

# Claim Appeals in NaviNet®



## Provider Education

- Summer 2023

# CURRENT STATE



Currently, to initiate an Appeal, Reconsideration or Claim Timely Filing Dispute online, providers must download and fill out forms from [NebraskaBlue.com](https://NebraskaBlue.com) and attach those to the claim in NaviNet. There is no way to tell that the request was received by Blue Cross Blue Shield of Nebraska (BCBSNE) and no response back to NaviNet to indicate any status on the request.

# Current State

- Requires forms to be manually completed and attached to the claim in NaviNet.
- No tracking number is provided.
- No running history stored on NaviNet, other than when documents are attached.

Claim Status Details | [Redacted]

Appeal Attach Investigate History View/Print

Finalized (Claim Status as of 11/22/2022)

The claim/line has been paid. Accepted for processing.

**ADDITIONAL DETAILS**  
Patient a/c: 0  
Clearinghouse: 2009498201  
Trace Number:

**INSURANCE DETAILS**  
BCBS of Nebraska  
Member ID: YKV100098971  
[View Eligibility and Benefits](#)

To submit an Appeal, Reconsideration or a...

Cancel Attach

**Claim and Service Line Details:**

Service	Units	Date(s)	Revenue Code	Status	Billed Amount	Paid Amount
1 73030-26, -RT, -GC	1.0	11/05/2022 to 11/05/2022	--	Finalized The claim/encounter has completed the adjudication cycle and no more action will be taken. Claim was processed as adjustment to previous claim.	\$28.40	\$1.76

Documents (2)

Name	Source
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# NEW

With the new NaviNet Claim Appeals application, providers will submit claim disputes directly to BCBSNE by clicking an “Appeal” button, selecting information from the provided drop down menus and including any supporting documentation. Filling out forms will no longer be necessary, and requests will be tracked within NaviNet.

Sign in to NaviNet and under HEALTH PLANS  
Select Blue Cross and Blue Shield of Nebraska to  
access the plan.

# New- Instructions

The screenshot shows the NantHealth NaviNet interface. The top navigation bar includes the NantHealth logo, 'NaviNet', and three menu items: 'WORKFLOWS', 'HEALTH PLANS', and 'ADMINISTRATION'. Below the navigation bar is a search bar with the placeholder text 'Type here to search for any plan ...'. Below the search bar is a section titled 'My Plans' with a list of plans. The first plan, 'Blue Cross and Blue Shield of Nebraska', is highlighted in yellow. Below it is 'Medicare'. To the right of the 'My Plans' section is a section titled 'Want AllPayer Access?' with a list of plans: 'Aetna Better Health of Michigan', 'HealthPlus of M', 'BCBS of Michigan (Institutional)', and 'Humana'.

# New-Instructions cont.

The next screen is known as “Plan Central.”  
Here are the workflows to view eligibility and  
claims details for our members.

NantHealth | NaviNet | WORKFLOWS | HEALTH PLANS | ADMINISTRATION

Blue Cross and Blue Shield of Nebraska

**Workflows for this Plan**

- Eligibility and Benefits
- Claim Status
- Remittance Advice
- Resource Center
- Spine Pain Management Prior Authorization
- Med Policy Blue
- Pre-Service Review for Out of Area Members
- Inpatient Precertification
- Medical/Radiology Preauthorization

**Pre-Authorization/Pre-Certification or Medical Policy Tools should only be used for members with current BCBSNE Member ID cards (Plan Number 259/759)**

**News and Announcements**

**Now Available!**

Blue Cross and Blue Shield of Nebraska (BCBSNE) is excited to announce new enhancements available through NaviNet!

- View both the front and back of a BCBSNE members' ID card through the Eligibility and Benefits workflow.
- After completing an Eligibility and Benefits search, you will have the option to view the BCBSNE members' schedule of benefits summary.
- Access to additional details on claims that encounter issues before adjudication via Claim Status Search.
- All BCBSNE Member ID cards will be available for viewing as of Monday, Oct. 24.

For more information on all transactions available on NaviNet for BCBSNE, please visit the [NaviNet Help Center](#).

**Read the Update Newsletter**

- ▶ [Incorrect Prefix Assignment – Tyson Group Members \(Jan. 3, 2023\)](#)
- ▶ [EHA Member Information \(July 29, 2022\)](#)

**BlueCross BlueShield Nebraska**

**Hours of Availability**  
Mon-Sat: 5:00am-3:00am CT

**Quicklinks**

- [Submit Pharmacy Prior Authorization](#)
- [Submit Medical & Radiology Prior Authorization](#)

**Resources**

- [Policies and Procedures](#)
- [Claims Edits](#)
- [Forms for Providers](#)

**Contact Us**

# New- Instructions cont.

Prior to using the Claim Appeals application for the first time, providers would need to set up notifications for new responses to an appeal (this includes reconsiderations and claim timely filing disputes) by clicking on the Notifications (bell icon) and then the Settings tab.

We recommend choosing the option to be notified of new Claim appeal responses as well as Claim documents, as Appeal Outcome and Reconsideration letters will also be sent to NaviNet.

Users may set up notifications to alert within NaviNet or by email.

