Quick Reference Guide

For Claim & Clinical Reconsideration Requests

You can submit a reconsideration request for a full medical necessity review if you receive a clinical claim denial. This reference guide explains the submission process as well as the information required.

Submission Process

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

- **Online**: UHCprovider.com/claims > Submit a Claim Reconsideration / Begin Appeal Process
- **Mail**: Fill out the Claim Reconsideration Request Form. Send the completed form with your claim and supporting documentation to the address on the form.

Required Documents

Include supporting documentation when submitting a reconsideration request.

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:

- Patient name and address
- Patient member ID number
- Provider name and address
- Reference and/or claim number

Please attach the following medical necessity documentation:

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

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:

For electronic claims: Submit an electronic data interchange (EDI) acceptance report that shows UnitedHealthcare or one of its affiliates received, accepted and/or acknowledged the claim submission within the timely filing period. **A submission report alone isn't considered proof of timely filing for electronic claims. You must also include an acceptance report.**

For mailed claims: Submit a screenshot from your accounting software that shows the date the claim was submitted. The screenshot must show the:

- Patient name
- Date of service
- Submission date within the timely filing period

Claim was denied/closed for "Additional Information"

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

- Patient name and address
- Patient member ID number
- Provider name and address
- Reference number

Include any additional information that's been requested.

Doc#: PCA-1-007993-09152017_12082017

UnitedHealthcare® Community Plan

Claim was denied/closed for Coordination of Benefits information

Please include the following on your reconsideration form:

- Primary payer paid amount 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. For Medicare claims don't enter any amounts included at the line level.
- Adjustment reason code from the 835 ERA or EOB. For Medicare claims don't enter any amounts included at the line level.
- Adjustment amount.
- Medicare paid amount when UnitedHealthcare is the secondary payer to Medicare.
- Medicare approved amount when UnitedHealthcare is the secondary payer to Medicare.
- Patient responsibility amount from the 835 ERA or the Medicare EOB.
- Medicare acceptance of assignment.

For Medicare claims, submit professional claims at the line level if the primary payer provides the information, and submit institutional claims at either the line or claim level. The service level and claim level should be balanced. For all other claims submit professional claims at the line level as allowed by the primary payer. Institutional claims should be submitted at the claims or line level. The service level and claim level should be balanced. UnitedHealthcare follows 837p Health Care Claim Encounter – Professional (837p) and 837i Health Care Claim Encounter – Institutional (837i) guidelines.

Resubmission of a corrected claim

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

- Make the changes in your practice management system so the corrections will print on the amended claim. You may not write on the claim itself.
- 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 practice management system help desk or your software vendor doesn't offer this feature, stamp or write "Corrected Claim" on the CMS 1500 form.
- The care provider and patient must be listed on the claim or all charges for that day will be required for reconsideration.
- After completing the reconsideration form, mark the box on Line 4 for Corrected Claims.
- In the comments section, list the specific changes made and rationale or other supporting information.

UB04: UB Type of Bill should be used to identify the type of bill submitted:

- XX5 Late charges
- XX7 Corrected claim
- XX8 Void/cancel previous claim

Claim was processed with an incorrect rate resulting in over/underpayment

Indicate the contract amount expected for the code or case rate compared to the amount you received. Please include any other factors related to the over or underpayment.

Claim was 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 wasn't required, please include the date, time and reference number of that call and the name of the representative you spoke to. Please let us know if notification was not possible because the service was performed on an emergency basis.

Resubmission of a bundled claim
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.

Revised DRG/cost outlier payment due to MedReview determination
If you received a revised DRG/cost outlier payment from MedReview, you can submit a challenge of initial determination. See the instructions in your MedReview determination letter.

DRG Claims
Appeals Department at MedReview Inc.
Attention: Michele Smith
199 Water Street, 27th Floor
New York, NY 10038

Cost Outlier Claims
Appeals Department at MedReview Inc.
Attention: Mildred Lecoin
199 Water Street, 27th Floor
New York, NY 10038

If you don't agree with MedReview's challenge determination, you can file a claim reconsideration with UnitedHealthcare Community Plan. Go to UHCprovider.com/claims > Submit a Claim Reconsideration / Begin Appeal Process.

Other claim reconsideration requests
If your claim denial doesn't fall into one of these categories, submit your request form with additional supporting information.

Questions?
More information about the reconsideration process and claims dispute rights is in your Provider Administrative Manual. You can also call Provider Services at **888-650-3462**.