
Appeal, Adjustment and Record Submissions

Katie Foster- Provider Training, Operations

Agenda

- Appeals and Adjustments- Overview
- Submitting an Appeal/Adjustment
- Electronic Submission
- Submission Tips

Appeals and Adjustments- Overview

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

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

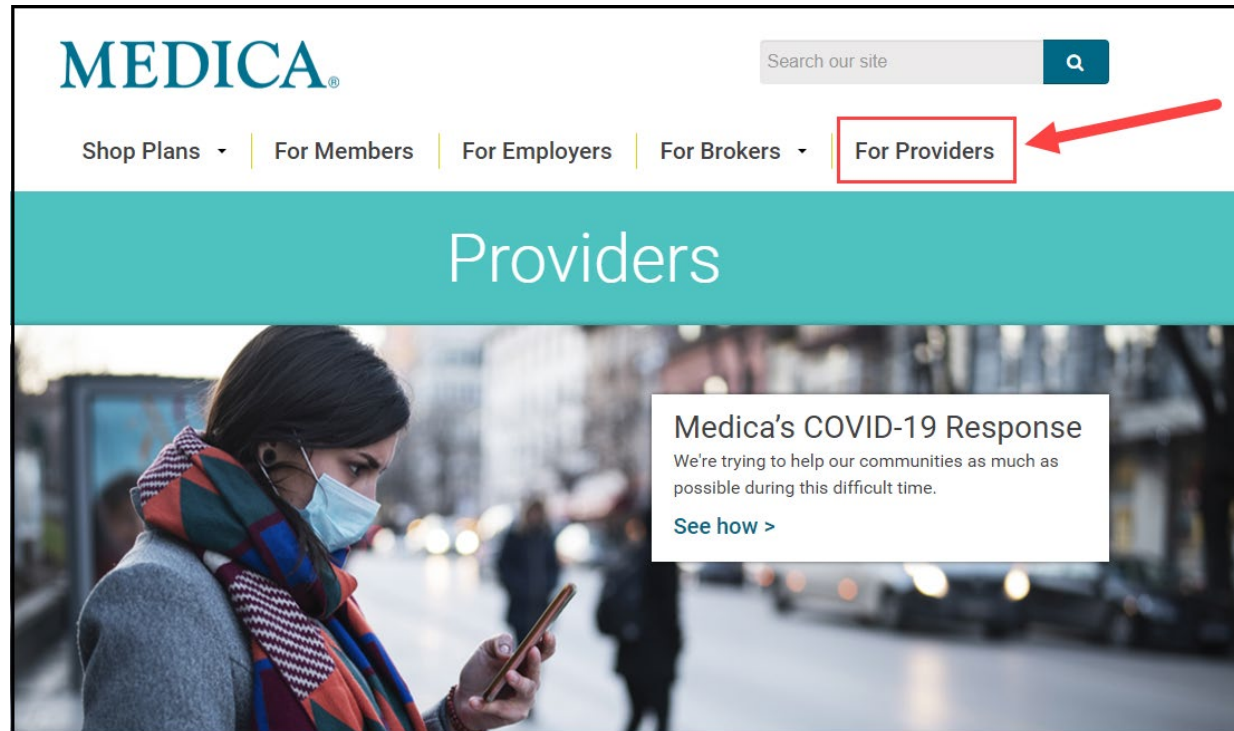


Submitting an Appeal/Adjustment

Submitting an Appeal/Adjustment

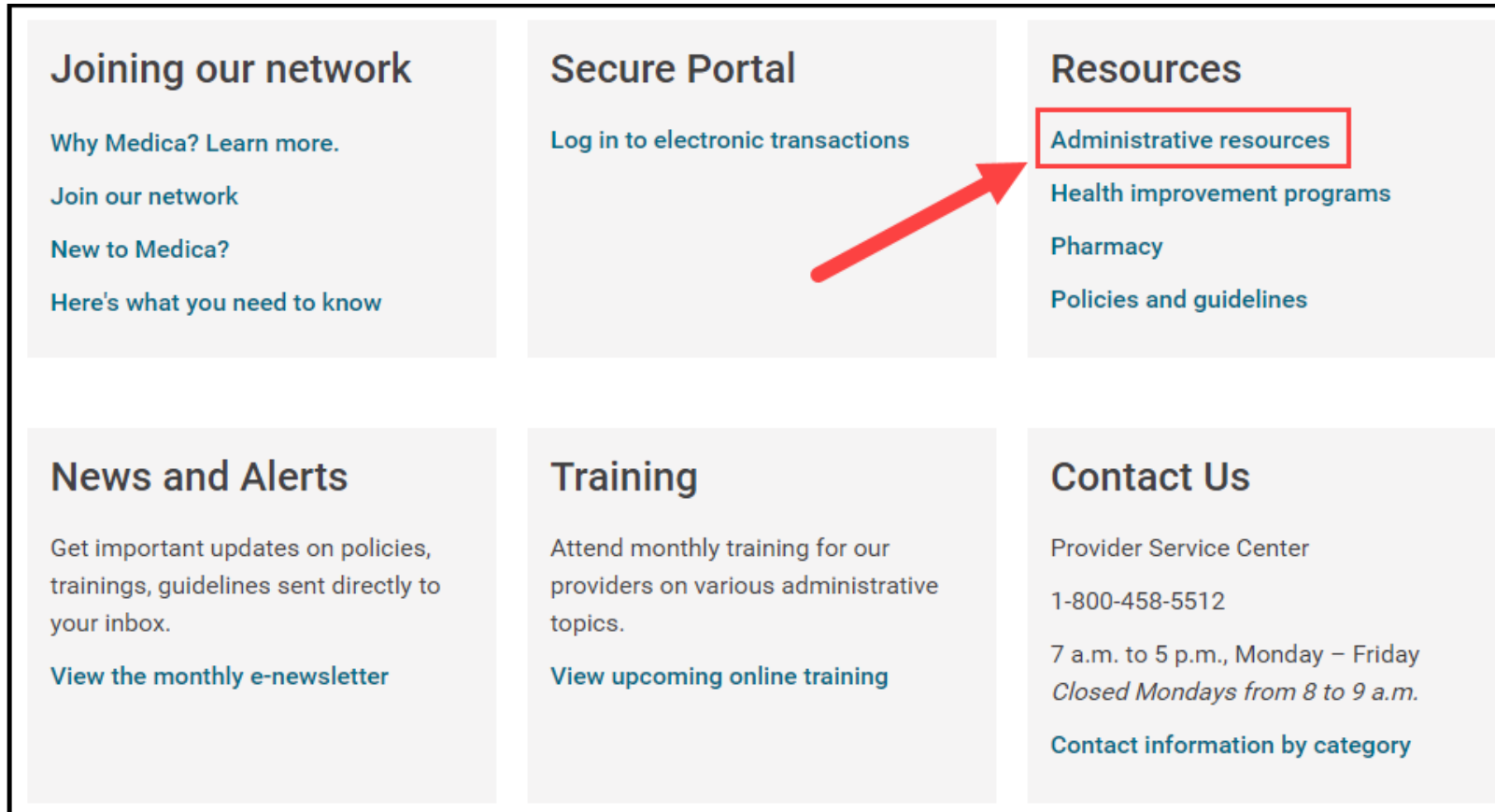
Locating the Appeal/Adjustment Form:

[Medica.com->For Providers->Resources->Administrative Resources->Claim Tools](#)



Submitting an Appeal/Adjustment

Locating the Appeal/Adjustment form:

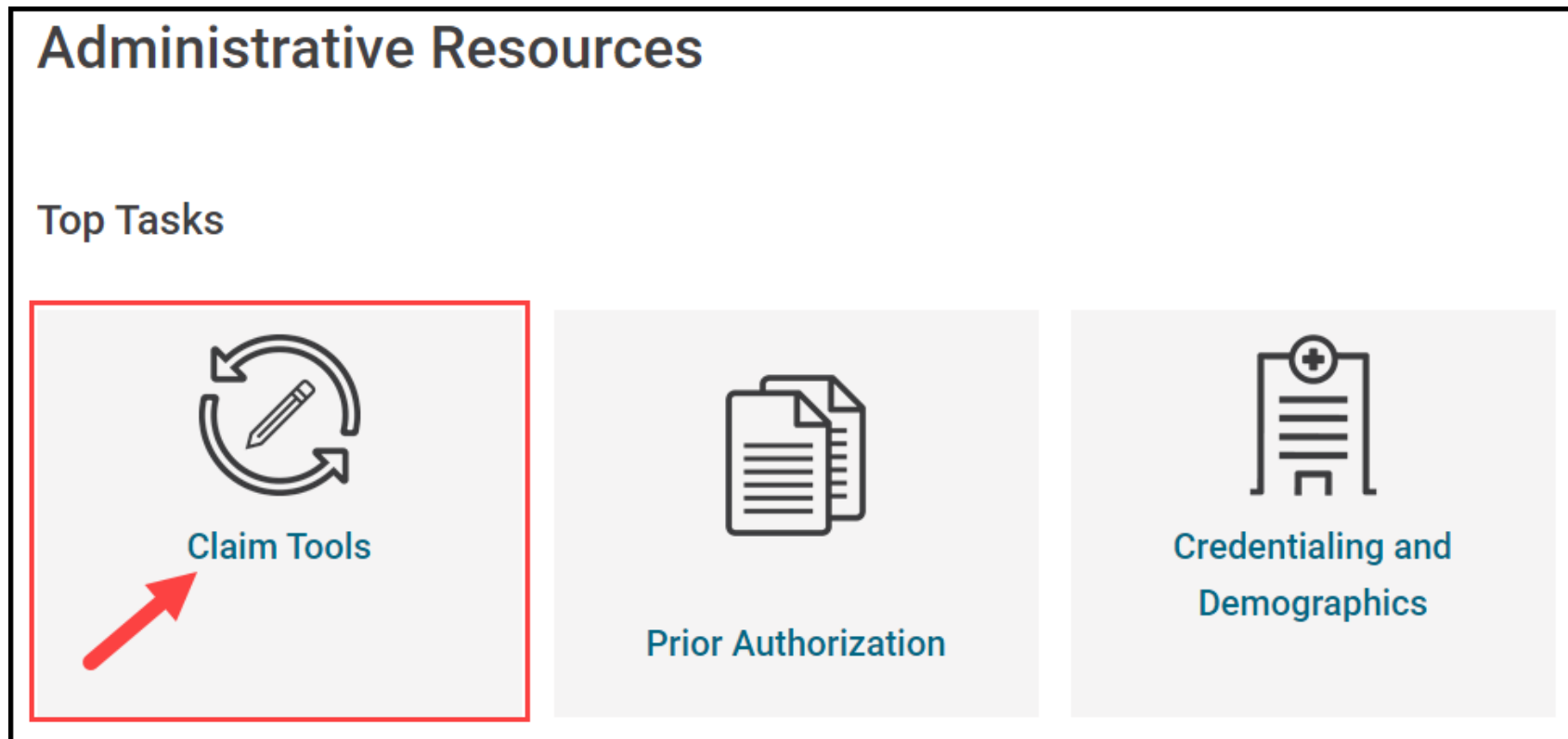


The image shows a grid of six website navigation categories. A red arrow points from the 'Secure Portal' category to the 'Administrative resources' link within the 'Resources' category.

<h3>Joining our network</h3> <ul style="list-style-type: none">Why Medica? Learn more.Join our networkNew to Medica?Here's what you need to know	<h3>Secure Portal</h3> <ul style="list-style-type: none">Log in to electronic transactions	<h3>Resources</h3> <ul style="list-style-type: none">Administrative resourcesHealth improvement programsPharmacyPolicies and guidelines
<h3>News and Alerts</h3> <ul style="list-style-type: none">Get important updates on policies, trainings, guidelines sent directly to your inbox.View the monthly e-newsletter	<h3>Training</h3> <ul style="list-style-type: none">Attend monthly training for our providers on various administrative topics.View upcoming online training	<h3>Contact Us</h3> <ul style="list-style-type: none">Provider Service Center1-800-458-55127 a.m. to 5 p.m., Monday – Friday<i>Closed Mondays from 8 to 9 a.m.</i>Contact information by category

Submitting an Appeal/Adjustment

Locating the Appeal/Adjustment form:



Submitting an Appeal/Adjustment

Locating the Appeal/Adjustment form:

Claim Tools

Billing Related to COVID-19


- [Provider COVID-19 Special Edition \(PDF\)](#)
- [Provider Coronavirus \(COVID-19\) FAQ \(PDF\)](#)

Administration of Claims and Products

- [Claim Submission and Product Guidelines](#)
- [Primary Payer Information for Medicare and Medicaid Products](#)

