Appeal, Adjustment and Record Submissions

Katie Foster- Provider Training, Operations

MEDICA®

Agenda

Appeals and Adjustments- Overview

Submitting an Appeal/Adjustment

Electronic Submission

Submission Tips

Appeals and Adjustments- Overview

Appeals and Adjustments

Definitions

- An Adjustment is a transaction that is made to correct a claim after it has been processed. If a claim is processed incorrectly or a corrected claim is sent, an adjustment will be made to reverse the original claim payment

- An Appeal is a request to change a decision in the way a claim is being processed and is sent with supporting documentation as to why the charges should be reconsidered

- Requests for an adjustment or appeal will be reviewed by clinical or coding staff accordingly

Reasons for an Appeal/Adjustment

- Provider is underpaid or overpaid
- Incorrect provider is reimbursed
- Medica claim audit procedure uncovers an error
- Medica staff receives new information about a claim or an agreement under which it was processed
- Reconsideration/review of a decision made on the original claim submitted

Appeals and Adjustments

Timeframes

- Requests for appeals/adjustments must be made within 12 months of the claim processing date

- If a request for more information is received, the corrected claim or additional information must be resubmitted and received at the designated claims address within 60 days of the date on the letter from Medica/Medica Vendor or PRA

Timeframe Exceptions

- Adjustments due to: (1) Coordination of Benefits recovery; (2) payments subject to subrogation recovery; (3) duplicate claims payments; and (4) retroactive terminations due to a retroactive determination of a member's eligibility for a government program or subsidy, are not considered corrective adjustments and may be made at any time by Medica.

Timeframe Exceptions

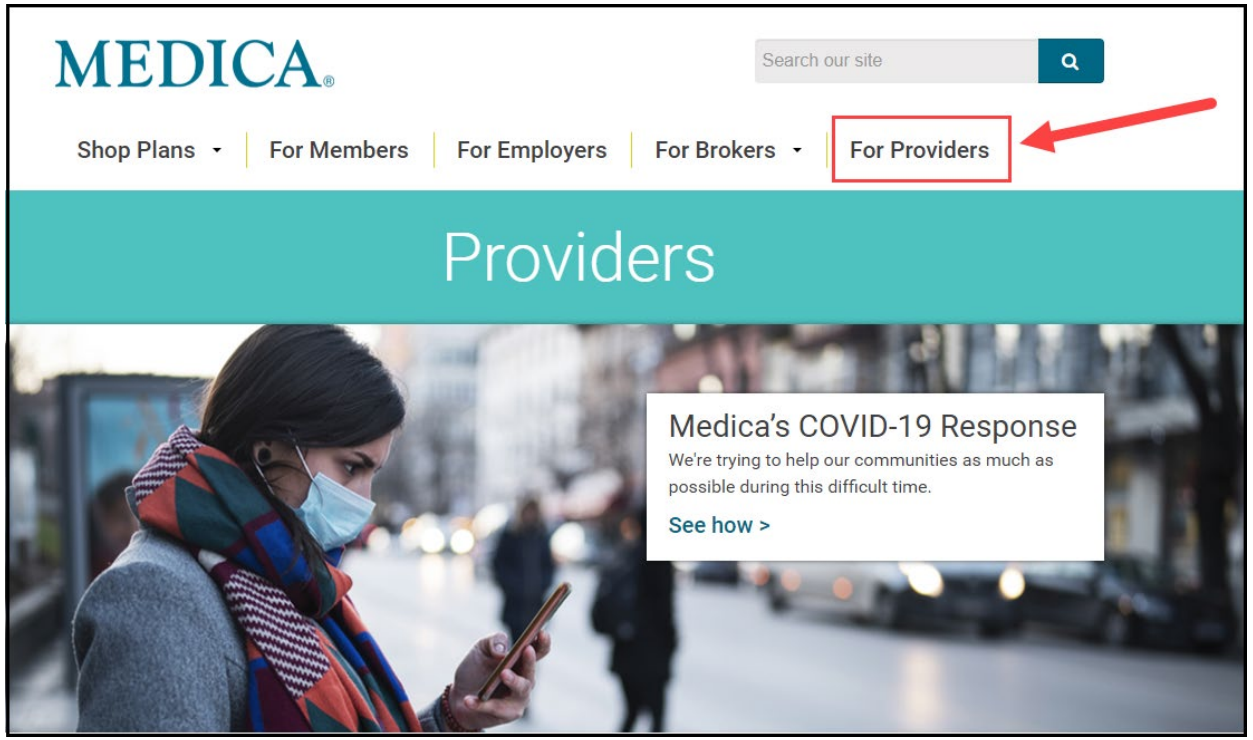
- Adjustments may also be made (through our Special Investigations Unit) as a result of erroneous, abusive or fraudulent billing. This can happen up to six years from the claim payment date, after the provider is advised of the nature of the adjustment

Submitting an Appeal/Adjustment

Submitting an Appeal/Adjustment

Locating the Appeal/Adjustment Form:

Medica.com->For Providers->Resources->Administrative Resources->Claim Tools



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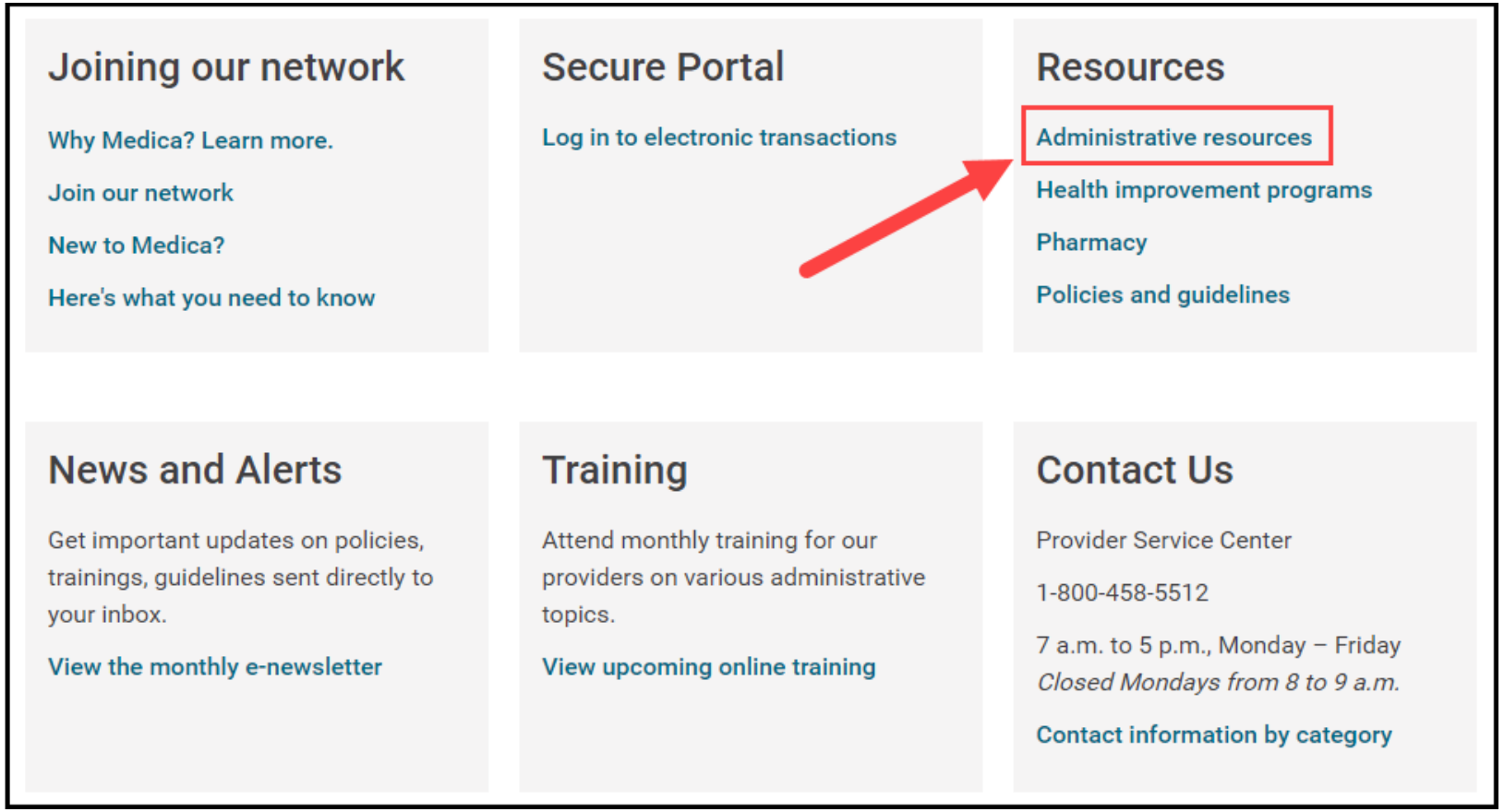