Users who do not have an email attached to their profile user will be prompted to set one up.

Summary Notifications Settings

**Notify me about...**  
\* indicates notifications that do not trigger emails.

- Claim appeal responses
- Claim documents
- Claim investigation responses
- Documents requesting a response
- Eligibility and benefits patient updates \*

**How would you like to receive your notifications?**

Frequency of Pop-ups  
As soon as they arrive

Frequency of Emails  
Every hour

Emails will be sent to [lori.siciliani@nebraskablue.com](mailto:lori.siciliani@nebraskablue.com).  
You can change your email address using [My Account](#)

# Starting a new Claim Appeal

From the Plan Central screen, search for a claim by going to the “Claim Status” workflow:

The screenshot displays the NantHealth NaviNet interface. At the top, the navigation bar includes the NantHealth logo, 'NaviNet', and menu items for 'WORKFLOWS', 'HEALTH PLANS', and 'ADMINISTRATION'. On the right side of the navigation bar are icons for a flag, a bell, a question mark, and a user profile. Below the navigation bar, the text 'Blue Cross and Blue Shield of Nebraska' is visible. The main content area features a sidebar on the left with a list of workflows for the plan, where 'Claim Status' is highlighted in yellow. A prominent blue banner at the top of the main content area reads: 'Pre-Authorization/Pre-Certification or Medical Policy Tools should only be used for members with current BCBSNE Member ID cards (Plan Number 259/759)'. Below this banner, the 'News and Announcements' section is titled 'Now Available!' and contains a paragraph stating that BCBSNE is excited to announce new enhancements available through NaviNet. This is followed by a bulleted list of three items: viewing ID cards, accessing benefits summaries, and accessing claim status search. A link to the NaviNet Help Center is provided for more information. On the right side of the interface, there is a 'BlueCross BlueShield Nebraska' logo, a 'Hours of Availability' section (Mon-Sat: 5:00am-3:00am CT), a 'Quicklinks' section with links for pharmacy and medical/radiology authorization, and a 'Resources' section with links for policies, claims edits, and forms for providers.

**Workflows for this Plan**

- Eligibility and Benefits
- Claim Status**
- Remittance Advice
- Resource Center
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### News and Announcements

**Now Available!**

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**BlueCross BlueShield Nebraska**

**Hours of Availability**  
Mon-Sat: 5:00am-3:00am CT

**Quicklinks**

- [Submit Pharmacy Prior Authorization](#)
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**Resources**

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- [Claims Edits](#)
- [Forms for Providers](#)

On the “Claim Status: Search” screen, enter the member’s information in the required fields.

Providers may search by single date of service or a date range. Search results will reflect any claim with a date of service up to six years in ago, but the search range can only be up to 24 months.

A claim appeal may be started on any claim in a finalized/denied status. Claims that are not yet finalized will not be eligible for an appeal, reconsideration or claim timely filing dispute.

NantHealth | NaviNet

WORKFLOWS ▾ HEALTH PLANS ▾ ADMINISTRATION ▾

< Back to BCBS of Nebraska | Claim Status: BCBS of Nebraska

### Claim Status: Search

Please be sure to allow 30 days from submission for information to be available.

[Reset Search Fields](#)

Billing Entity

Member ID

Last Name

First Name

Date of Birth

Claim Status Details

Service Start: 11/05/2022

Service End: 04/28/2023

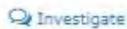
Claim ID: Optional

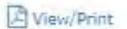
[Reset Search Fields](#) [Search](#)

Claim status results will appear as follows. Claim Status Details will now contain a new “Appeal” button. A reminder will appear on finalized/denied claims regarding how to submit your appeal:

Claim Status Details |







✔ **Finalized** (Claim Status as of 11/22/2022)
 Claim ID:  Service Dates: 11/05/2022 to 11/05/2022

The claim/line has been paid. Accepted for processing.

**ADDITIONAL DETAILS**

Patient a/c: 0

Clearinghouse:

Trace Number:

**INSURANCE DETAILS**

BCBS of Nebraska

Member ID:

[View Eligibility and Benefits](#)

**Total Billed:** \$28.40

**Total Paid:**

Payment Number:

(Paid on 11/22/2022)

[Remittance Details](#)

