

Provider Webinar Claim Disputes, Appeals Submissions

Alfonso Diaz, Network Relations Manager
Lucy Dawson, Manager, Claims Dispute

What is a claims dispute?

Overview	File dispute based on	Before initiate dispute	How to file
<ul style="list-style-type: none">Dispute involving the payment or denial of a claim, imposition of a sanction or reinsurance	<ul style="list-style-type: none">Claim denialClaim paymentDissatisfaction with claim payment	<ul style="list-style-type: none">Ensure other attempts to resolve the matter have failedContact CICR Team and/or Network Management representativeFollow all applicable laws, policies, and contractual requirements	<ul style="list-style-type: none">Must be filed in writingReceived within 12 months after the date of service or within 12 months after the date of eligibility is posted or within 60 days of the date of the denial

Required documentation

Submit to the Mercy Care Appeals department

- State the factual and legal basis for the relief requested
- All supporting documentation

Mercy Care responsibilities

- Acknowledge a claim dispute within 5 business days of receipt
- Claim dispute will be reviewed, and a decision will be rendered within 30 days after receipt
- An extension may be requested for up to 45 days

Notice of decision

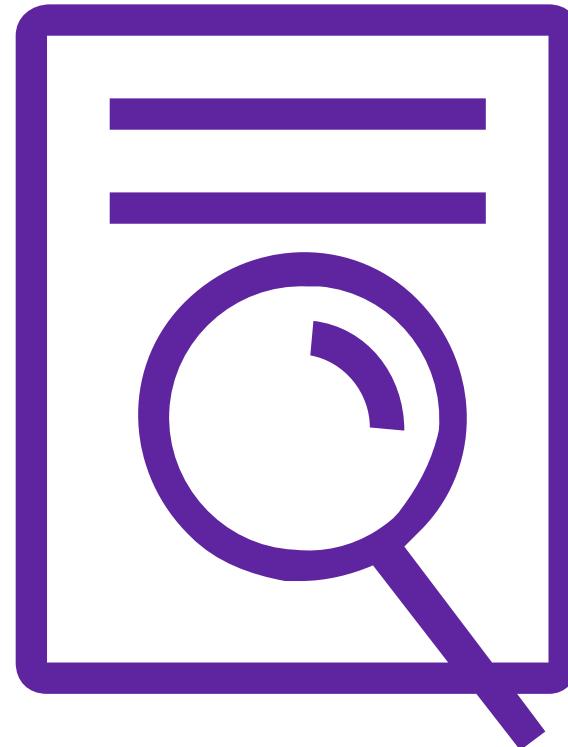
Notice of Decision (NOD) includes:

- 30 days to review – exceptions
 - Can exceed 30 days, up to 45 days
- The date of the decision
- The factual and legal basis for the decision
- The provider's right to request a State Fair Hearing



Claims dispute upheld or overturned

- Upheld decision
 - A decision when original determination is maintained
- Overturned decision
 - The original processing is incorrect or incomplete and is reversed
 - Partially overturned is an when the original decision was reversed, but not entirely in the provider's favor



Appeal upholds



Once a Notice of Decision is received, the next option is to file a State Fair Hearing

- Network Management is unable to reverse the decision
- If the denial is for a different reason when overturned, you can file another dispute
 - Ex: Timely filing was overturned, reprocessed, then denied for no prior authorization

Submitting claim dispute

Send via:

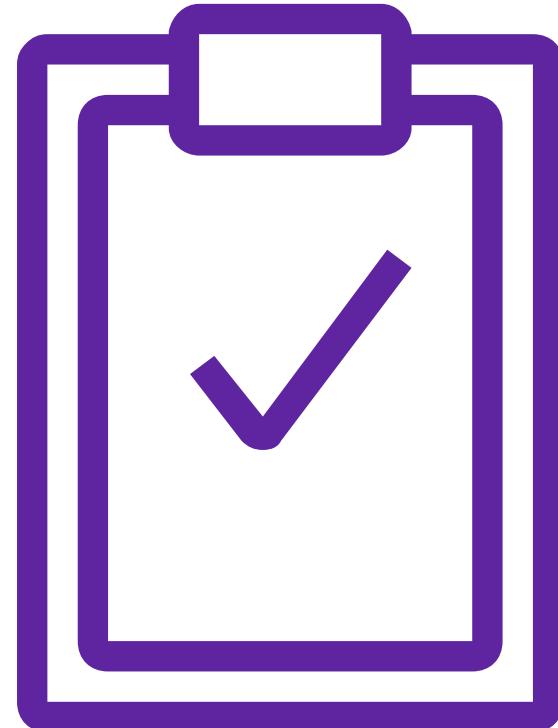
- Fax*
 - 602-351-2300
- Mail
 - 4500 E. Cotton Center Blvd.
Phoenix, AZ 85040
Attention: Mercy Care Appeals
- Email
 - Mercycareappeals@aetna.com



*Preferred method, receive acknowledgement letters sooner

Prior to submitting claim dispute

- Work with CI/CR regarding denials
 - Provider load challenges
 - Provider not credentialed
 - Denial trends or projects
- Usually not overturned (are upheld)
 - Timely filing issues
 - Prior authorizations
 - Retro authorizations
 - MCA PAR providers
 - No appeal rights
 - Resubmission through claims department



Submitting claims resubmission or corrected claims



Resubmissions and corrected claims:

- Mercy Care Claims Department
 - Mercy Care
PO Box 982975
El Paso, TX 79998-2975
 - Mercy Care RBHA
PO Box 982976
El Paso, TX 79998-29760
- If claims resubmission or corrected claim, please send to above address
Attention: Resubmissions
- Electronic submission through electronic clearing house

What should not be sent to claim disputes

- Corrected claims
 - Adding XX7, appeal document stating corrected claim
 - Changing or adding modifiers, units, CPTs, or any change
 - Changing a date or adding more days
- Resubmissions
 - Changing or adding modifiers, units, CPTs, or any change
 - Changing or adding dates
 - Changing bill types
- Claims that were not processed
 - Voided or claims not submitted to Claims department
 - EDI denials

Corrected claims

2022-01-13 16:54												1 2 >> WVMRFA2MEAP01																											
RESUBMISSION CORRECTED CLAIM												CTRL #	SN3120		P 9/9																								
												REC #	SN3120		OF BILL																								
												5 PFD. TAX NO.	0217																										
												4 EMPLOYEE COVERAGE		THROUGH																									
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B433 / B831.3		B4 PATIENT NAME		B4 PATIENT ADDRESS		B4 AZ = 85007																																	
		b Phoenix																																					
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38		Mercy Care (Medicaid)																																					
ATTN:		RESUBMISSIONS																																					
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58 INSURED NAME		59 INSURER'S POL. NO.		60 INSURED'S UNIQ. ID		61 GROUP NAME		62 INSURANCE GROUP NO.																															
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63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME																																			
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Resubmissions

SIGN		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		MM : DD : YY		M <input type="checkbox"/>	F <input checked="" type="checkbox"/>												
b. RESERVED FOR NUCC USE		d. AUTO ACCIDENT?				e. OTHER CLAIM ID (Assigned by NUCC)													
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		PLACE (State)															
c. RESERVED FOR NUCC USE		e. OTHER ACCIDENT?				f. INSURANCE PLAN NAME OR PROGRAM NAME													
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				MERCY CARE PLAN													
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)				g. IS THERE ANOTHER HEALTH BENEFIT PLAN?													
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 10 and 11													
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who submits assignment below.																			
SIGNED SIGNATURE ON FILE				DATE 072121															
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY)		15. OTHER DATE (MM/YY)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM/YY)		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/YY)													
MM : DD : YY		MM : DD : YY		MM : DD : YY		MM : DD : YY													
QUAL:		QUAL:		FROM: 07162021		TO: 07162021													
18. OUTSIDE LAB?																			
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		\$ CHARGES																	
19. RESUBMISSION CODE																			
20. ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Refer A-L to service line below (24E) ICD-10: 0																			
A. R07.89		B. L		C. L		D. L													
E. _____		F. _____		G. _____		H. _____													
I. _____		J. _____		K. _____		L. _____													
24. A. DATE(S) OF SERVICE From MM DD YY		B. PLACE OF SERVICE ENG		C. CPT/NCPCS		D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Universal Classification)		E. MODIFIER		F. DIAGNOSIS PICKER		G. DAYS OR UNITS		H. RATE Per Unit		I. ID. QUAL		J. RENDERING PROVIDER ID #	
1. 07162021		23		Y		71046		26 59		A		82.00		1.0		22		NPI	
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4. _____		_____		_____		_____		_____		_____		_____		_____		_____		NPI	
25. UN/OR SUPPLIER INFORMATION																			

Claims not processed

Sincerely,

Proprietary and Confidential



Claims not processed

14926028110

Mercy Care
4755 S 44th Place
Phoenix, AZ 85040

202108162350 Date: 08/11/2021

Return Service Requested

31733 0-5234 SP 0-560 SINGLE PIECE

520

ENV 31733 1 OF 2

 mercy care

Dear Provider,

The attached claim(s) are being returned to your office due to the following reason(s):

Please call the claims inquiry line at (602) 263-3000 or (800) 624-3879 to verify that your claim was processed correctly or for clarification of information before initiating a grievance. The claims inquiry line is open from 8:00 AM to 5:00 PM, Monday through Friday. To request a provider registration packet, contact AHCCCS at (602) 417-7670 or (800) 794-6862, 801 E. Jefferson St., MD 4100, Phoenix, AZ 85034 or online at www.ahcccs.state.az.us.

Please send claim resubmission to:

Mercy Care
P.O. Box 52089
Phoenix, AZ 85072-2089

Rejection Code	Explanation

Rejected Claim Detail

Patient Name	Member ID	Date of Birth	Date of Service	Claim Number	PCN	Billed Amount	Received Date	Rejection Code(s)

Mercy Care Claims Department

The provider must follow all applicable laws, policies and contractual requirements when filing a claim dispute. According to the Arizona Revised Statute, Arizona Administrative Code and AHCCCS guidelines, all claim disputes related to a claim for system covered services must be filed in writing and received by Mercy Care within twelve months after the date of service, within twelve months after the date that eligibility is posted or within sixty days after the date of the denial of a timely claim submission, whichever is later [A.R.S. §36-2903.01(B)(4) and A.A.C. R9-34-405(A)].

Additional information

- Visit our website
 - <https://www.mercycareaz.org/>
- Provider Manual
 - <https://www.mercycareaz.org/providers/completec�포르포비더스/manual>
- Claims
 - <https://www.mercycareaz.org/providers/completec�포르포비더스/claims>
 - [Mercy Care Claims Processing Manual](#)

Questions

Follow us @MercyCareAZ



Thank you

