



Binder: Provider HMO Policy & Procedure Manual
Policy Title: Inquiry and Appeal Process for Post-Service Claims

Author:

Original Date: 5/29/02

Replaces:

Approval:

A handwritten signature in black ink, which appears to read "Rafe R. Delaney, M.D.", is written over the "Approval:" label.

Title: Vice President & Chief Medical Officer

POLICY

Practitioners and Providers have the right to appeal certain post-service claims decisions of OSF HealthPlans as described in this policy and to appear before the Appeals Committee.

PURPOSE

To establish a process whereby a practitioner or provider may appeal a post-service claim decision of OSF HealthPlans.

PROCEDURE

1. Practitioners or Providers may inquire as to the basis for a post-service claim denial by contacting Provider Services.
 - A. Provider Services will determine if the claim was accurately processed. Processing errors will be corrected without a written appeal.
 - B. Examples include but are not limited to: date range discrepancy, unit discrepancy, missed authorization or referral, and data entry errors.
2. Practitioners may submit an appeal for a post-service claim that has been denied due to no referral/pre-authorization in which the member is being held harmless from financial liability.
 - A. Practitioners must submit the appeal in writing by completing the Provider Appeal form.
 - B. OSF HealthPlans must receive the completed Provider Appeal form within 180 days of the denial.
 - C. The appeal will be reviewed by the Chief Medical Officer with a determination being made as soon as possible but no later than 45 days from receipt of the appeal.

- D. If the provider has answered “No” to any of the questions on the Provider Appeal form, a corrective action plan must be submitted indicating the step(s) being taken to prevent a recurring denial.
- E. OSF HealthPlans may elect to propose modifications to the provider’s corrective action plan if deemed necessary in order to:
 - i. allow for a more suitable means for avoiding a subsequent denial;
 - ii. ensure the provider’s ability to comply with the plan; and/or
 - iii. allow for monitoring of the provider’s compliance by OSF HealthPlans.
- F. The practitioner will be allowed an opportunity to review any modifications that OSF HealthPlans proposes to the corrective action plan.
- G. If a corrective action plan cannot be mutually agreed upon, the denial will not be overturned.
- H. If the practitioner fails to comply with a corrective action plan that was previously mutually agreed upon, subsequent denials which the provider appeals will be upheld.

INSURANCE WAIVER

PATIENT: _____

PROVIDER: _____

DATE: _____

**DESCRIPTION
OF SERVICES:** _____

The Patient, who has signed below, understands that the health care services to be provided by the above-named provider on today's date as indicate above, may be covered by either an insurance policy issued by OSF Health Plans, Inc. or may be covered under an employer health benefit plan administered by OSF Health Plans, Inc. The Patient understands that by signing this Waiver, the Patient will be responsible for paying for the described health care services even though the described services may be covered by insurance or by an employer health care benefit plan.

In exchange for avoiding possible delays in obtaining the described health care services, the Patient understands that by signing this Waiver, the Patient agrees to pay the Provider in full at the Provider's regular and normal billed charges without expectation of reimbursement from the employer health care benefit plan or OSF Health Plans, Inc.

Patient does hereby waive and release any and all claims for insurance and any other benefits relating to the health care services described in this form which the Patient now has or may acquire at a future date. Patient understands that he or she will be required to use his or her own funds and/or other assets to pay the Provider in full for the described health care services. Patient releases OSF Health Plans, Inc and/or the employer benefit plan in which Patient is a participant from any and all responsibility and liability of every kind and nature whatsoever relating to the services described above. Patient promises to pay Provider in full for these services at Provider's normal and regular billed charges.

**Signature of Patient or
Authorized Representative**

**Name of Patient or
Authorized Representative.**