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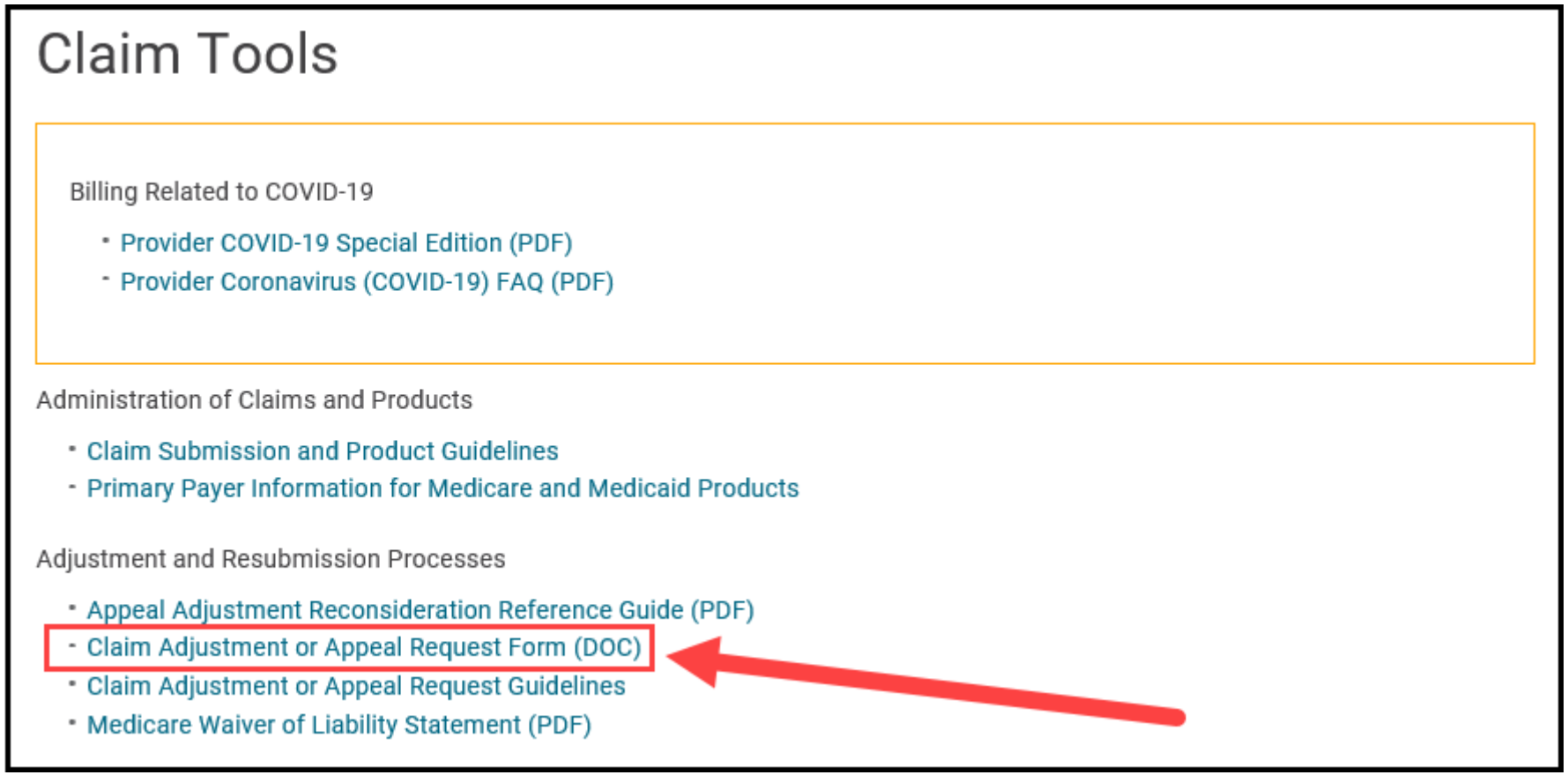


Submitting an Appeal/Adjustment

Appeal/Adjustment Form:

MEDICA®

CLAIM ADJUSTMENT OR APPEAL REQUEST FORM

NOTE: Appeals related to a claim denial for lack of prior authorization must be received within 60 days of the denial date. All other adjustments and appeals must be received within 12 months of the original denial date. **One form per claim.**

FOR MEMBERS WITH GROUP/POLICY:

with only numbers (payer ID 94265) send to:	**beginning with B or IFB** (payer ID 12422) send to:	**beginning with A** (payer ID 71890, 53589 or 88090) send to:
Medica PO Box 30990 Salt Lake City, UT 84130	Medica PO Box 21051 Eagan, MN 55121-0051	Medica PO Box 211435 Eagan, MN 55121-0051
Or fax this form to: 1-801-994-1076	Or fax this form to: 952-992-1427 Or submit this form electronically	Or fax this form to: 952-992-3024 Or submit this form electronically

PROVIDER INFORMATION:

Practitioner Name: Tax Identification Number (TIN):

Facility/Group Name:

Provider Number (10 or 11 digits): Provider Patient Account Number:

CONTACT INFORMATION:
Requester: Phone Number: Fax Number: Date:

CLAIM INFORMATION:

Member (Patient) Name:

Member Group and ID Number: Date(s) of Service:

Claim Number: Denial / Reason Code(s):

REASON FOR REQUEST:

- ☐ Timely Filing – claims submitted beyond 180 days from DOS or 12 months from the disallow date
- ☐ Pricing – Incorrect payment or application of benefits
- ☐ Eligibility – Payment issues for ineligible charges, claim processed as incorrect member, incorrect order of payment or other issues related to member eligibility
- ☐ Medical Policy – Request a determination of medical necessity or a denial for failure to obtain prior authorization. ***60 days in the case of lack of prior authorization.*** Supporting documentation is required.
- ☐ Code Review – Request of coding decision; supporting documentation required
- ☐ Other -