Adjustment and Resubmission Processes

- [Appeal Adjustment Reconsideration Reference Guide \(PDF\)](#)
- [Claim Adjustment or Appeal Request Form \(DOC\)](#)
- [Claim Adjustment or Appeal Request Guidelines](#)
- [Medicare Waiver of Liability Statement \(PDF\)](#)



Submitting an Appeal/Adjustment

Appeal/Adjustment Form:

MEDICA®		
CLAIM ADJUSTMENT OR APPEAL REQUEST FORM		
<i>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.</i>		
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 Or fax this form to: 1-801-994-1076	Medica PO Box 21051 Eagan, MN 55121-0051 Or fax this form to: 952-992-1427 Or submit this form electronically	Medica PO Box 211435 Eagan, MN 55121-0051 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:			
<input type="checkbox"/> Timely Filing – claims submitted beyond 180 days from DOS or 12 months from the disallow date			
<input type="checkbox"/> Pricing – Incorrect payment or application of benefits			
<input type="checkbox"/> Eligibility – Payment issues for ineligible charges, claim processed as incorrect member, incorrect order of payment or other issues related to member eligibility			
<input type="checkbox"/> Medical Policy – Request a determination of medical necessity or a denial for failure to obtain prior authorization. <i>60 days in the case of lack of prior authorization.</i> Supporting documentation is required.			
<input type="checkbox"/> Code Review – Request of coding decision; supporting documentation required			
<input type="checkbox"/> Other - _____			
SUPPLEMENTAL DOCUMENTATION ATTACHED:			
<input type="checkbox"/> Remittance Advice <input type="checkbox"/> Refund <input type="checkbox"/> Medical Records			
<input type="checkbox"/> 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: _____			

Submission Variables

Claim Tools

Billing Related to COVID-19


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Submitting an Appeal/Adjustment


Submission Variables


Claim Adjustment or Appeal Guidelines


Claim adjustment or appeal requirements differ by state and product type. The product type will be identified by the group/policy number on the member ID card.


Not sure how to find the group/policy number? [View sample Medica ID card](#)


Select the scenario below that best meets your needs:

I am a provider from Minnesota and the group/policy is IFB or letters and numbers. 

I want to file an adjustment.	I want to file an appeal.
Use the electronic tool Submit a paper form (DOC)	 Use the electronic tool Submit a paper form (DOC)

I am a provider from Minnesota and the group/policy is numbers only. 

I am a provider NOT from Minnesota and the group/policy is IFB or letters and numbers. 

I am a provider NOT from Minnesota and the group/policy is numbers only. 

Submitting an Appeal/Adjustment

Sample ID Card

MEDICA
Individual & Family Health Plans

Here is where you find the Group/Policy number

Payer ID: 12422
ID: **1234567891** Group/Policy: **IFB**

Name:
John Samplemember 00

Dependents:
Jane Samplemember 01
Joe Samplemember 02
Julie Samplemember 03
Jake Samplemember 04
Joshua Samplemember 05

Care Type: Applause MN
SVC Type: Medical

For your best benefits, use the Applause Network

Rx BIN: 003858
Rx PCN: A4
Rx GROUP 6MEDICA

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:

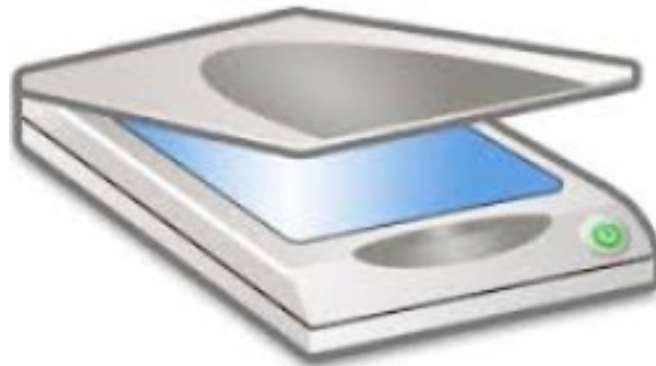
with only numbers (payer ID 94265) send to:	beginning with B or IFB (payer ID 12422) send to:	beginning with A (payer ID 71890, 53589 or 88090) send to:
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Or fax this form to: 1-801-994-1076	Or fax this form to: 952-992-1427 Or submit this form electronically	Or fax this form to: 952-992-3024 Or submit this form electronically



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



Submission Process:

Claim Adjustment or Appeal Guidelines

Claim adjustment or appeal requirements differ by state and product type. The product type will be identified by the group/policy number on the member ID card.

