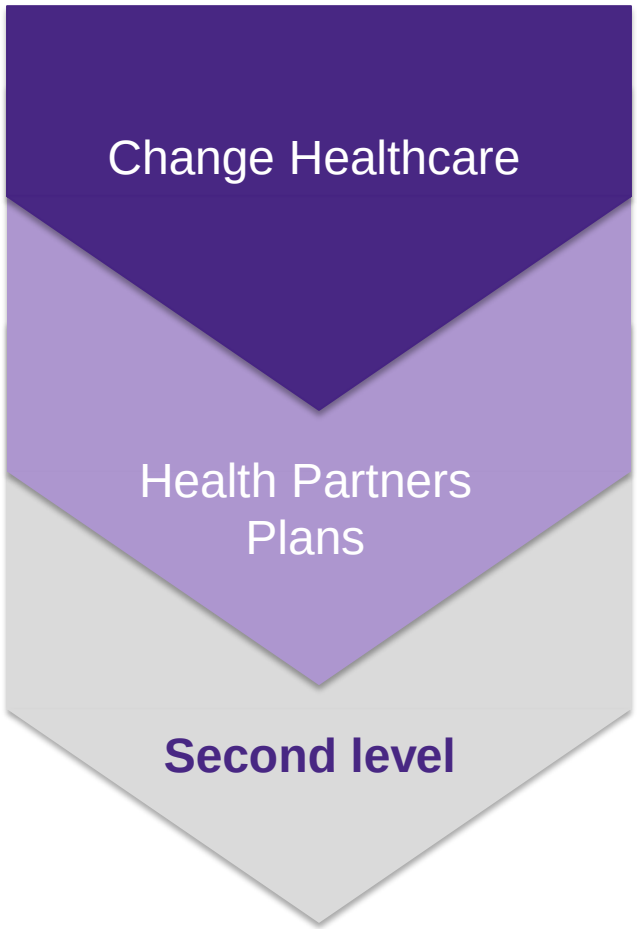
Timely Filing Protocols

- HPP uses Change Healthcare as the gateway for all electronic submissions for billing services and/or electronic interchange vendors.
- All claims are accepted through Change Healthcare and submitted to HPP, they have generated as well as a first-level rejection report of the claims not passing Change Healthcare edits.



Timely Filing Protocols

- Once Change Healthcare edits are passed, HPP's system edits for the member, provider and coding information and these edits generate a second level of acceptance and/or error reports.
- Providers should check with their billing service and/or electronic interchange vendor to fully understand how the HPP provides specific information.



Timely Filing Protocols

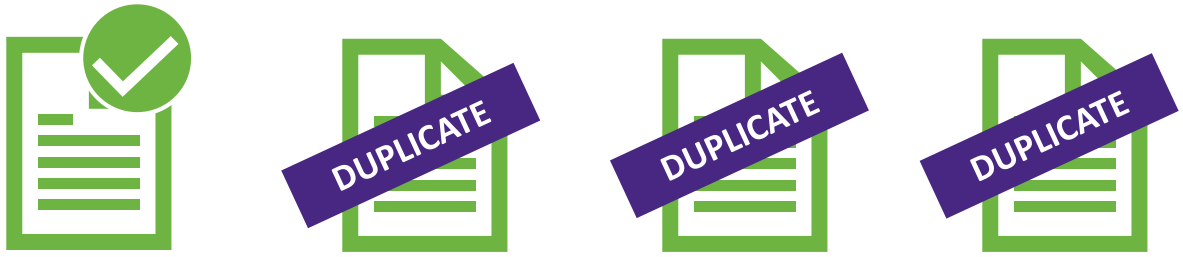
During the 180 calendar day initial filing period, a provider may resubmit a non-accepted (invalid or EDI rejected) claim as often as necessary to have it accepted. It is the provider's responsibility to ensure that their claims are accepted.

For your convenience, our Rapid Reconsideration program provides an easy way to request a claim reconsideration. Call to speak live with a claim reconsideration specialist who can reprocess a claim (or confirm a denial) while you're on the line.

Timely Filing Protocols

- Once an initial claim is accepted, any subsequent (repeat) filing, regardless if it is paper or electronic, will be denied as a duplicate filing. The initial claim, however, will be processed.

Please note: If the claim does not appear on an EOP within 45 calendar days of submission as paid, denied or as a duplicate of a claim already under review, and no rejection notice has been received, the provider must pursue the claim status to ensure it was accepted.



