

Michigan Department of Health and Human Services (MDHHS)

Affordable Care Act Incentive Payment Program
1/01/2013 through 12/31/2014

Medicaid Health Plan Appeal Request

TEST 1: BASIC STRUCTURE & VERIFICATION: Confirm valid claim data internally & confirm that encounter data was submitted to State for a respective claim; to ensure valid claim, confirm claim is for professional component only and confirm that encounter was “accepted” by the State; confirm that claim was for a date of service covered in the paycycle (see conventions matrix) and confirm that claim was accepted into State encounter system within the allowable accepted date range (see conventions matrix). Please note in other manual payment projects, the program schedule for date of service ranges and accepted date ranges has been the most common point of confusion for providers.

TEST 2: 0 PAID: If 0 paid claim, confirm that encounter was submitted with an allowable adjustment reason code. (1, 2, 3, 16, 24, 100, 133, 139, 142, 143, 256)

TEST 3: PROCEDURE CODE: Confirm the encounter contains an eligible procedure code (see fee schedule information).

TEST 4: RENDERING NPI: Confirm encounter was submitted to State with rendering NPI data; confirm rendering NPI is a PCP eligible rendering NPI. (Note: we have discovered a significant deficiency with many encounters at this testing point- it appears a few plans have submitted a substantial volume of encounters with no rendering NPI data – this data must be resubmitted through the encounter void/adjustment process and can then be eligible for adjustment in future paycycle lookback adjustments)

TEST 5: SNAF TEST: Confirm encounter rendering NPI is NOT a SNAF eligible NPI.

TEST 6: RATE TEST: Confirm encounter does not have a procedure code with a Medicaid rate exceeding Medicare rate.

TEST 7: DUAL ELIGIBLE: If encounter is for a dual eligible claim the claim will be excluded until a future paycycle. Encounter data for dual claims will need to be resubmitted by all plans to reflect stand-alone Medicare financial data under the Medicare-only payer ID (beneficiary a Medicaid/Medicare eligible beneficiary for the month of service of the claim, then we are excluding the claim until later date).

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Medicaid Health Plan Appeal Request Form

INSTRUCTIONS

Rendering Provider:

Fully complete all portions of this form and return with supporting documentation to your respective Medicaid Health Plan (MHP) appeals coordinator. The Medicaid Health Plan must review the appeal prior to submission to MDHHS. Without resolution to the appeal, it will be submitted to MDHHS for additional study and review.

ISSUE TYPE (CHECK ONE ONLY)

- Rendering Provider appeal
Has Medicaid Health Plan reviewed internally? Yes No
- Accounting Issue
(i.e. Rate application, calculation issue, timing issue)
- Volume Issue/Data Missing
(i.e. Charges/Health Plan Paid Amount Too Low/Missing Claims Data)

REQUESTOR INFORMATION

Date of Request:	Health Plan:	Requested By:
Contact Name:	Contact E-mail:	Contact Phone:

(All Items Must Be Completed)

Date of Service:	Verification Deadline:	Payment Date Validated by Health Plan:
TCN (MDHHS unique claim identifier):	ERN (MHP unique claim identifier):	Provider Claim Billing NPI #:

SUMMARY (Include cell range reference information if including data workbooks)

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January 2016