Not sure how to find the group/policy number? [View sample Medica ID card](#)

Select the scenario below that best meets your needs:

I am a provider from Minnesota and the group/policy is IFB or letters and numbers. -

I want to file an adjustment.	I want to file an appeal.
Use the electronic tool Submit a paper form (DOC)	Use the electronic tool Submit a paper form (DOC)

I am a provider from Minnesota and the group/policy is numbers only. +

I am a provider NOT from Minnesota and the group/policy is IFB or letters and numbers. +

I am a provider NOT from Minnesota and the group/policy is numbers only. +

Logging into Provider Portal:

Electronic Transactions

Provider Login

The page you are requesting is a secure page. Please log in.

Username

Password

[Log in](#)

Request an Account

Providers may request access to the secure provider portal by calling the Provider Service Center at 1-800-458-5512.

Billing agencies must work directly with providers to get access.

Login Assistance


[Forgot password](#)

[Forgot username](#)

[Frequently asked questions](#)

Electronic Transactions Menu:

Patient Service Transactions	
Administrative Referral Entry	+
Admission Notification	+
Check Claim Status	+
Electronic Payments and Statements	+
Eligibility Inquiry	+
Referral Status Inquiry and Modification	+
Request a Claim Adjustment or Appeal	+

 Need help with Electronic Transactions?

[View our User Guide for Medica Electronic Transactions \(PDF\)](#)

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:

Request a Claim Adjustment or Appeal Print

NOTE: Minnesota providers must follow the MN AUC guide for electronic submission of void/replacement claims. Refer to the AUC for details. Not sure which process to follow? [Review our guide](#)

Clear all fields

Requestor Information


Name:

Phone number:

Email address:

Patient Information

Clear Patient Information

Group number 

Submission Form Details:

Patient Information

Group number

Last name

First name

Member ID

Provider Information

Organization (TIN)

National Provider Identification (NPI)

Provider last name

Provider first name



Facility/Group name OPTIONAL






Provider patient account number OPTIONAL

Claim Information

Claim number

Denial/Reason code(s) OPTIONAL

Dates of service
  – 
Reason for request

- Timely Filing 
- Pricing 
- Eligibility 
- Medical Policy 
- Code Review 
- Corrected Claim
- Other

Submitting Attachments:



Supporting documentation type

Select at least one

- Remittance Advice
- Refund
- Medical Records
- Itemized Statements
- Corrected claim
- Other

Supporting document(s)

i Supporting documentation is required.

- A minimum of one supporting document is required.
- Only image and PDF files (.pdf, .jpg, .jpeg, .png, .tif, .tiff, .gif, .bmp).
- Maximum file size of 10 MB.
- Multiple files can be selected by holding the Shift key or the Ctrl key with the mouse pointer.

Choose Files No file chosen

Submit

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

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

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

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

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](https://www.medicare.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

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

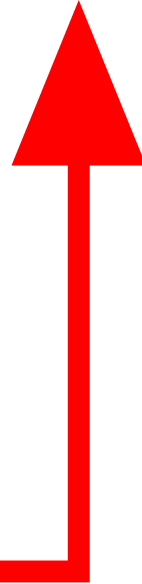
Submission Tips

Second Level Appeals:

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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:		
<input type="checkbox"/> Timely Filing – claims submitted beyond 180 days from DOS or 12 months from the disallow date <input type="checkbox"/> Pricing – Incorrect payment or application of benefits <input type="checkbox"/> Eligibility – Payment issues for ineligible charges, claim processed as incorrect member, incorrect order of payment or other issues related to member eligibility <input type="checkbox"/> Medical Policy – Request a determination of medical necessity or a denial for failure to obtain prior authorization. <i>60 days in the case of lack of prior authorization.</i> Supporting documentation is required. <input type="checkbox"/> Code Review – Request of coding decision; supporting documentation required <input type="checkbox"/> Other - _____		
SUPPLEMENTAL DOCUMENTATION ATTACHED:		
<input type="checkbox"/> Remittance Advice <input type="checkbox"/> Refund <input type="checkbox"/> Medical Records <input type="checkbox"/> 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: _____		

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: _____



IMPORTANT

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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