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# Appeals

# Overview

- Appeals
- Three Levels of Appeals
- Pre-Appeals

# Appeals Check List

- Information needed to process an appeal:
  - Provider name
  - Alaska Medicaid Contract ID number
  - Contact name and phone number
  - Recipient name
  - Recipient ID number

# Appeals Check List, cont.

- To review the appeal, we need:
  - Date of service
  - Service or procedure code
  - Reason for request
  - Supporting documentation
  - RA for claim being appealed

# What May Be Appealed?

- Denied or reduced claims
- Denied or reduced prior authorization
- Disputed recovery of overpayment
- Disputed admissions and continued stays
- Expedited appeal for inpatient services

# Actions That Are NOT Appeals

- Checking claim status
- Checking eligibility
- Timely changes to claims:
  - Adjustments/voids
  - Correction and resubmission
- Response to Resubmission Turnaround Documents (RTDs)

# Actions That Are NOT Appeals, cont.

- Request for a new code to be reviewed for Medical Assistance coverage
- Recipient request for a Fair Hearing
- A provider request for re-review of an Affiliated Computer Services (ACS) prior authorization decision with additional information



# Before Filing an Appeal

- Review claim and attachments:
  - Recipient information
  - All Prior Authorizations (PAs) for recipient and provider ID numbers
  - Claim history
  - Procedure or diagnosis codes

# Before Filing an Appeal, cont.

- Review claim and attachments, cont:
  - Pricing
  - Provider information
  - Resubmission Turnaround Documents
  - Adjustments

# Before Filing an Appeal, cont.

- Review claim and attachments, cont:
  - Remittance Advices (RAs)
  - Provider billing manuals
  - Check Eligibility Verification System (EVS) for current eligibility
  - Denial reason edit code

# Three Levels of Appeals

- First level appeals
- Second level appeals
- Commissioner level appeals

*Always follow proper sequence.*

# First Level Appeals/ACS Reviewed

- Appeals must be in writing
  - Use the appeal form
  - Include:
    - A copy of the claim
    - A copy of the RA
    - Supporting documentation
    - Completed adjustment or void request, if applicable
    - A copy of the disputed decision, if applicable
  - Mail to: Affiliated Computer Services, Inc.  
Provider Services Unit  
P. O. Box 240808  
Anchorage, AK 99524-0808



# First Level Appeals/Qualis Reviewed

- Disputed hospital admission
- Continued stay
- Selected procedures identified in the pre-certification list

<http://www.qualishealth.com>

# First Level Appeals/Qualis Reviewed, cont.

- Expedited appeals for inpatient services:
  - An accelerated review is requested when care is not certified and is imminent or ongoing.
    - Precertification review
    - Recertification review
    - Two days from receipt of “Notice of Non-Certification”
    - Two days following receipt of “Notice of Non-Certification,” Qualis responds through standard appeal process.



# First Level Appeals/Qualis Reviewed, cont.

- Standard appeal:
  - A review requested when care has been non-certified
  - May be submitted by fax, telephone or in writing within **180 days** of the date shown on a non-certification notice
  - A complete legible copy of the entire medical record must be submitted in order for Qualis Health to conduct the review
  - Qualis Health will issue the standard appeal decision within 30 days of the request



# First Level Appeals/Qualis Reviewed, cont.

- Behavioral Health:
  - Psychiatric admissions and continued stays
  - Residential Psychiatric Treatment Center (RPTC) admissions and continued stays

# First Level Appeals/Qualis Reviewed, cont.

- Request for Reconsideration
  - In writing within **10 days** of decision
  - Justify differing medical opinion

# First Level Appeals/Qualis Reviewed, cont.

- Expedited and standard appeals mailed to:

Qualis Health

Attn: Care Management Department/Appeal Review

10700 Meridian Ave North, Suite 100

P.O. Box 33400

Seattle, WA 98133-0400

Phone: (800) 783-9207

Fax: (800) 826-3630

<http://www.qualishealth.org>



# First Level Appeals

## Division of Behavioral Health Reviewed

- Denied or reduced prior authorization
  - Service limit extension for substance abuse treatment
  - In writing:
    - 180 days from the denied or reduced PA request
  - Basis for appeal and supporting documentation