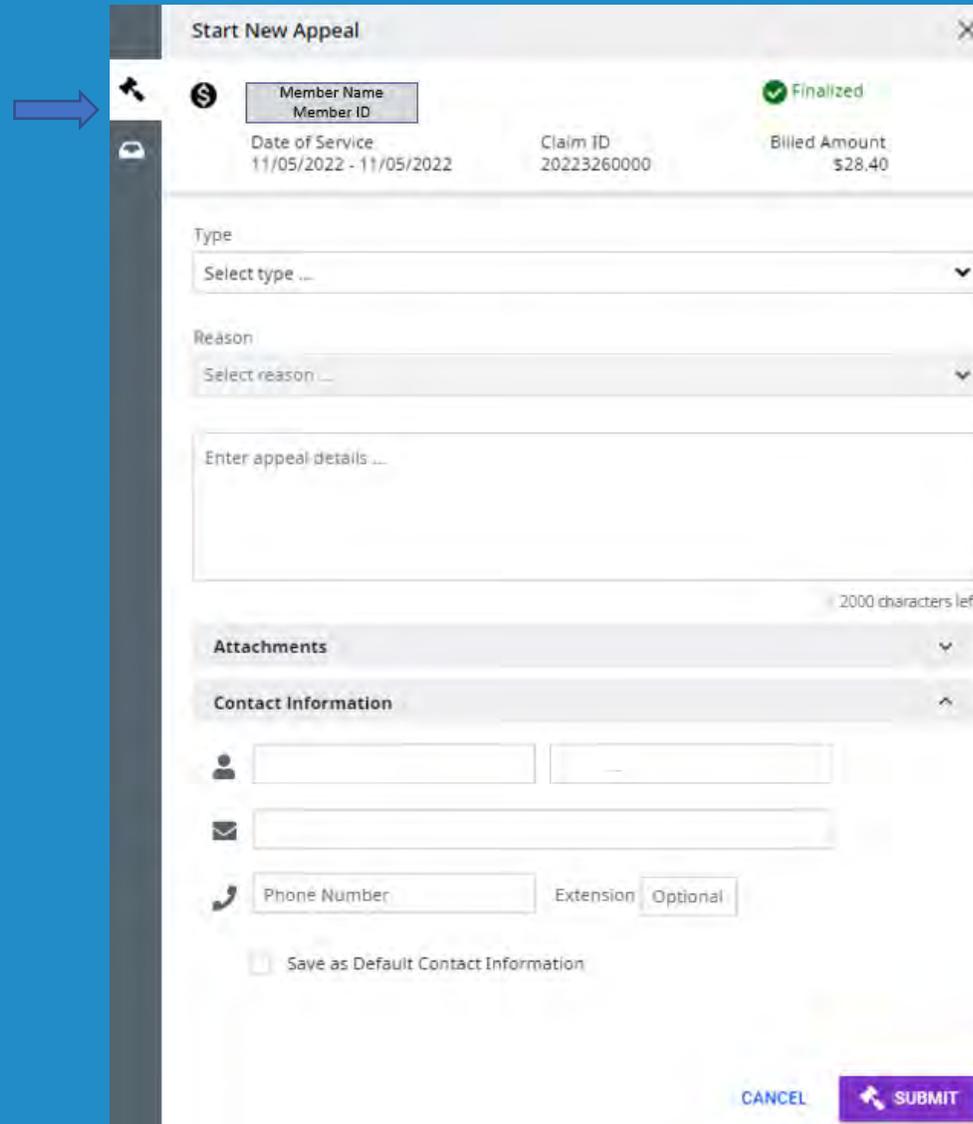
To submit an Appeal, Reconsideration or a Claim Timely Filing Dispute, use the Appeal button. 

**Claim and Service Line Details:**

Service	Units	Date(s)	Revenue Code	Status	Billed Amount	Paid Amount
1 <input type="text"/>	1.0	11/05/2022 to 11/05/2022	--	<span style="color: green;">✔</span> <b>Finalized</b> The claim/encounter has completed the adjudication cycle and no more action will be taken. Claim was processed as adjustment to previous claim.	\$28.40	<input type="text"/>

**Note:** The “Attach” button still contains the functionality to submit documentation to BCBSNE regarding Risk Optimization requests. The request types of Appeal, Reconsideration and Claim Timely Filing Request will now exist under the “Appeal” button.

Clicking the “Appeal” button brings up a window where the user can start a new appeal or show existing appeals. Click the gavel button to start a new request or click the inbox to see existing requests that have already been submitted.



The screenshot shows a web application window titled "Start New Appeal" with a close button (X) in the top right corner. On the left side, there is a dark sidebar containing two icons: a gavel icon and an envelope icon. A purple arrow points from the left towards the gavel icon. The main content area displays the following information:

- Member Information:** Member Name, Member ID, Date of Service (11/05/2022 - 11/05/2022), Claim ID (20223260000), and Billed Amount (\$28.40). A green checkmark and the word "Finalized" are visible in the top right of this section.
- Type:** A dropdown menu with the text "Select type ...".
- Reason:** A dropdown menu with the text "Select reason ...".
- Enter appeal details ...:** A large text input area with a character count of "2000 characters left" at the bottom right.
- Attachments:** A section with a dropdown arrow.
- Contact Information:** A section with an upward arrow and several input fields:
  - Two input fields for name (first and last).
  - One input field for email.
  - Input fields for "Phone Number" and "Extension" (with an "Optional" label).
  - A checkbox labeled "Save as Default Contact Information".
- Buttons:** "CANCEL" and "SUBMIT" (with a gavel icon) are located at the bottom right of the form.

In the “Type” drop down, users may choose from one of the three request types: Appeal, Reconsideration or Claim Timely Filing Dispute:

A screenshot of a web form's 'Type' dropdown menu. The menu is open, showing three options: 'Appeal', 'Reconsideration', and 'Claim Timely Filing Dispute'. The text 'Select type' is visible at the top of the dropdown list.

