Neighborhood Health Plan OF RHODE ISLAND™

910 Douglas Pike, Smithfield, RI 02917

Requests for Claim Review

Reminders and New Terminology

January 1, 2024

Neighborhood Health Plan of Rhode Island (Neighborhood) is reminding providers of the processes for requesting claim reviews to reduce confusion and improve efficiencies in the processing of these requests. A claim review is a request for a modification to a previously submitted claim and includes claim adjustments, claim reconsiderations, and claim corrections.

Neighborhood has a variety of forms and processes to request a modification to a claim. Providers should visit Neighborhood's Forms page and click on the Claim Form Finder which includes a table identifying the most common reasons a claim modification is requested. If a provider believes that changes should be made to a claim, or to a payment decision rendered on a claim, please follow the processes below.

Corrected (Replacement) and Voided Claims
Corrected claims are used to void or to submit changes, such as correcting a diagnosis code, CPT or HCPCS code, or date of service, or adding additional information such as an NDC number or modifiers, to a previously processed claim. Unless stated otherwise in your contract, claims must be resubmitted with all appropriate information within three hundred and sixty-five (365) days from the date of service.

Claim Adjustments
Providers may request to have an adjustment made to a previously processed claim for reasons such as, but not limited to, coordination of benefits, payment modifications, or timely filing. Unless stated otherwise in your contract, adjustment requests for previously adjudicated claim must be submitted within sixty (60) days from the date on the initial remittance advice (RA) statement.

Claim Reconsideration
A reconsideration is a review, with medical notes, of a claims payment decision. Unless stated otherwise in your contract, claims reconsideration requests must be submitted within sixty (60) days from the date on the initial RA or within sixty (60) days of an adverse determination of an adjustment request.

Administrative Appeals (formerly Claim Disputes)

As of **March 1, 2024**, claim disputes will be referred to as "**Administrative Appeals**." This name change will be reflected in several Neighborhood materials and resources including:

- Provider Appeal Form (previously known as the "Provider Claim Dispute and Provider-Initiated Appeal Form")
- Claim Form Finder
- Quick Reference Guide
- Provider Manual

A provider can submit an Administrative Appeal for Neighborhood to review and reverse a claim denial due to no authorization, adverse Reconsideration Request decision, and/or adverse Adjustment Request decision.

These administrative appeals must be filed to Neighborhood's Grievances and Appeals Unit (GAU) within 60 days from the:

- Claim denial due to no authorization;
- Reconsideration request denial date; and/or
- Adjustment request denial date.

Note: Administrative Appeals submitted without a prior claim denial for authorization, adverse adjustment request, or adverse reconsideration request will not be processed.

To facilitate an Administrative Appeal, providers should submit a completed Provider Appeal Form (nhpri.org/Providers > Provider Resources > Forms) to Neighborhood's GAU, along with a copy of the denied claim/clear reference to the denied claim, and/or a remittance advice, as well as specific supporting documentation as to why the denial should be waived or reconsidered. Administrative Appeals can also be securely emailed to GAUMailbox@nhpri.org or faxed to 401-709-7005.

If you have any questions regarding this communication, please contact Neighborhood's Provider Services at 1-800-963-1001.