Department of Health and Social Services  
Division of Behavioral Health  
Attn: Claims Appeal Section  
3601 C Street, Suite 878  
Anchorage, AK 99503-5923



# First Level Appeals/Division of Senior and Disability Services (DSDS) Reviewed

- Denied or reduced PA requests
  - Administrative wait and swing bed stays at acute care facilities
  - Long Term Care facility admissions and continued stays
  - Home and community-based service
  - Personal Care Attendant services

# First Level Appeals/Division of Senior and Disability Services (DSDS) Reviewed

- In writing:
  - 180 days from the denied or reduced PA or service request
- Basis for challenge
- Supporting documentation

# First Level Appeals/Division of Senior and Disability Services (DSDS) Reviewed

- Mail to:

Department of Health and Social Services  
Division of Senior and Disabilities Services  
Attn: Claims Appeal Section  
550 W. 8th Avenue  
Anchorage, AK 99501



# First Level Appeals/Dept of Health and Social Services (DHSS) Reviewed

- Denied enrollment
- Disenrollment

# First Level Appeals/Dept of Health and Social Services (DHSS) Reviewed

- In writing:
  - **180 days** from the denied enrollment or disenrollment decision.
- Basis for the challenge
- Supporting documentation
- **Decision final**

Department of Health and Social Services

<http://www.hss.state.ak.us/publicnotice/regulations.cfm#LtGovernor>



# First Level Appeals Review and Decision

- Once an appeal has been reviewed, a determination letter will be sent to the provider.
  - Wait for decision before taking further action.
- If you are dissatisfied with the first level appeal decision, you may submit a second level appeal in writing to the Division or Office listed for second level appeals.
  - Not applicable for enrollment/disenrollment appeals

# Examples of First Level Appeal Issues

- Timely Filing Issues
- Insufficient Medical Justification
- ClaimCheck<sup>®</sup> issues
  - 437 – denials
  - 434 – bundled
  - Children's Clinic
  - Pediatric

# Timely Filing

- All claims must be filed within 12 months of the date services were provided to the recipient.
- The 12-month timely filing limit applies to all claims, including those that must first be filed with a third party carrier.

# Insufficient Medical Justification/ Medical Records Required

- When appealing denied claims that required medical justification or medical records, ensure the information sent with the appeal:
  - Is for the correct date of service
  - Is for the correct recipient
  - Supports the procedure/diagnosis codes
  - Is for the correct service

# Insufficient Medical Justification/ Medical Records Required, cont.

Examples of denial reasons:

- Edit 289 - Medical justification/Medical records required
- Edit 946 - Insufficient medical necessity justification

# ClaimCheck® Issues

## Automated Voids:

- Paid claims will be compared to claims being processed based on the same provider, same recipient, and same date of service. When an invalid relationship is found, an automated void of the previously paid claim may occur or the current claim may deny.
- The associated explanation of benefits (EOB) for an automated void will appear on the “voided claims” page of the RA. If the total dollar amount of the automated voids exceeds the amount of your paid claims/adjustments, an accounts receivable will be set up. This balance will be collected on future RAs.

