Chapter 12: Correcting Claim Errors

All claims submitted to Health Choice Insurance Co. (Health Choice) are extensively edited by the Health Choice claim processing system. When a claim fails an audit or an edit, an error record is created and the claim denies. All failed edits related to the claim denial are displayed on the Remittance Advice with an action code. A description of the action code is listed on the last page of the Remittance Advice.

Claim Resolution Services

Provider offices are encouraged to keep their billings timely and review every remittance advice thoroughly upon receipt. There may be occasions when a provider may request the status of a specific claim or have questions regarding payment or the denial of a claim. The Health Choice Provider Portal or Health Choice Member Services Department at 1-855-452-4242 is the resource for such information.

Understanding Action Codes

A relatively small number of errors account for the vast majority of pended and denied claims. The attached list of Action Codes provide information if the Action code applies to a 1500 or a UB claim form, the Action code (as shown on the providers remittance advice) and a description of the Action Code. (See Exhibit 12.0 – Action code list)

Claim Resubmission

If a claim was denied due to a billing error, the corrected claim must be resubmitted within twelve (12) months of the date of service/discharge.

If the claim was denied due to a request for a medical documentation, please include a copy of the claim, a copy of the Remittance Advice, and the requested documentation within the resubmission.

Denial Decision

Providers may request a reconsideration of a claim denial by resubmitting the claim with the appropriate documentation and /or necessary corrections or by calling the Claims Resolution Services Unit (CRS). If you have attempted to resolve your claim issues with the CRS Unit but are still dissatisfied with the outcome, please see Chapter 15 for additional information.