Provider Payment Dispute Policy

Applies to the following CarePartners of Connecticut products:

- ☒ CareAdvantage Premier
- ☒ CareAdvantage Prime
- ☒ CareAdvantage Preferred
- ☒ CarePartners Access

The following payment policy applies to providers who render services to members of the CarePartners of Connecticut plans selected above.

In addition to the specific information contained in this policy, providers must adhere to the policy information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

OVERVIEW

A provider has the right to file a payment dispute if he or she disagrees with a claim decision regarding the denial or compensation of a claim. Disputes and corrected claims may not be submitted for claims that have not previously been adjudicated.

Limitation of Dispute Process

CarePartners of Connecticut will consider payment disputes and adjustment requests for claims with dates of service within the current year and the two previous calendar years. Corrected claims and duplicate claim denial disputes received after that time will not be considered.

Providers who disagree with the compensation, adjudication or denial of a claim may submit a payment dispute. Payment disputes must include a copy of the EOP, appropriate documentation and a completed Request for Claim Review Form. A separate dispute form must be submitted for each adjustment, along with any supporting documentation. **All incomplete submissions will be returned.**

Note: Cloned documentation (i.e., information that is duplicated across patient documentation that is not specific to the encounter and/or member) does not meet medical necessity requirements and will not be accepted as evidence of the service billed.

CORRECTED CLAIMS AND LATE CHARGES

CarePartners of Connecticut accepts electronic, online and paper corrected claims, in accordance with guidelines of the National Uniform Claim Committee (NUCC), the Medicare Managed Care Manual, and HIPAA EDI standards.

Note: Provider payment disputes that require additional documentation must be submitted on paper.

Electronic Submissions

To submit a corrected facility or professional claim electronically, enter the frequency code (third digit of the bill type for institutional claims; separate code for professional claims) in Loop 2300, CLM05-3 as one of the following:

- **7** (corrected claim)
- **5** (late charges)
- **8** (void or cancel a prior claim)

Enter the last 8 digits of the original claim number in Loop 2300, REF segment with an F8 qualifier. For example, for claim #000123456789, enter **REF*F8*23456789**.

Online Claim Adjustments

Registered providers may submit claim adjustments using the secure Provider website. Providers who are not registered users of the website may register via the Provider login page.

Follow the instructions when submitting online claim adjustments. After the transaction has been completed, providers will receive a tracking number as confirmation. Providers submitting paper documentation that corresponds to an online claim adjustment must submit the online tracking sheet so that the claim is processed accurately.

Note: Some claims may not be adjustable online. If a claim cannot be adjusted online, a message will appear indicating the claim is not adjustable. Refer to the section below regarding submitting claim adjustments via mail.

Paper Submissions

Disputes and corrected claims must be single-sided and include a completed Request for Claim Review Form. Both corrected claims and disputes should be mailed to the following address:

CarePartners of Connecticut
P.O. Box 9162
Watertown, MA 02471-9162

Corrected Facility Claims

1. On the UB-04 (CMS-1450) form, enter either 7 (corrected claim), 5 (late charges), or 8 (void or cancel a prior claim) as the third digit in Box 4 (Bill Type).
2. Enter the original claim number in Box 64 (Document Control Number).

Corrected Professional Claims

1. In Box 22 (Medicaid Resubmission Code) on the CMS-1500 form, enter the frequency code 7 under Code.
2. Enter the original claim number under "Original Ref No."

Late Charges

Services submitted after initial submission of the claim are considered late charges. Late charges applied to claims must be submitted within 60 days of the date of service (for outpatient claims) or date of discharge (for inpatient or institutional claims).

FILING DEADLINE

The filing deadline is 60 days from the date of service for outpatient claims or 60 days from the date of hospital discharge for inpatient or institutional claims. If a member has multiple insurance plans, the filing deadline for claims submission is 60 days from the date of the primary insurer's EOP.

To be considered for review, requests for review and adjustment for a claim received over the filing deadline must be submitted within 120 days of the EOP date on which the claim originally denied. Disputes received after 120 days will not be considered.

For additional information, refer to the Claim Requirements and Dispute Guidelines chapter of the CarePartners of Connecticut Provider Manual.

Proof of Timely Filing

Documented proof of timely submission must be submitted with any request for review and payment of a claim that was previously denied due to the filing deadline.

