COMMUNITY FIRST HEALTH PLANS

CLAIM APPEALS: QUICK REFERENCE GUIDE

Claim & Clinical Reconsideration Requests

If you receive a clinical claim denial, you may submit a reconsideration request for review.

This reference guide outlines the submission process and required documentation for consideration.

Submission Process

Complete the Claim Appeal Form. You can do this by mail or online.

- **Online:** The Claims Department Appeal Submission Form is located under the Office Management tab in the Provider Portal. Claim appeals can be submitted securely through the Provider Portal.

- **Mail:** Download/print the Claims Department Appeal Submission Form available at Medicaid.CommunityFirstHealthPlans.com/Resources/Claims. Send the completed form with your claim and supporting documentation to the address printed on the form and provided below.

Community First Health Plans
Attn: Claims Department
P.O. Box 240969
Apple Valley, MN 55124

Claim Appeal: Required Documentation

Documentation is required for claim appeal consideration. Please review the following claim denial scenarios and necessary supporting documentation for each.

SCENARIO #1: Claim denied/closed for "No Authorization on File" or "Does Not Meet Medical Necessity".

Please include the following on the first page of the request:

- Member ID number
- Provider name and address
- Date of service
- Reference and/or claim number
  - » Claim number must be the most recent claim number on the last EOP

Please attach the following medical necessity documentation:

- Medical records
- Lab reports
- Radiology reports
- Any other pertinent medical necessity documents

For delivery exceeding global stay/NICU claim appeals, submit prior authorization within 30 days of add date.

For claims for admissions when coverage is not identified within normal time requirements, submit retro eligibility prior authorization form showing ADD date of recipient, if applicable.

Please Note: Claims without prior authorization will not be considered unless written rationale stating extenuating circumstances with documented evidence is submitted.

SCENARIO #2: Claim denied/closed as "Exceeds Timely Filing".

Timely filing is the time limit for filing claims. Denials are usually due to incomplete or invalid documentation. Please include the following supporting documentation:

- **For electronic claims:** Submit an electronic data interchange (EDI) acceptance report that shows Community First accepted and/or acknowledged the claim submission within the timely filing period.

Please Note: A submission report alone is not considered proof of timely filing for electronic claims. You must also include an acceptance report or rejection letters.

SCENARIO #3: Claim denied for "Additional Information needed."

Please include the following on the first page of the request:

- Patient name and address
- Member ID number
- Provider name and address
- Date of service
- Reference and/or claim number.
  - » Claim number must be the most recent claim number on the last EOP.
- Any additional information requested

Please attach the following medical necessity documentation:

- Medical records
- Lab reports
- Radiology reports
- Any other pertinent medical necessity documents

SCENARIO #4: Claim denied for "Coordination of Benefits" information.

Please include the following on your reconsideration form:

- Amount paid by Primary Payer for each service line on the 835 Electronic Remittance Advice (835 ERA) or explanation of benefits (EOB). Include the paid amount on institutional claims at the claim level.
- Adjustment group code from the 835 ERA or EOB.
- Adjustment reason code from the 835 ERA or EOB.
- Adjustment amount.
- Primary payor paid amount when Community First is the secondary payor.
- Primary payor approved amount when Community First is the secondary payor.
- Patient responsibility amount from the 835 ERA or the Primary EOB.

SCENARIO #5: Claim denied for "Prior Notification/Prior Authorization Information."
Include a prior authorization number and other documents that support your request.

- If you spoke to a customer service representative and were told that notification was not required, please include the date, time, and reference number of that call and the name of the representative you spoke to.
- If notification was not possible because the service was performed on an emergency basis, please indicate this and include documentation.

Please attach the following medical necessity documentation:

- Medical records
- Lab reports
- Radiology reports
- Any other pertinent medical necessity documents
- Retro eligibility form showing ADD date of recipient, if applicable.

Claims without prior authorization will not be considered unless written rationale stating extenuating circumstances with documented evidence is submitted.

Resubmission of a Corrected Claim

Corrected claims must be resubmitted in their entirety to meet the Health Insurance Portability and Accountability Act (HIPAA) requirements. Please follow these guidelines:

- Make the changes in your billing system so the corrections will print on the amended claim.
  - » Please do not use handwritten remarks, because they may not be legible. Community First is not responsible for written documentation that is illegible.
- Attach the entire corrected claim, including line items that were paid correctly. Partial requests will be denied.
- Enter the words "Corrected Claim" in the comments field on the claim form.
  - » If your claims system or your software vendor does not offer this feature, stamp, or write "Corrected Claim" on the claim form.
- The Rendering/Billing provider and NPI/Taxonomy must be on the claim.
- XX5 Late charges
- XX7 Corrected claim
- XX8 Void/cancel previous claim

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Over/Underpayment

If a claim is processed with an incorrect rate resulting in over/underpayment, indicate the contract amount expected for the code or case rate compared to the amount received.

Please include any other details or relevant information related to the over or underpayment.

Resubmission of Bundled Claims

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 of why the bundling is incorrect.

The content of this document is subject to change as a result of payor updates or changes in process requirements. Please log in to the Community First Provider Portal for important updates. If you need assistance, call Community First Provider Relations at 210-358-6200.