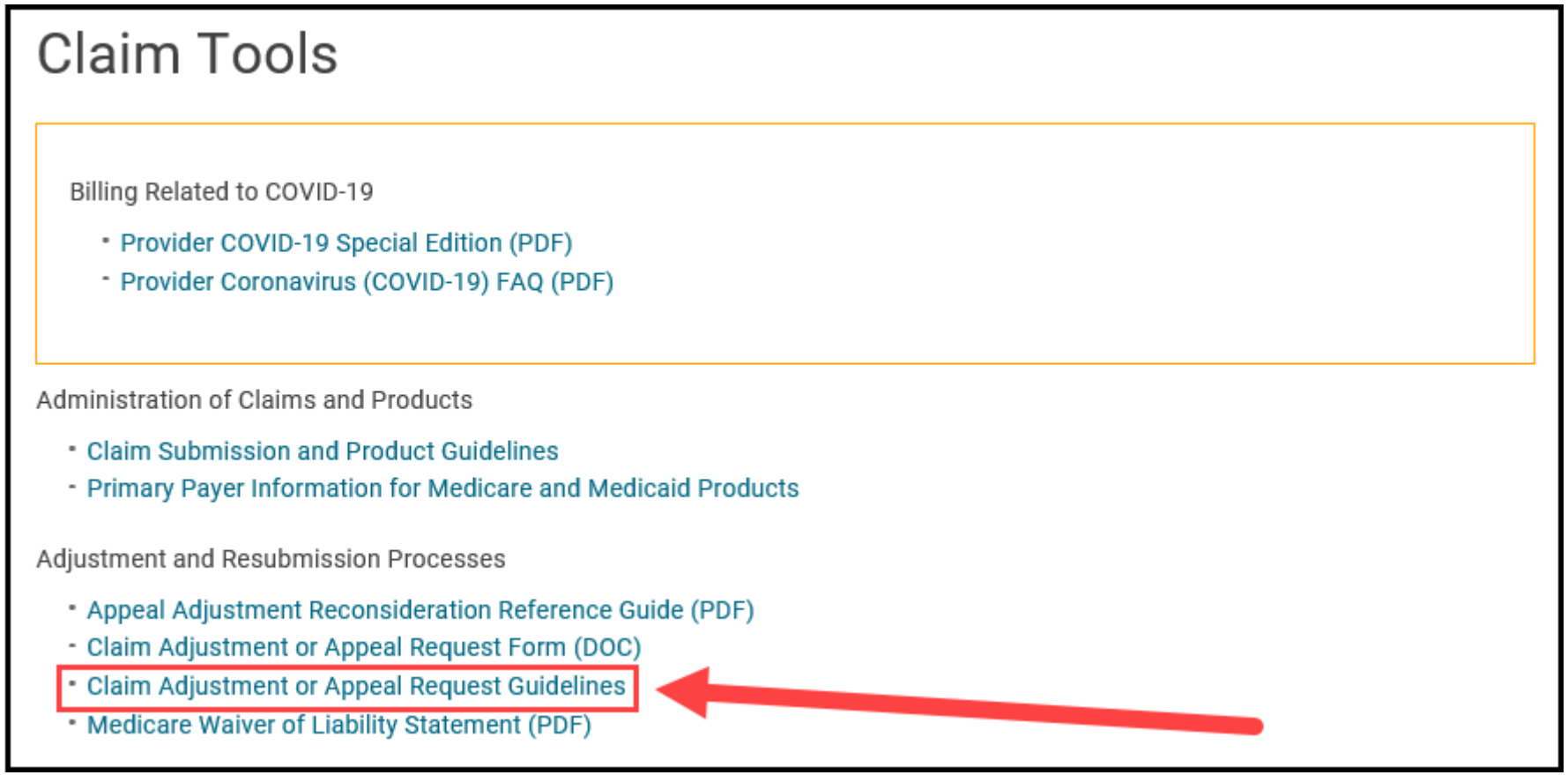
SUPPLEMENTAL DOCUMENTATION ATTACHED:
☐ Remittance Advice ☐ Refund ☐ Medical Records
☐ Other (e.g. timely filing documentation such as practice management notes)

After you have received a response for your initial request and if you still do not agree, you may appeal by adding your rationale below and attach supporting documentation. Please submit to the appropriate address above.

TOTAL NUMBER OF PAGES:

Submitting an Appeal/Adjustment

Submission Variables



Submitting an Appeal/Adjustment

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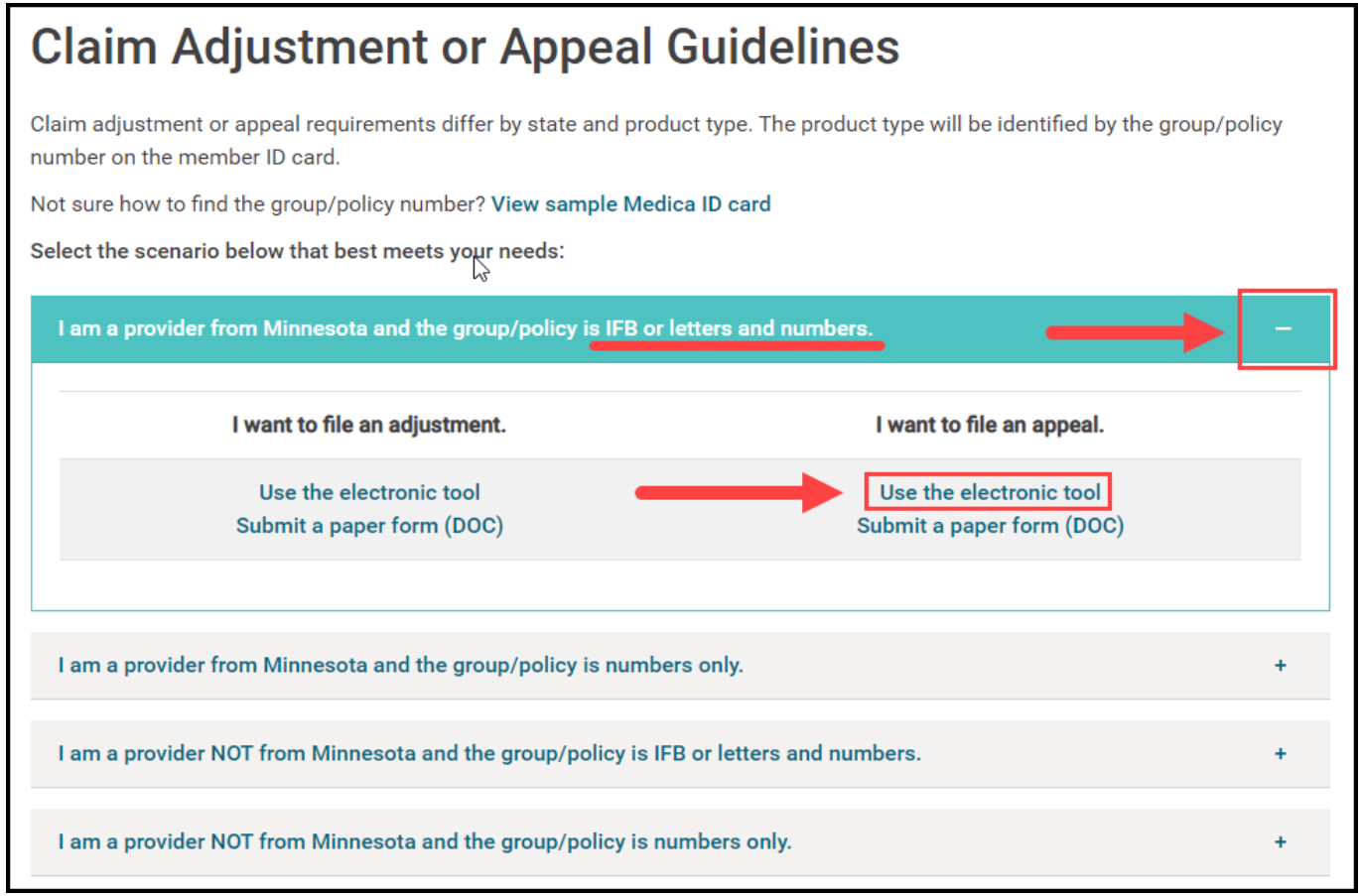
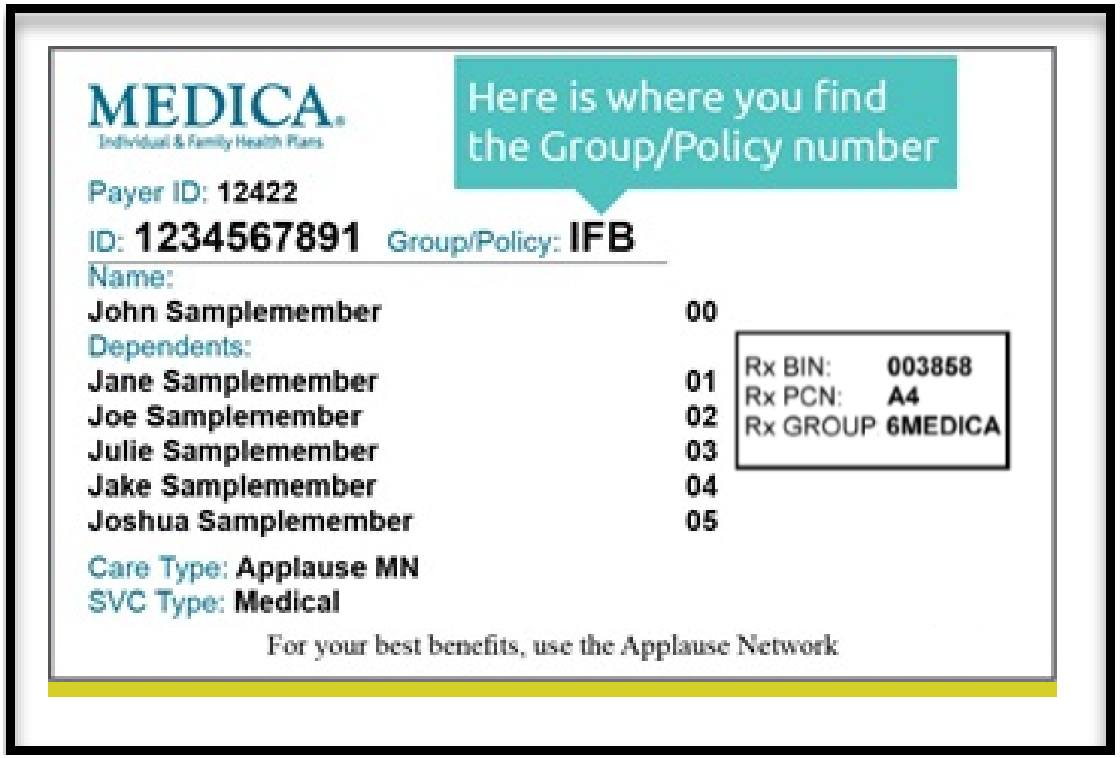
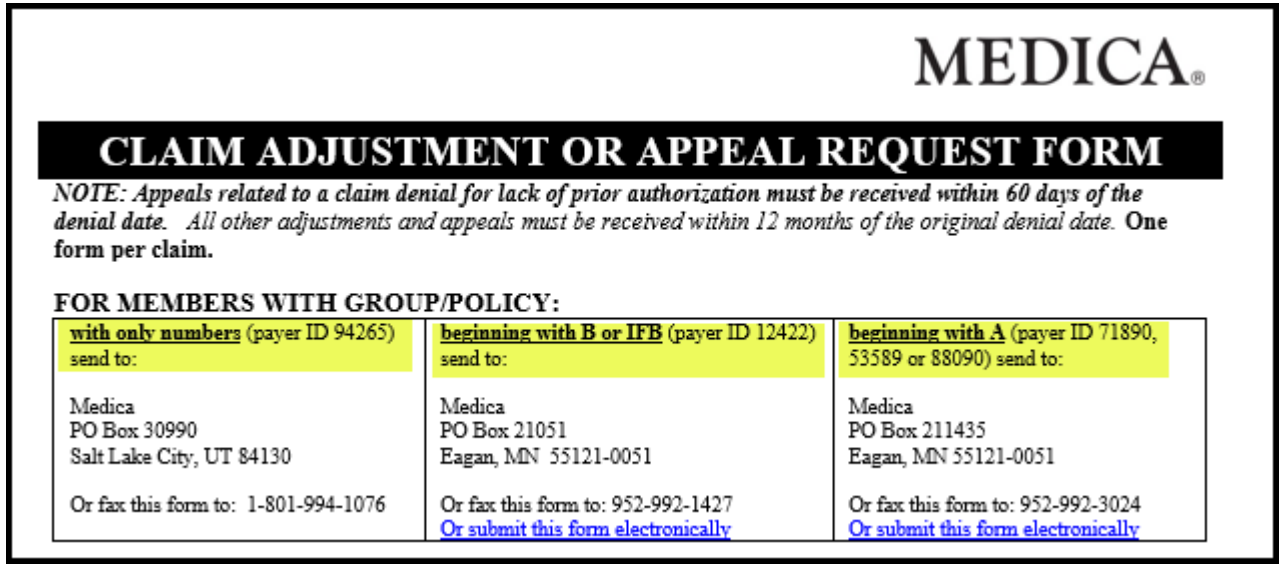


Submitting an Appeal/Adjustment

Sample ID Card





MEDICA

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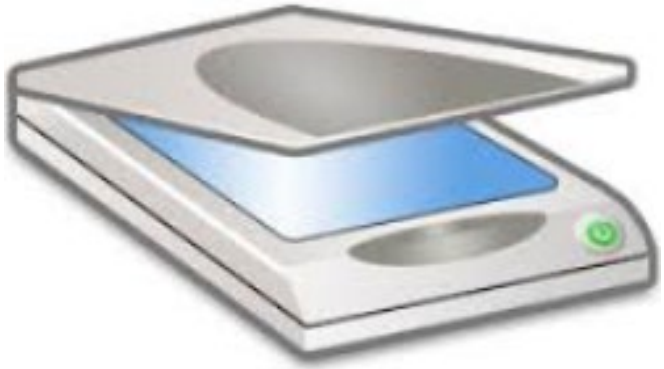
Electronic Submission