Then, in the “Reason” drop down, users may choose from one of the reasons available for your request type. The drop-down list for each type will change according to which type you choose. Please note the specific information and instructions that apply to each request type:

### Appeal -

A screenshot of the 'Appeal' form. The 'Type' dropdown is set to 'Appeal'. Below the dropdown, there are several paragraphs of text providing instructions on how to file an appeal, including a 60-day timeline and requirements for documentation. At the bottom, the 'Reason' dropdown is open, showing a list of reasons for denial such as 'Denied Not Medically Necessary', 'Denied Experimental or Investigative', and 'Contract Exclusion or Duplicate Service'.

### Reconsideration -

A screenshot of the 'Reconsideration' form. The 'Type' dropdown is set to 'Reconsideration'. The form contains instructions regarding the review process, such as 'A Reconsideration is a request to review a claim with additional information not previously provided'. The 'Reason' dropdown is open, showing options like 'Manufacturers Invoice for Pricing', 'Other Insurance Information (COB)', and 'Billing or Coding Dispute with Medical Rationale'.

### Claim Timely Filing Dispute -

A screenshot of the 'Claim Timely Filing Dispute' form. The 'Type' dropdown is set to 'Claim Timely Filing Dispute'. The form provides instructions on the 30-day review period and lists specific reasons for denial, such as 'Claim submitted with incorrect ID/patient name' and 'Provider system issue and/or human error which caused the claim or late charges to be filed outside your timely filing allotment'. The 'Reason' dropdown is open, showing options like 'Member ID card was not obtained' and 'Total Obstetrical (OB) care'.

After a type and reason are selected, a user may choose to add additional details in the free form text box and attach any supporting documentation. Please note that the preferred method to attach documents is to combine all pages into one document if possible. Your document(s) must be in a .pdf format in order to attach it to the request.

Enter your contact information and then submit your request. The “Save as Default Contact Information” check box allows this information to be saved as default for future use.

The screenshot shows a web form with the following sections:

- Enter appeal details**: A large text input area with a placeholder "Enter appeal details" and a character count of "2000 characters left".
- Attachments**: A section with a plus icon and "Add Document" link. Below it, a document titled "Timely\_Filing\_Overrid... .pdf" is attached with a dropdown menu set to "Supporting Documentation" and a trash icon.
- Contact Information**: A section with input fields for name (first and last), email, and phone number. The phone number field has "Extension" and "Optional" sub-fields. A checkbox labeled "Save as Default Contact Information" is located below the phone number field.
- Buttons**: "CANCEL" and "SUBMIT" buttons are located at the bottom right of the form.

