Contract Rate, Payment Policy or Clinical Policy Appeal

Appeals

Description

An appeal that is submitted to us due to a contract rate, payment policy or clinical policy dispute should include a completed *Universal Provider Request for Claim Review Form* with corresponding documentation. The appeal must include one of the following or the appeal will be returned unprocessed.

- You must submit a written explanation of the requested change(s) on the *Universal Claim Review Form*.
- You must attach the remittance advice and identify the claim the Plan should review.
- You must attach supporting documentation that contract terms/rates were incorrectly applied.
- You must attached supporting documentation that a policy either clinical or payment related was incorrect.

Examples of documentation are as follows:

- Office visit notes
- Surgical/operative notes
- Medical invoices
- Letter of explanation

Appeal Response

- If the appeal is received within the filing limit, Well Sense Health Plan will review the appeal.
- A determination is made within 30 days following receipt of an appeal that is accompanied by the appropriate documentation.
- Appeals submitted beyond the filing limit will not be considered.
- After the appeal has been reviewed a resolution letter with be mailed to the provider describing the decision.

Second Level Appeal

The Plan offers two levels of internal administrative review to providers. If the initial review results in an administrative denial, you have the opportunity to file a second administrative appeal to the Plan. An Administrative Appeals committee automatically reviews all second level appeals and decisions rendered by the Administrative Appeals committee are final decision by the Plan.

Required and Supporting Documentation

In addition to the information listed above, a copy of the denial along with additional supporting documentation for denied claim that specifically outlines the reason for a second level appeal.

Second Level Appeal Response

- If your request for a second level appeal is received beyond the Plan's filing limit, the Plan will uphold the original denial.
- If the appeal is received within the filing limit, it will be reviewed by the Administrative Review committee which will provider a final decision on the claim.
- A determination is made within 30 days following receipt of an appeal that is accompanied by the appropriate documentation.
- After the appeal has been reviewed a resolution letter will be mailed to the provider describing the decision.

Appeals Address
Well Sense Health Plan
Claims Resolution Unit
Attn: Provider Appeals
P.O. Box 55282
Boston, MA 02205