Electronic Submission

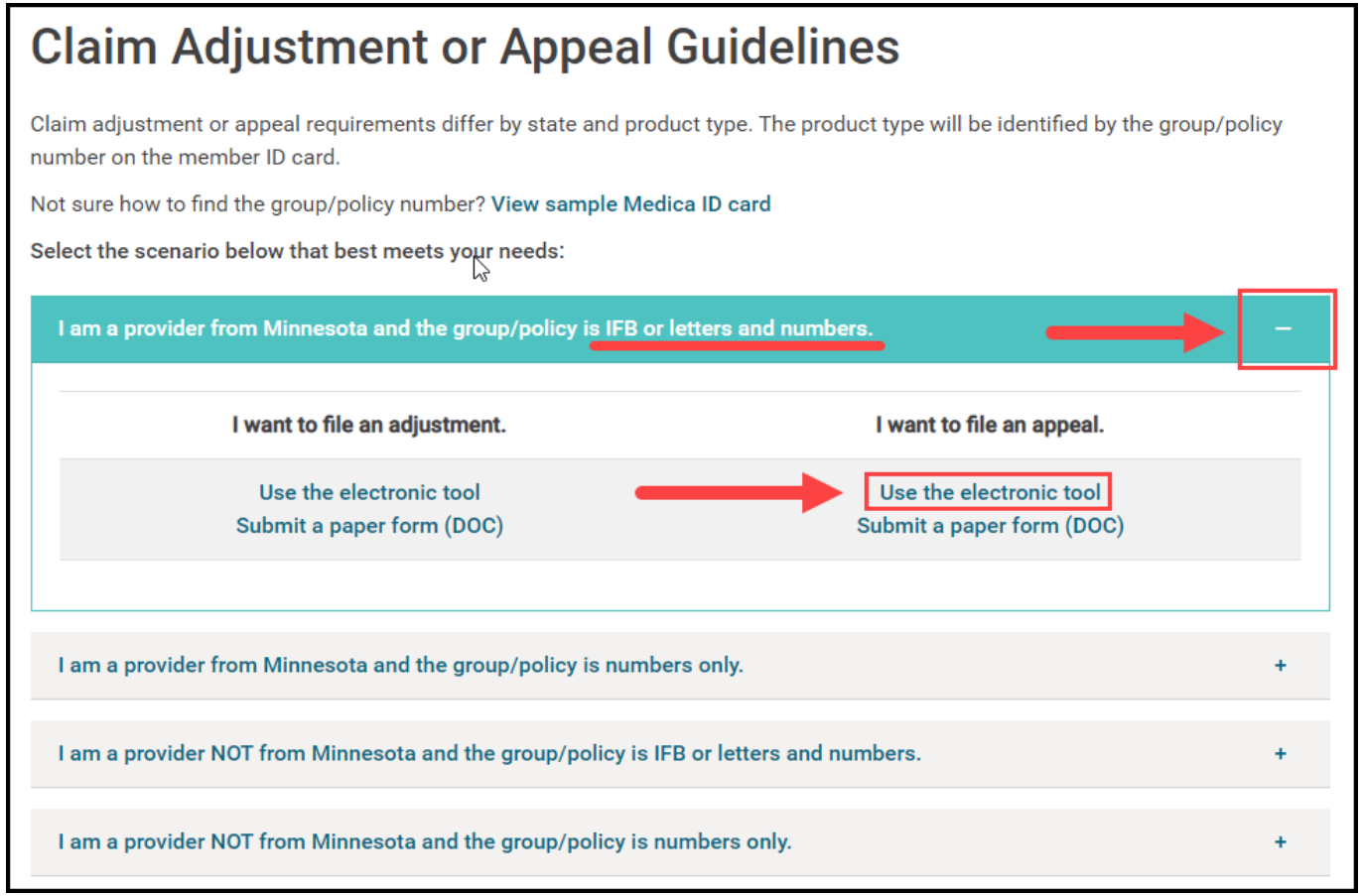
Overview

- For alpha-numeric group numbers and Individual/Family Business (IFB) claims, providers can scan documents, save the files to a desktop or hard drive and then attach them to a secure electronic form

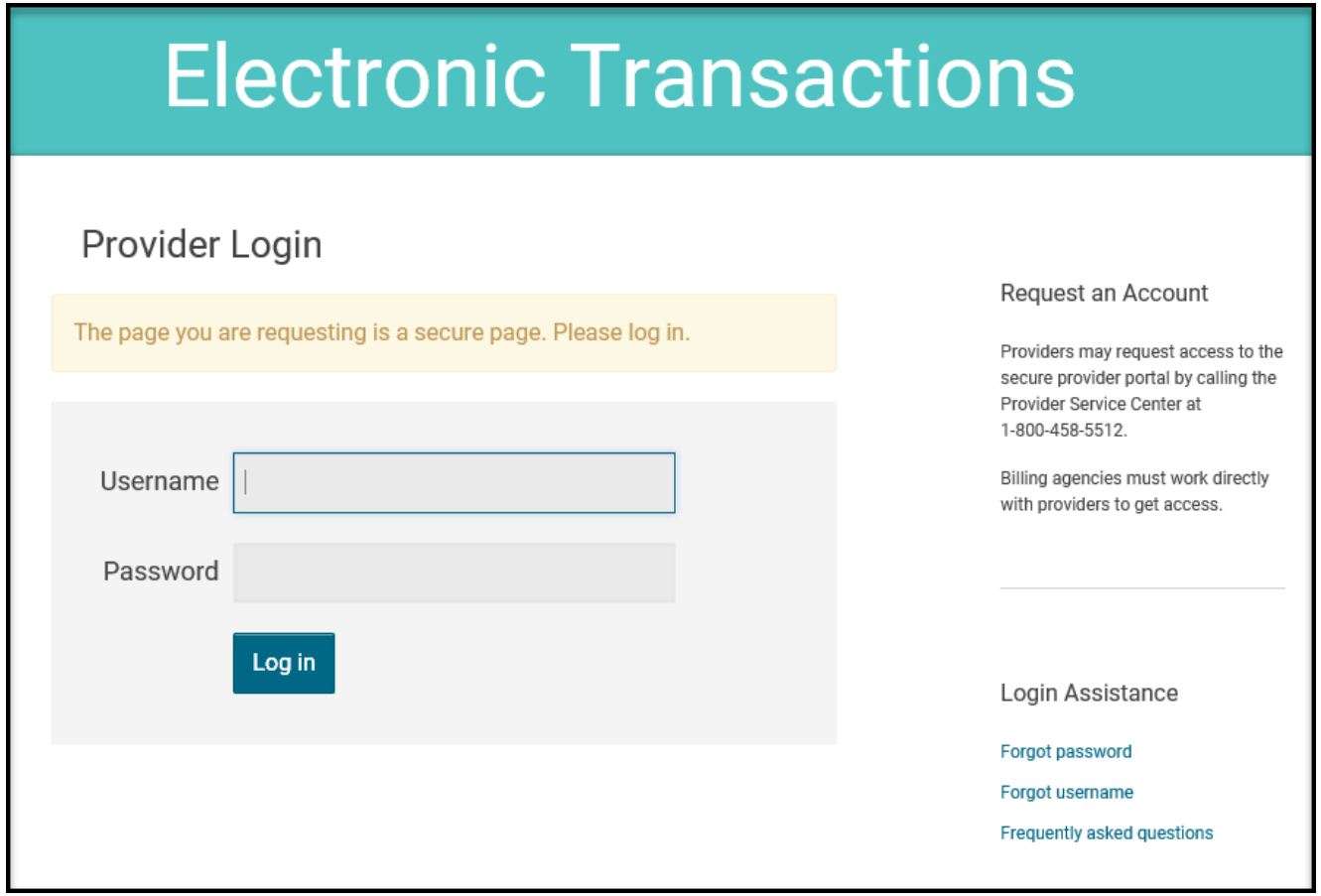


Electronic Submission

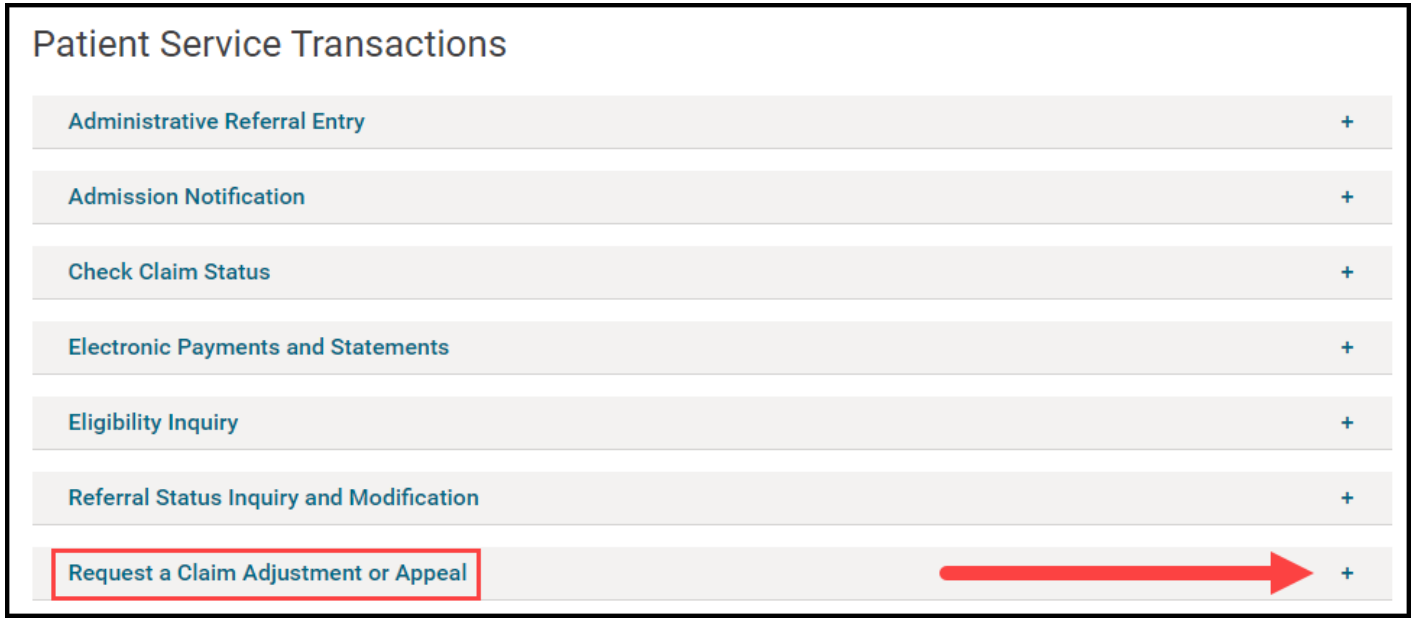
Submission Process:



Logging into Provider Portal:



Electronic Transactions Menu:



Electronic Submission

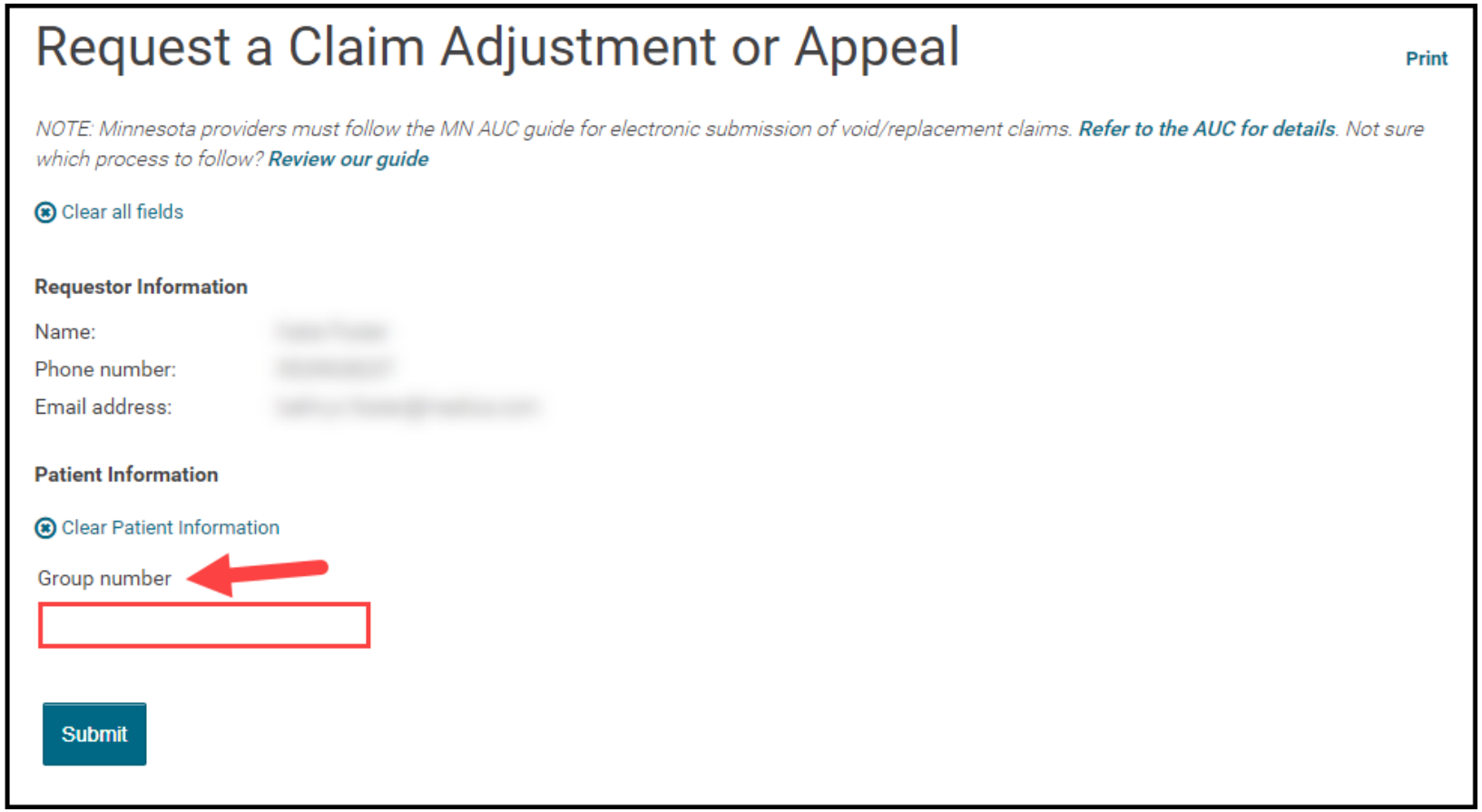
Request Options:

Request a Claim Adjustment or Appeal —

The patient's Group/Policy number is:	5 or 6 digits	**Use the online form**
	"IFB" or alphanumeric	**Use the online form**
	Policy # is 10 digits and starts with 230 (230XXXXXXX)	This is a Medicare Supplement plan. Appeals should be sent directly to Medicare since Medicare is the primary payer.

Minnesota providers must follow the **MN AUC guide for electronic submission of void/replacement claims**. Not sure which process to follow? **View Medica Claim Adjustment or Appeal Guidelines**

Submission Form Details:



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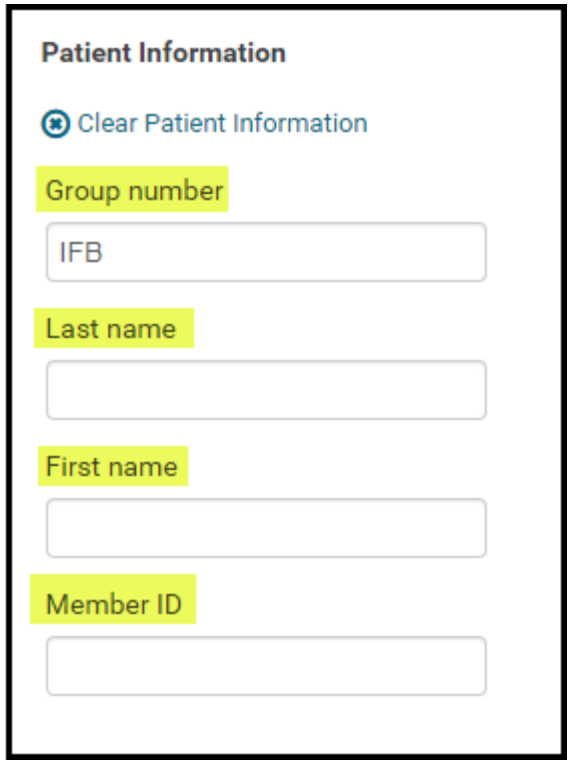
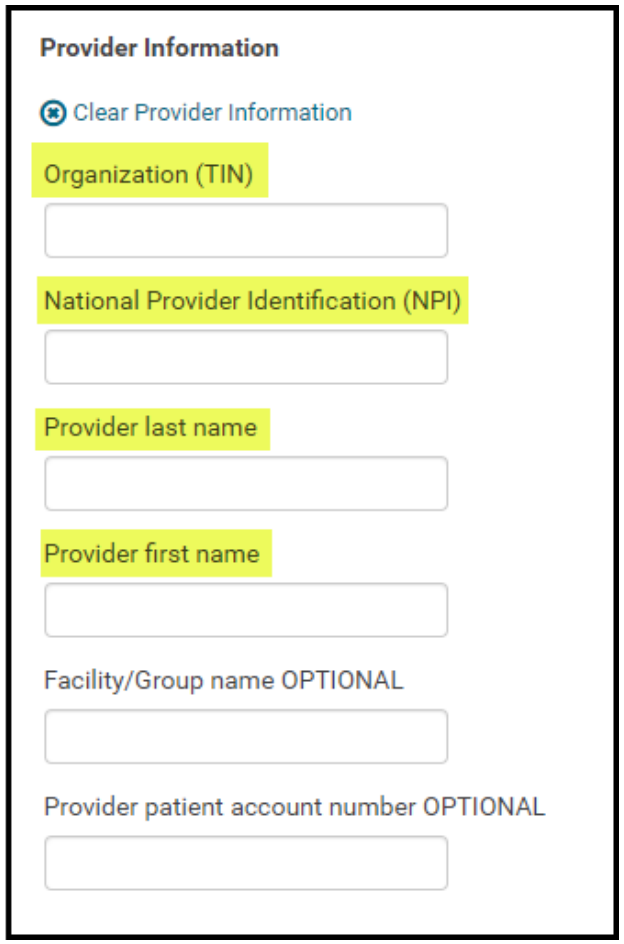
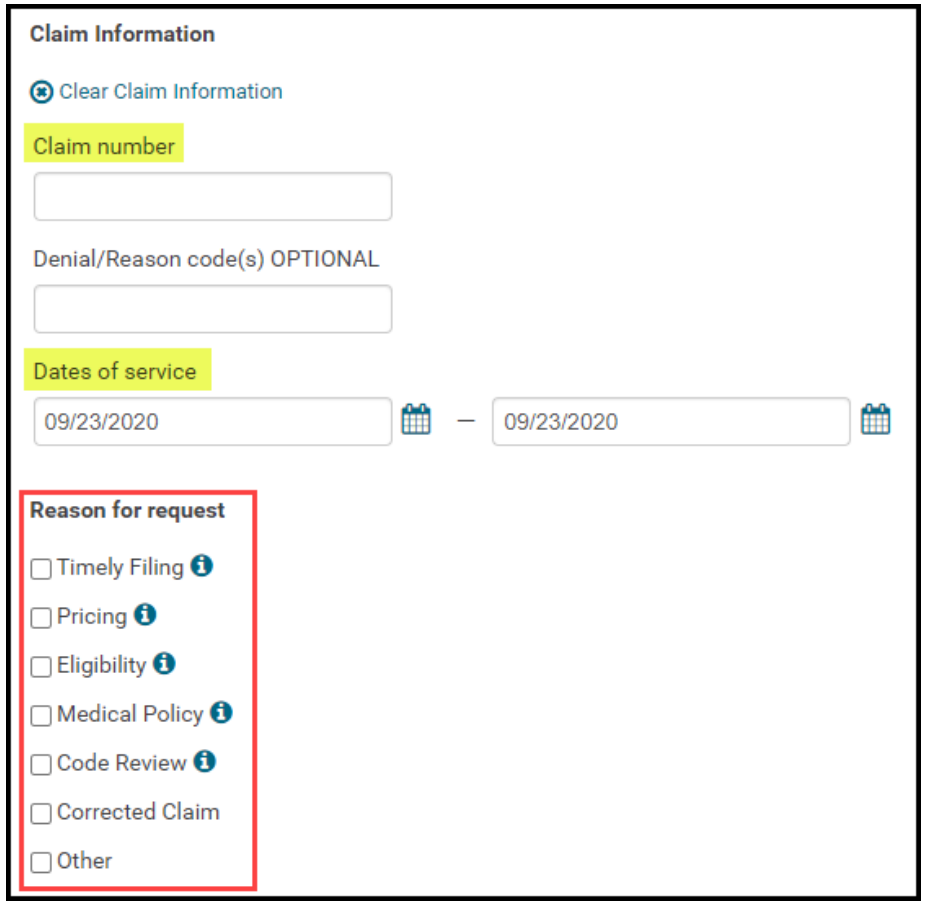
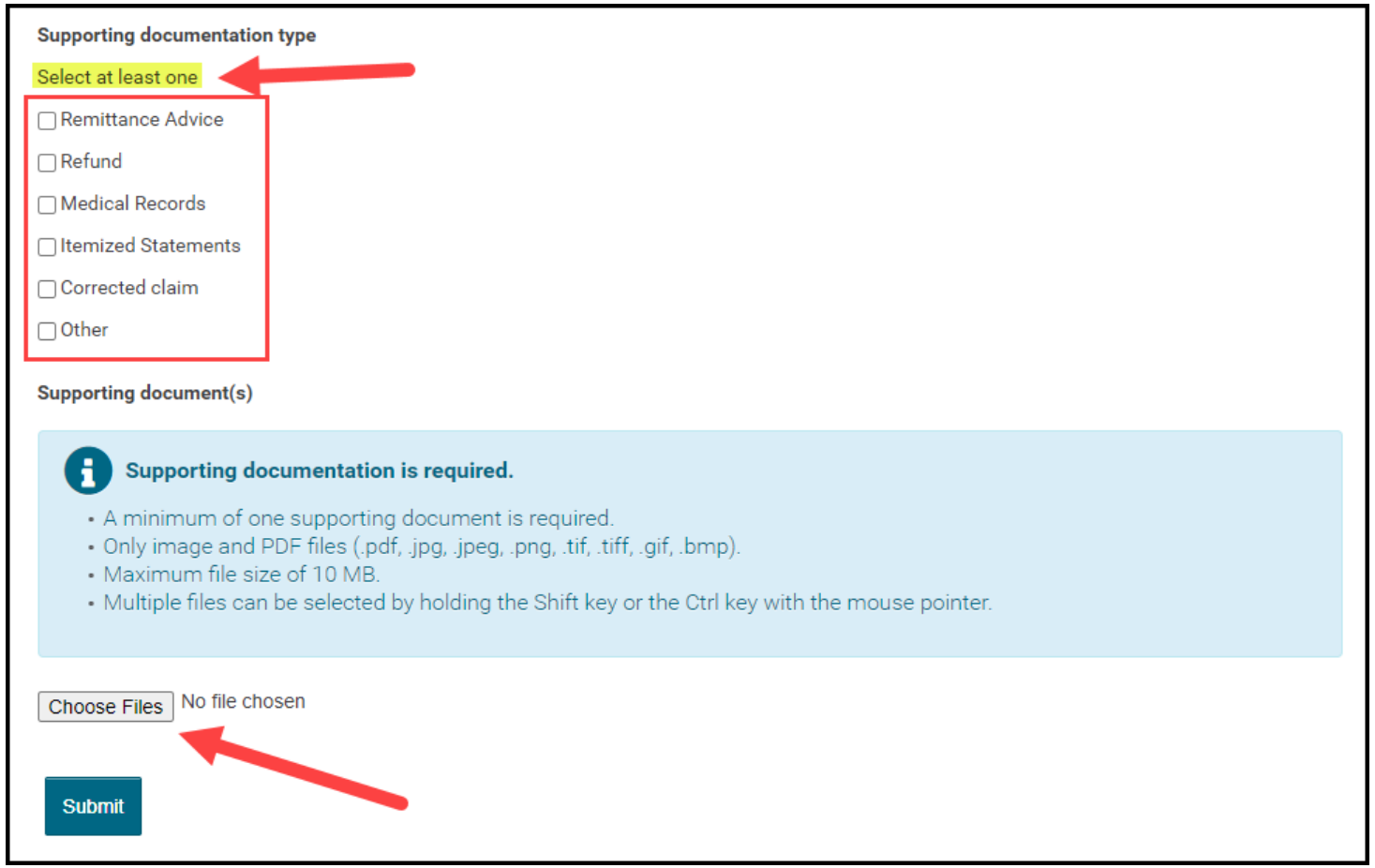