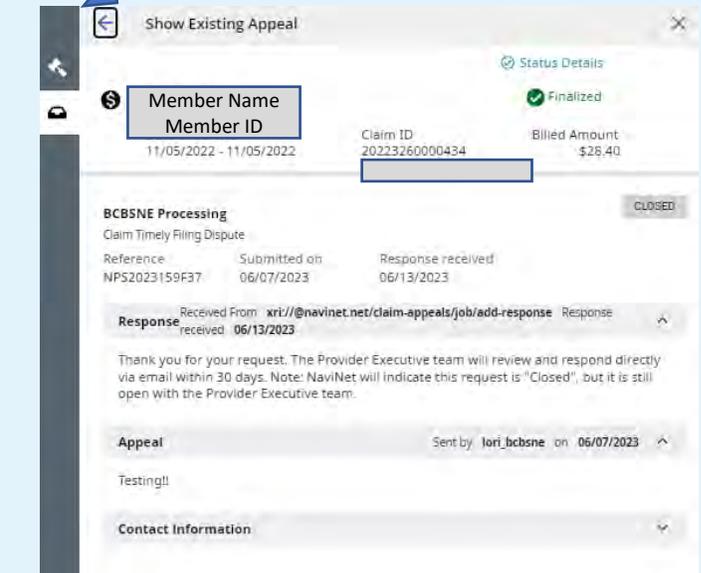
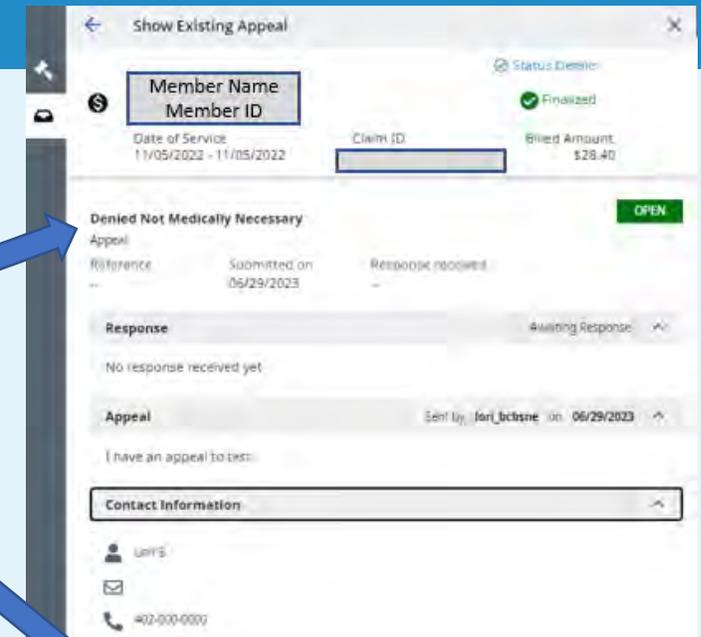
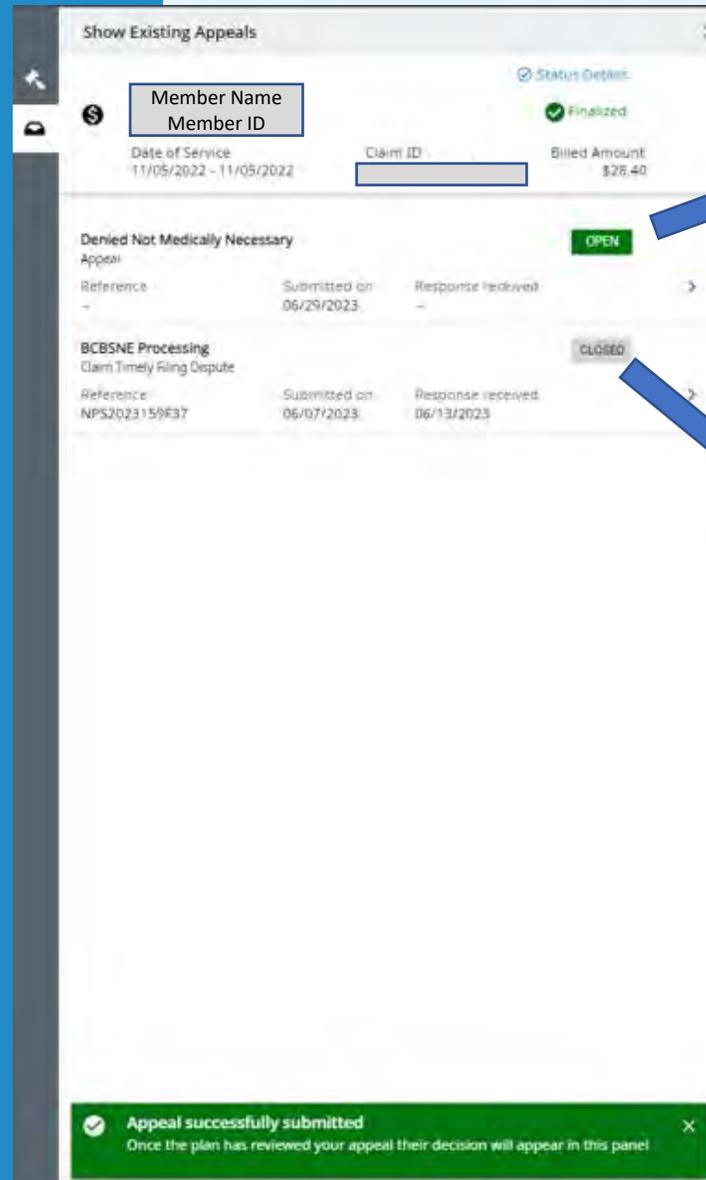
This new process no longer requires users to download the appeal, reconsideration and/or timely filing override request forms from NebraskaBlue.com. All information is submitted online, and only supporting documentation needs to be attached to your request if needed.

Providers no longer need to fill out these forms!

review your request and processed under a new claim must be submitted by Blue Cross and Blue Shield of Nebraska. All charges to be filed must use the information via: 72.

Once the request has been submitted successfully, a message will appear at the bottom right of the screen, confirming it was sent.

Requests that BCBSNE has not yet responded to will remain in an "OPEN" status. If the request has been responded to, the user will receive a message specific to that request and the appeal will indicate "CLOSED."



Depending on the outcome of the request, there are a variety of response messages, providing instruction on what has been done with the request. The Reference number field will also then be populated with a value. This value is a valid number on the BCBSNE systems that you may reference.

Responses to Appeals, Reconsiderations and Claim Timely Filing Disputes can take time to resolve. If at any time there is a question regarding the status of a request, just click on the “Investigate” button in the Claim Status Details and send an inquiry to Customer Service.

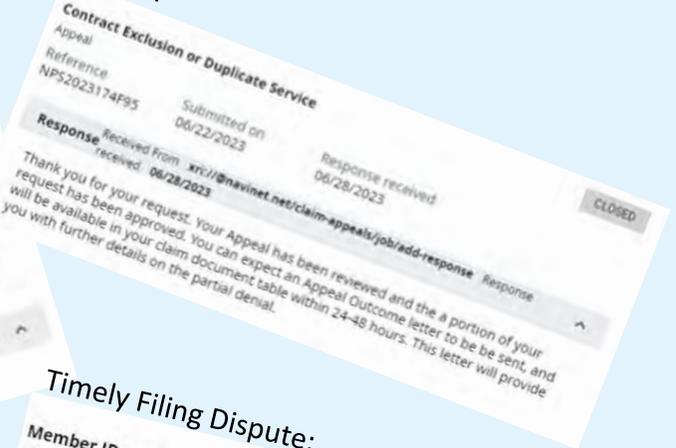
Responses will vary, based on the outcome of your request.