The following are considered acceptable proof of timely submission for paper claims submissions:

- Copy of EOB/EOP from the primary insurer that shows timely submission from the date that carrier processed the claim
- Printout of patient account ledger that shows the date that the member was billed, when insurance information is not made available by the member
- Copy of EOP from another carrier if the member did not identify him/herself as a CarePartners of Connecticut member at the time of service
- Copy of a personal injury protection (PIP) letter received by CarePartners of Connecticut within 90 days of the date on the letter
- Copy of a workers' compensation denial received by CarePartners of Connecticut within 90 days of the date of the denial

The following are considered acceptable proof of timely submission for electronic claims submissions:

- Providers who submit their claims electronically through a clearinghouse or directly to CarePartners of Connecticut must send:

- A copy of the report that shows the claim was accepted at CarePartners of Connecticut with a claim number
- The corresponding EDI vendor or clearinghouse claim acknowledgement report or SHIPAA 277CA showing that the claim was received by CarePartners of Connecticut, as evidenced by a CarePartners of Connecticut claim number.

If a report indicates a rejection at the clearinghouse, the claim will not be considered for reprocessing. It is the provider's responsibility to review all reports from the clearinghouse and/or CarePartners of Connecticut and review any rejected claims at that time. Rejected claims must be corrected and received by CarePartners of Connecticut within the previously stated timely filing limits.

Circle the claim that is disputed on both the report(s) and the EOP. Details on the report requirements are listed below:

EDI Through	Reports Required for Proof of Timely Submission	Report Detail
Direct to CarePartners of Connecticut One or the other required	Claims Acceptance Summary Report **or** Claims Acceptance Detail Report	Claims accepted at CarePartners of Connecticut by claim number
Change Healthcare™/ WebMD/Envoy One or the other required	Provider Claim Status Report (RPT-10) **or** Special Handling/Unprocessed Claims Report (RPT-11)	Claims accepted at CarePartners of Connecticut by claim number
Change Healthcare™/ WebMD/Healthwire One or the other required	Provider Claim Status Report (RPT-10) **or** Special Handling/Unprocessed Claims Report (RPT-11)	Claims accepted at CarePartners of Connecticut by claim number
Capario	INS (insurance) Response Report	Claims accepted at CarePartners of Connecticut by claim number
MD On-line	Acceptance Report in your **LinkMail Box**	Claims accepted at CarePartners of Connecticut by claim number

Note: If acceptable proof of timely submission is received, the claim will be reprocessed. When the disputed claim is reprocessed, a subsequent denial may be generated. In this instance, a new dispute must be submitted with the appropriate proof since each denial is based on the current message code on the claim.

PROVIDER DISPUTES AND APPEALS

Providers who disagree with the compensation, adjudication or denial of a claim can submit a payment dispute. Payment disputes must include a copy of the EOP, appropriate documentation and a completed Request for Claim Review Form. Registered providers may submit disputes and appeals using the CarePartners of Connecticut secure provider website. Providers who are not registered users of the website may register via the Provider login page.

Follow the instructions when submitting online claim adjustments.

Compensation/Reimbursement Appeals

- Submit a typed letter of medical necessity (LOMN) explaining why the service was necessary.
- Attach the EOP and circle the claim to be reviewed.
- Submit all supporting documentation in the form of invoices, operative notes, office notes, radiology/pathology report(s) or any necessary medical record information for a fee adjustment request.

Appeals for Unlisted Procedure Code Denials

Appeals for denials resulting from the billing of an unlisted procedure code must include operative notes that identify the service(s) performed associated with the unlisted code.

Note: The portion of the operative notes that identifies the unlisted service must be underlined. Operative notes that are not underlined to indicate the service performed may delay consideration of payment.

Appeals for Lack of Information, Prior Authorization, Inpatient Notification, or Level of Care

- Submit a typed, case-specific letter of appeal, including the rationale for disputing the denial along with the necessary supporting clinical documentation.
- Attach a copy of the claim and the EOP.
- Lack of prior authorization denials may only be appealed with evidence the proper procedure was followed, or with a valid reason the proper procedure to obtain the appropriate authorization was not followed.
- Lack of Information denials should include the pertinent clinical information as well as an explanation of the reason clinical information was not communicated concurrently, or evidence that the information was transmitted.
- Level of care appeals should include clinical information to justify an inpatient level of care, including Interqual acute criteria and records supporting the contention that these criteria were met concurrently, or a justification for an exception to those criteria.

CarePartners of Connecticut considers relevant supporting documentation to be a copy of the provider's original information faxed/submitted to CarePartners of Connecticut and relevant medical records. If authorization is applicable, please include the authorization number received verbally or in writing from CarePartners of Connecticut.

DOCUMENT HISTORY

- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- August 2019: Removed reference to Claims Submission Policy (retired)
- January 2019: Clarified online dispute and appeals submission process
- December 2018: Document created

AUDIT AND DISCLAIMER INFORMATION

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.