A B JONES MD  
543 MAIN STREET  
ANCHORAGE AK 99508

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
REMITTANCE ADVICE

DATE: 03/06/01  
REMITTANCE: 123456  
REMIT SEQ: 123  
PAGE: 4

PROVIDER NO:MD0001  
CLAIM TYPE 13 - PHYSICIAN SERVICES  
VOIDED CLAIMS

CLIENT ID	RECIPIENT	NAME	CLAIM CONTROL #	MED REC NBR	RENDER PROV	LINE	SERVICE DATES	PROCEDURE CODE/DESCRIPTION	PROC MOD	UNITS	BILLED	ALLOWED	OTH-DED	PAYMENT	EOB STATUS
0600000002	SMITH	KF	10591800001	00003	MD0001	01	122800 122800	99212 OFFICE OR OTHER OUTPATIENT		1	73.00-	52.91-	3.00	49.91-	462 VOID
VOID ICN:1040115104601 DATED: 020901															
THIRD PARTY		0.00	CO-PAYMENT	3.00-	CLAIM TOTAL						73.00-	52.91-	3.00	49.91-	
VOIDED CLAIM		TOTALS	1 CLAIM LINES	TPL	0.00						73.00-	52.91-	3.00	49.91-	



# Second Level Appeals

- No later than **60 days** after first level appeal decision
- Include:
  - Description of the issue or decision being appealed
  - Reason for request
  - Copy of decision of first level appeal
  - Copy of denial or payment notice
  - Copy of original claim
  - All information and materials for consideration

## Second Level Appeals, cont.

- Except for timely filing appeals, the decision by the Department of Health and Social Services is a final administrative decision.
- Providers have the right to appeal to the superior court under the Alaska Rules of Appellate Procedure.

# Appeals to the Commissioner

- For challenging timely filing decisions **only**
- After second level has been denied by DHSS
- In writing --- Do not initiate by telephone:
  - No later than **60 days** from date of second level appeal decision
  - Include clear description of timely filing issue

# Commissioner Level Appeals

- Send to:

Commissioner's Office  
Department of Health and Social Services  
P.O. Box 110601  
Juneau, AK 99811-0601

# Pre-Appeals Process

- Only for exceptional circumstances:
  - Submit documentation to support exception
  - Examples:
    - Outpatient labs, then admitted to IP hospital
    - Asthma in office, then admitted to IP hospital
- Use Appeals form
  - Distinguish as Pre-Appeal
  - Submit with claim
- Response via future RA

# Pre-Appeals

- Send to:

Affiliated Computer Services, Inc.  
Attention: Pre-Appeal Review  
P.O. Box 240808  
Anchorage, AK 99524-0649



# Need More Help?

The ACS Website at <http://medicaidalaska.com>

- Provides the necessary information you will need for successful billing.
- Includes access to Provider Medicaid Billing Manuals and fee schedules.

Or, you may call the following Departments by dialing:  
*(907) 644-6800 or (800) 770-5650 (Toll-free in Alaska).*

Option keys are noted below:

**Billing/Coverage/Claim Status Questions:** *Option 1 or  
(800) 770-5650 (Toll-free in Alaska), option 1, 1*

**Electronic Commerce Customer Support/PayerPath:** *Option 3 or  
(800) 770-5650 (Toll-free in Alaska) option 1, 4*

**Provider Inquiry** *(907) 644-6800 option 1 or  
(800) 770-5650 (Toll-free in Alaska) option 1, 1*

**Enrollment Questions:** *Option 2 or  
(800) 770-5650 (Toll-free in Alaska), # 1, 3*



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# Preparing for HIPAA 5010

- Centers for Medicare and Medicaid Services (CMS) Standard
- 5010 Implementation January 1, 2012
- Regulate Electronic Transmission of Healthcare Transactions
- 5010 Transactions Testing



# Preparing for ICD-10

- Center for Medicare and Medicaid Services (CMS) Mandate
- Two components
  - ICD-10-CM Diagnosis Codes
  - ICD-10-PCS Institutional Procedure Codes
- Service Date Driven
  - Outpatient Claims
  - Inpatient Claims
- Prepare Now



# Resources

- CMS ICD-10 Website
- <http://www.cms.gov/ICD10/>
- Affiliated Computer Services (ACS) Alaska Medical Assistance Website
- <http://medicaidalaska.com>



# Resources

- CMS 5010 D.0 Websites
  - <http://www.cms.gov/Versions5010andD0/>
  - <http://www.cms.gov/MFFS5010D0/>
- Affiliated Computer Services (ACS) Alaska Medical Assistance Website
  - <http://medicaidalaska.com>