See examples below

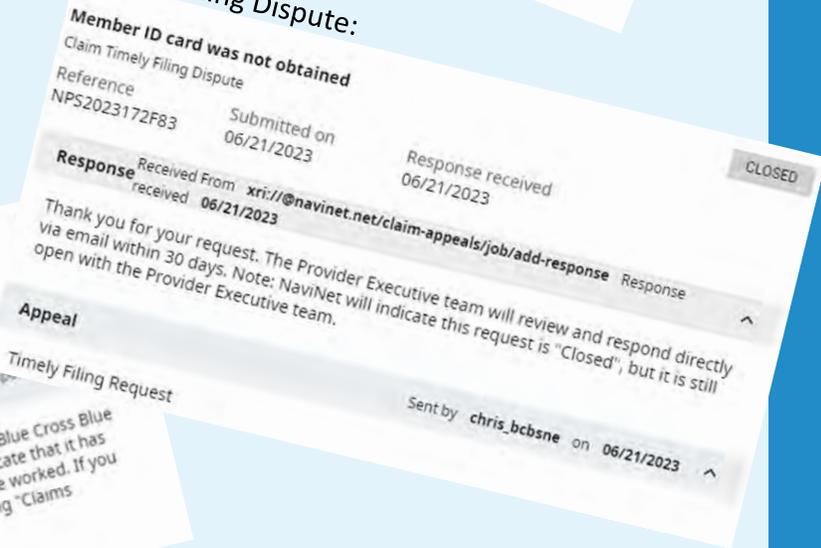
Reconsideration:



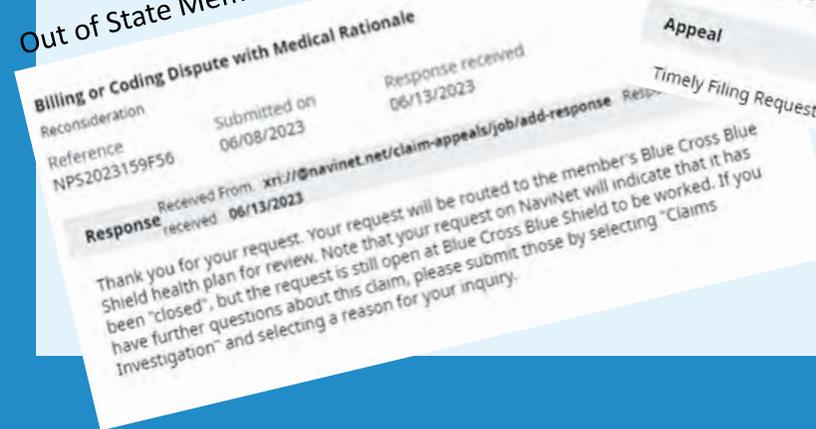
Appeal:



Timely Filing Dispute:



Out of State Member:



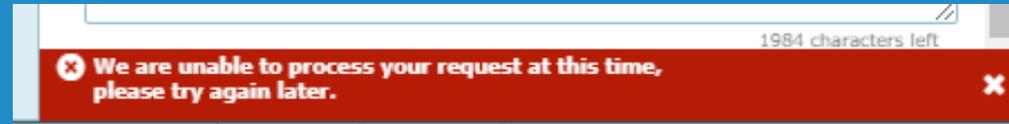
While the Claim Appeal application will contain a history of each request submitted, clicking the “History” button on the Claim Status Details page will also show any previous actions taken on that claim.



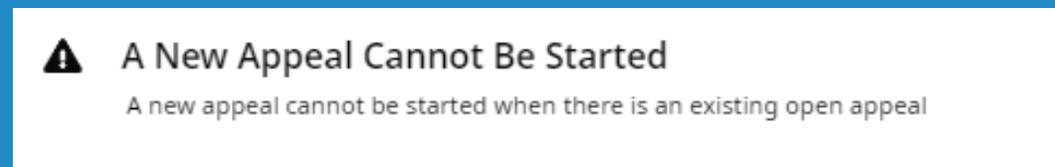
The screenshot shows a software interface with a top navigation bar containing icons for 'Attach', 'Investigate', 'History', and 'View/Print'. The 'History' button is highlighted with a green bar. Below this, a window titled 'History (33)' is open, displaying a list of actions. Each action entry includes an icon, a description, the actor (represented by a redacted box), and the timestamp.

Action	Actor	Timestamp
Appeal Request (Denied Not Medically Necessary)	[Redacted]	Jun 29, 2023 1:37pm
Investigation (Other Claims Questions)	[Redacted]	Jun 13, 2023 3:40pm
Appeal Response (BCBSNE Processing) from Health Plan	[Redacted]	Jun 13, 2023 1:03pm
Appeal Request (BCBSNE Processing)	[Redacted]	Jun 07, 2023 3:32pm
Investigation (Claim in process over 30 days from submission)	[Redacted]	Jun 07, 2023 3:18pm

An error box will appear if there was an issue with the submission. Users should attempt the request later and if issues still occur may contact NaviNet support to resolve.



