Provider Reconsideration Process for Claim Denials

According to 10A NCAC 22J .0102 PETITION FOR RECONSIDERATION REVIEW:

- A provider may request a reconsideration review within 30 calendar days from receipt of final notification of payment, payment denial, disallowances, payment adjustment.
- Final notification of payment, payment denial, disallowances and payment adjustment mean that all administrative actions necessary to have a claim paid have been taken by the provider and the Division or the fiscal agent has issued a final adjudication. If no request is received within the respective 30-day period, the Division's action shall become final.
- A request for reconsideration review shall be in writing and signed by the provider or the provider's representative and contain the provider's name, address, and telephone number. It shall state the specific dissatisfaction with the Division's action and should be mailed to: Appeals, Division of Health Benefits, 2501 Mail Service Center, Raleigh, North Carolina 27699-2501.
- The provider may appoint another individual to represent him/her. A written statement setting forth the name, address, and telephone number of the representative so designated shall be sent to the address listed in Paragraph (b) of this Rule*. The representative may exercise any rights given the provider in the review process. Notice of meeting dates, requests for information, or hearing decisions shall be sent to the authorized representative. Copies of such documents shall be sent to the petitioner only if a written request is made.

  * *address in bullet #3*

PROCESS:

When a provider reconsideration request is submitted to DHB, the Provider Reconsideration specialist verifies that it is in conformance with the above guidelines. If it meets qualifications for a Provider Reconsideration Review, a final adjudication is issued from DHB. The *Final Notification of Adjudication* is sent to the provider via certified mail, with instructions on how to ask for a reconsideration hearing. The provider has 30 days from receipt of the *Final Notice of Adjudication* to request a hearing with the DHHS Hearing Office.

If the request does not meet the guidelines for a reconsideration review, the appeals team issues a notice to that effect. Examples of requests that do not meet guidelines for reconsideration review include (but are not limited to) the following:

- **Adjustment request or claim review for medical necessity**: These all have action pathways within NC Tracks. These items, with the appropriate GDIT processing forms attached, should be sent by the provider to GDIT.
- **Resubmission of claims per EOB Instructions:** EOBs frequently instruct providers to resubmit with additional information, medical records and/or modifiers. When resubmitting a claim for reprocessing, please electronically enter the claim through the NCTracks Provider Portal or through a batch X12 transaction.
- **Requests with missing information:** DHB is unable to process mailing arriving at DHB Appeals Unit that do not include all the following: Provider name, address, telephone number, and a statement regarding the specific dissatisfaction with DHB's action.
- **Requests for Time Limit Override:** Basic time limit override requests should be submitted through NCTracks on a *Medicaid Resolution Inquiry Form.* Effective February 5, 2017 the Medicaid Resolution Inquiry Form will no longer be required if the claim requiring the time limit override is submitted electronically through the NCTracks Provider Portal or through a batch X12 transaction. Providers are encouraged to use this new method because the Medicaid Resolution Inquiry Form will eventually be phased out.