
SUMMARY

This section explains the process and requirements for processing and submitting claims to MCC Employer Groups and Claims Payers.

CLAIMS CHECKLIST

- Verify Member's Eligibility and Benefits.
- Make sure that appropriate pre-certifications are obtained prior to submittal of claim.
- Use CPT coding schemes from 2001 to designate procedures and ICD- 9-CM codes for diagnoses.
- Submit claims to the claims office identified on the back of the members ID card.
- Bill within 180 days.

MAILING CLAIMS

Check the back of the member ID card for appropriate claim billing address.

EOB

For each claim submitted, Employer Groups and Claims payers will issue an EOB (Explanation of Benefits). The EOB will state the amount paid on the claim, or why the claim was denied. Explanation codes are listed on the EOB. These codes explain how the claim was processed.

SUMMARY

This section explains the process and requirements on how to appeal claims for MCC Employer Groups and Claims Payers.

CLAIM APPEALS

THE PURPOSE OF THE CLAIMS APPEALS PROCESS IS TO:

- Allow the provider to voice concerns and appeal claim denials or perceived under payments.
- Ensure these concerns are acted upon promptly.
- Ensure the concerns are addressed consistently and fairly.

YOUR REQUEST FOR CLAIM REVIEW WILL BE EXPEDITED WHEN YOU INCLUDE THE FOLLOWING:

- Cover letter explaining your request for review/reconsideration
- Copy of HCFA or UB92
- Copy of the EOB
- Supporting medical documentation (i.e., notes, reports, etc.)

1ST LEVEL APPEALS

Initially, the physician should address any question regarding claim payment or denial to Member Services at the telephone number on the member's identification card or by calling 800.572.9990. A Customer Service Associate (CSA) will investigate the claim and, when appropriate, forward the claim to a Medical Review Committee for review. The CSA or Committee will respond to the physician in writing after the claim has been reviewed.

OR

A written request for review may be sent to the Claims Office that originated the Explanation of Benefits.

2ND LEVEL APPEALS

A physician who is not satisfied with the 1st level determination may submit a written request for reconsideration to the Claims Payer or Employer Group. The Medical Director, or his designee, will review the issue and notify the physician of the decision in writing.

3RD LEVEL APPEALS

A physician who is not satisfied with the 2nd level determination may appeal to Managed Care Consultants (MCC) Medical Director's (or his designee's). The physician may submit a written request asking for a review of the decision rendered by the local Claims Payer or Employer Group.

IN ORDER TO QUALIFY FOR REVIEW AT THE 3RD LEVEL OF APPEALS, IT IS IMPORTANT TO FOLLOW THE PROCESS AND SUBMIT THE REQUESTED INFORMATION IN THE EXACT ORDER REQUESTED BELOW.

- Written request for review
- Medical records and pertinent notes
- Copy of the EOB
- Copy of letter of determination from the health plan's Medical Director