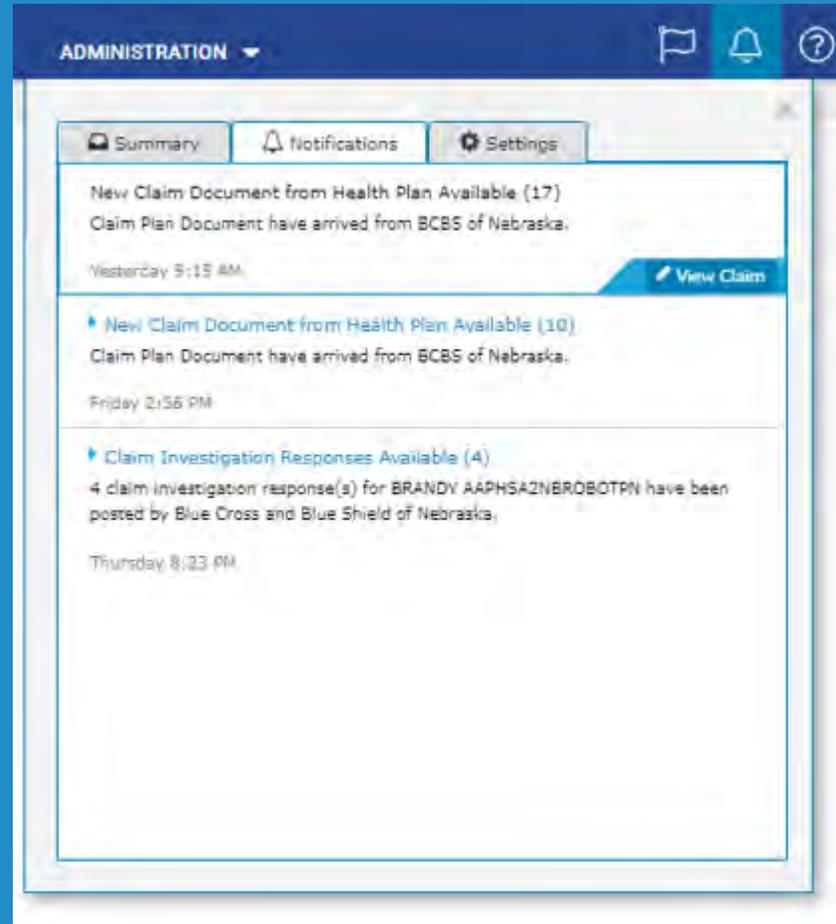
Also, be aware that only one request can be submitted on a claim at a time. If a user attempts to submit an appeal request on a claim that already has one open, the following message will be displayed:



# **Documents sent to NaviNet on a Claim Appeal**

In some cases, a document such as an Appeal Outcome or Reconsideration letter may be sent to NaviNet in support of the response to an appeal request.

If a user has notifications set up for claim documents, those will appear under the bell icon. Users may click that icon, and then the “Notifications” tab to see alerts. Then simply hover over each alert to view the claim or read the response.



If a document has been sent in response to your appeal request, there will now be a “Documents” table on the Claim Status Details screen, located beneath the “Claim and Service Line Details”.

If notifications are also set for documents, an alert will also appear on this screen to let the user know of a new document arriving:

**Claim Status Details** | Claim Status: BCBS of Nebraska

born on [redacted]

Attach Investigate History View/Print

**Finalized** (Claim Status as of 09/28/2022) Claim ID: [redacted] Service Dates: 09/25/2022 to 09/25/2022

The claim/line has been paid. Accepted for processing.

**ADDITIONAL DETAILS** NEW PLAN DOCUMENT AVAILABLE

Patient a/c: [redacted]  
 Clearinghouse Trace Number: [redacted]

**INSURANCE DETAILS**  
 BCBS of Nebraska  
 Member ID: [redacted]  
[View Eligibility and Benefits](#)

**Total Billed:** **\$221.90**  
**Total Paid:** [redacted]  
 Payment Number: [redacted]  
 (Paid on 09/28/2022)  
[Remittance Details](#)

**Claim and Service Line Details:**

Service	Units	Date(s)	Revenue Code	Status	Billed Amount	Paid Amount
1 [redacted]	1.0	09/25/2022 to 09/25/2022	--	Finalized The claim/encounter has completed the adjudication cycle and no more action will be taken. Responsibility Amount. The claim/encounter has completed the adjudication cycle and no more action will be taken. Charges applied to deductible.	\$81.90	[redacted]
2 [redacted]	1.0	09/25/2022 to 09/25/2022	--	Finalized The claim/encounter has completed the adjudication cycle and no more action will be taken. Accepted for processing.	\$140.00	[redacted]