The Reconsideration Process

Claim Inquiries and Reconsiderations

- The procedures for inquiring about the status of claims or to request reconsideration of a payment decision are provided in the section below.

Claim Inquiries

- All telephonic claim inquiries are directed through Health Partners Plans at **215-991-4350**, or **888-991-9023**.
- Providers may verify the following over the telephone:
  - Claim status
  - Payment amount
  - Check date and number
  - Denial and denial reason
- **Providers can also check claim status via Health Partners Plans provider portal at www.navinet.net/.**

The Reconsideration Process

Appeals Process

A provider can request a reconsideration determination for a claim that a provider believes was paid incorrectly or denied inappropriately, whether the result of a provider billing error or an HPP processing error.

Providers have three options to request a reconsideration of a claim.

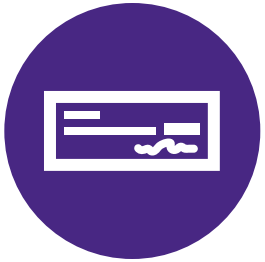
1. Telephone
2. Written Correspondence
3. Provider Portal

The Reconsideration Process

- A claim reconsideration request must be received within 180 calendar days from the date of the EOP advising of the adjudication decision.

- For your convenience, our Rapid Reconsideration program provides an easy way to request a claim reconsideration. Call to speak with a live claim reconsideration specialist who can reprocess a claim or confirm a denial while you're on the line.

The Reconsideration Process



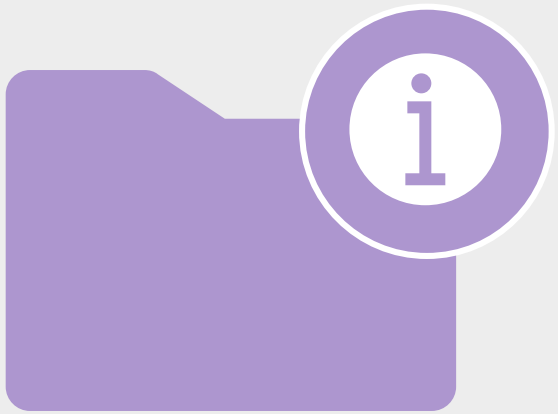
If the claim is approved for payment, a check will be processed and mailed during the next scheduled check run—in a maximum of eight days.

This service is available Monday to Friday, 8:30 a.m. to 4:30p.m., by calling **1-888-991-9023** or **215-991-4350**.

Please be sure to have the claim number or EOP ready when you contact the call center.

The Reconsideration Process

- ✓ Claim reconsideration requests should include a copy of the HPP EOP.
- ✓ Documentation supporting the assertion that the claim was paid incorrectly or why the denial should be overturned.



The Reconsideration Process

Other important points to remember:

- If the claim involves other insurance, information regarding the member's primary insurance coverage must be provided with a copy of the primary EOP/EOB.
- If the claim was denied for lack of authorization or services not matching the authorization; the provider must contact the appropriate utilization management area to address the authorization problem. Once resolved, submit a claim reconsideration request.

The Reconsideration Process

- If the claim was denied because the provider is non-participating, lacked authorization and the provider believes he or she is participating, there may be a problem with credentialing.

- HPP must be contacted, and this issue must be resolved before the claim can be reconsidered.

Please contact Health Partners Plans for assistance at **215-991-4350** or **1-888-991-9023** to verify provider information on file.

The Reconsideration Process

Claims that are denied because the requested authorization or level of care was not approved due to a medical necessity disagreement can be appealed for reconsideration.

Appeals for denials of Inpatient authorizations should be mailed to:

Health Partners Plans
Attn: Inpatient Provider Appeals
901 Market Street, Ste 500
Philadelphia, PA 19107

All other written requests for reconsiderations are directed through Claims Reconsideration Department/Recovery Department Services.

Reconsiderations of denials should be sent to:

Health Partners Plans
Attn: Claim Reconsideration
901 Market Street, Ste 500
Philadelphia, PA 19107

The Reconsideration Process

- The provider will be advised of the claim reconsideration outcome, generally within 30 calendar days of the date the written request was received by the Claim Services.

- Claims that are overturned and have payment issued will appear on the provider's EOP and no other notice will be provided. If the original denial is upheld, the provider will be sent a form letter advising of the right to dispute and appeal the outcome.

- Providers may also submit requests through the HP Connect provider portal.

To request assistance with access to HP Connect, providers may call Health Partners Plans at **1-888-991-9023** or **215-991-4350**.