Submitting Attachments:



Submission Tips

Submission Tips

Overview

- Understanding the reason for a denial and knowing when services are eligible for an adjustment/appeal can reduce a lot of rework when submitting appeal/adjustment requests

- We will now review some common denial reasons and how adjustments/appeals are processed at Medica

Submission Tips

Identifying the Denial Reason:

- Searching for the code in question on medica.com is a great way to find any associated Utilization Management (UM), Coverage or Reimbursement Policies

Submission Tips

Coverage Policies, UM Policies and Prior Authorization

- Coverage Policies and UM Policies contain clinical criteria used by Medica staff for prior authorization, appropriateness of care determination and coverage

- UM Policies include a list of codes that require Prior Authorization (excluding medical pharmacy "J Codes"):

Service Category	Policy Name	Current Procedural Terminology (CPT) Codes	Commercial products	Individual & Family Business (IFB) products	Medica Advantage Solution® PPO *as of 1/1/19*	Medica DUAL Solution® (MSHO); plus Medica AccessAbility Solution Enhanced (SNBC SNP) *as of 1/1/19*	Medica Choice Care (MSC+), Medica AccessAbility Solution® (SNBC)	Mayo Medical Plan (MMP) *as of 1/1/19*	Medica Health Plan Solutions (MHPS) *as of 1/1/19*
Air Ambulance Non-Emergent	Air Ambulance Non-Emergent	A0140, A0430, A0431, A0435, A0436, S9960, S9961	Yes	Yes	Yes	No	Yes	No	Yes
Bariatric Surgery	Bariatric Surgery	43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846,	Yes	Yes	Yes	No	Yes	Yes	Yes

Submission Tips

Clinical Review Process

- All adjustment/appeal requests due to a Coverage or UM policy will be reviewed by our clinical staff or a medical director
- When submitting a clinical appeal, make sure you are including all information required in the associated policy
- Clinical Reviews are typically completed within 30 business days

Submission Tips

Tips for Clinical Denials:

- Send complete documentation required (medical records, claim numbers) related to the service requested/denied after reviewing the affiliated policy on medica.com
- Submit correct contact/fax number, in case the nurse needs to reach out with follow up questions
- List the ordering provider (not the billing provider) and accommodating records.
  - Example: The Utilization Management team receives a lot of lab test appeals that include just the lab report- not the clinicals surrounding why the test was ordered. This is not sufficient to overturn a denial.

Reimbursement Policies

- Reimbursement Policies provide payment methodology based on a way a claim has been coded

- Common Reimbursement Policies:
  - Add-On Code
  - Assistant Surgeon
  - Global Days
  - Maximum Frequency per Day (Units)
  - Physical Medicine & Rehabilitation: PT, OT and Evaluation & Management

Coding Review Process

- All adjustment/appeal requests due to a Reimbursement Policy will be reviewed by our coding team
- Before submitting a coding appeal, review all associated Reimbursement Policies and confirm that you have billed with appropriate codes/modifiers
- If you need to correct coding based on the Reimbursement Policy, an adjusted claim can be sent instead of an appeal
- All coding reviews are completed within 90 business days

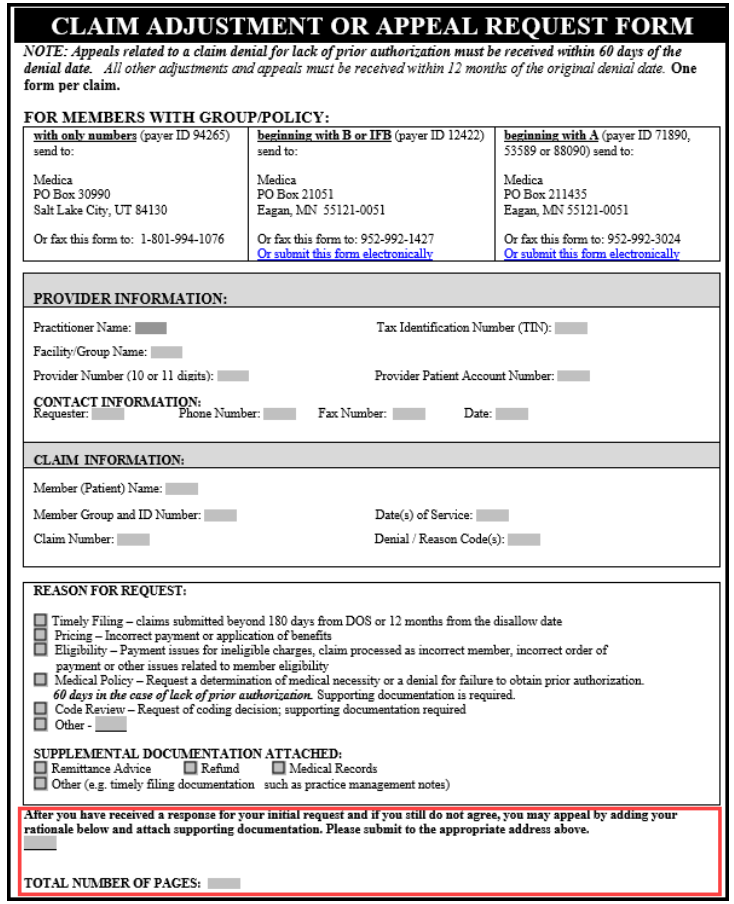
Submission Tips

Most Common Reasons for Coding Denials:

- Appeal states “not paid per contract, please reprocess”- no further information given
- A new claim is submitted with information attached for a claim that is already on file
- Electronic records of claim submission is not considered valid documentation to override Timely Filing
- Appeals for payment of medical pharmacy “J Codes” that require an authorization- these appeals need to go through Magellan directly
- Appeal received with medical records, but no information about what is being appealed, or why records are being sent
- Timely filing box is checked even if TF does not apply- this can cause the claim to be listed as TF in error

Submission Tips

Second Level Appeals:



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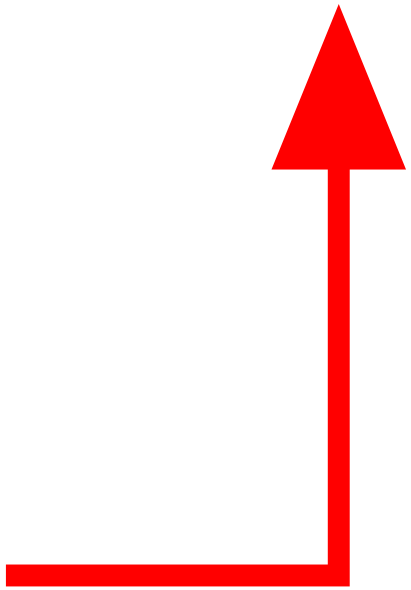

Submission Tips

Additional Tips:

- When submitting records, please be sure to call out the information in the documentation that applies to the appeal and clearly explain how the records support the services rendered

- Do not appeal issues when a claim is processing incorrectly per your contract- these will run through the system and likely process the same way. For more information regarding contract setup, reach out to your contract manager

Need Further Assistance? Contact the Medica Provider Service Center

- Providers can reach the Provider Service Call Center by calling 1-800-458-5512
- Call Center hours (CST):
  - Monday 7:00 a.m. to 5:00 p.m. (Closed 8:00 a.m. to 9:00 a.m. for department meetings)
  - Tuesday-Friday 7:00 a.m. to 5:00 p.m.
- PSC is the first point of contact for providers with eligibility, benefit, claim payment and claim process questions

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