**Documents (14)**

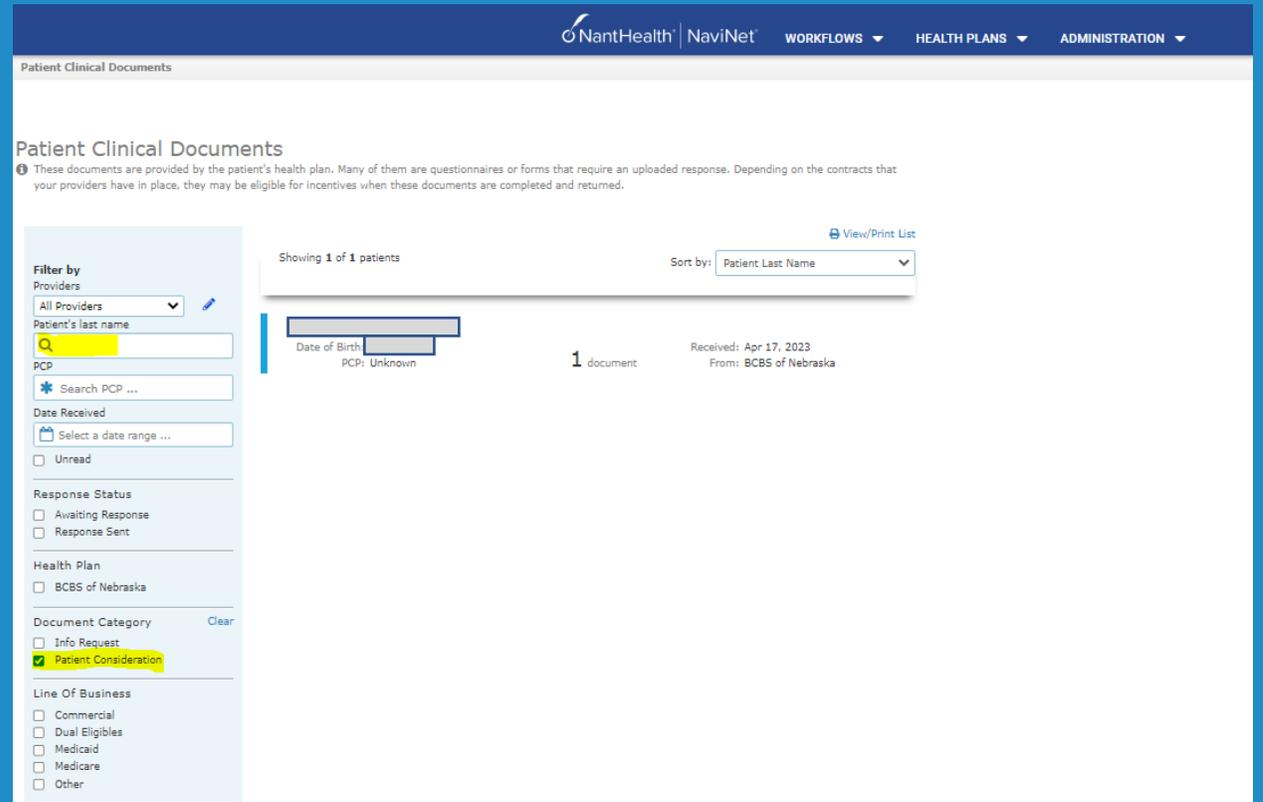
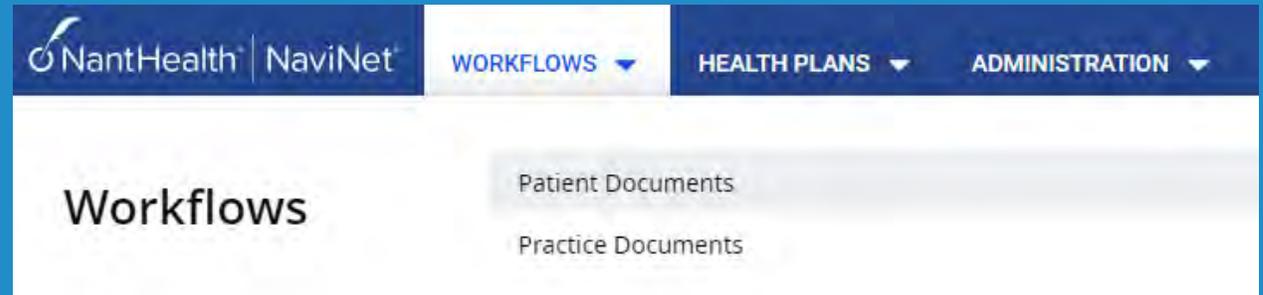
Name	Source
1 [redacted] Plan Document	Bcbsnebraska Health Plan 04/12/2023 4:22pm <span style="background-color: teal; color: white;">New</span>
2 [redacted] Appeals – Form and-or Letter Must be Included mockup_claim_document_041...	md_bcbsne 04/12/2023 4:01pm
3 [redacted] Plan Document	Bcbsnebraska Health Plan 04/12/2023 3:50pm <span style="background-color: teal; color: white;">New</span>



In case a document does not appear as expected within the Claim Status Details document table, these documents are also available under the WORKFLOWS, Patient Documents.

When in the Patient Documents, search by the Document Category of “Patient Consideration” and/or by the Patient’s last name.

Here the user can view, download and print patient documents, or mark them unread if needed. Documents sent as a part of a Claim Appeal response will remain on NaviNet for one year from the date they were sent.



# Questions

Please reach out to your Blue Cross Blue Shield of Nebraska representative with any questions.

