Claim Review / Appeal Process Provider Tip

Medicaid Provider Manual:
Chapter: General Information for Providers, **Section**: 17 – Provider Appeal Process
Chapter: Hospital, **Section**: 12 – Appeals

This Provider Tip is only in reference to Fee for Service Medicaid Providers, appeals for other payers must follow that entities appeal process

Appeal inquiries made by a provider often means a request to have the claim reviewed and not an actual request to file an official appeal, which is handled by the Michigan Office of Administrative Hearings and Rules (MOAHR).

Prior to undertaking the administrative burden of filing an official appeal with MOAHR, providers should contact Provider Support to have their issue/claim reviewed. This would be considered the initial review, which allows the issue to be reevaluated and ensure the issue/claim was processed correctly. Most times with the initial review there are simple billing/processing errors that can be resolved without going through the formal appeal process.

Below are general areas the provider needs to review prior to requesting the initial review and before filing an official appeal with MOAHR.

All Providers

- Review the claim. Review the CARC/RARC's and their definitions that are available on the WPC website to determine how the claim was processed. If errors are identified, the claim will need to be resubmitted or adjusted to reflect the correct information for proper adjudication. Please note: Only paid claims can be adjusted.

- If the claim denied for Timely Filing, review the Timely Filing Provider Tip to verify that the claim meets the guidelines and if necessary, that the appropriate claim note is reported. Please note: Any claim submitted after the Timely Filing requires a claim note.

- If the claim denied for Predictive Modeling, review the PM medical request letter, the services billed on the claim and the medical documents submitted to the DMP. For additional information on Predictive Modeling, reference the Predictive Modeling Provider Tip

- If the claim denied or incorrectly paid for Other Insurance, review the **other payer's information reported on the claim in CHAMPS versus** what is reported on the primary payers Explanation of Benefits (EOB) to ensure the information is accurate.

    - If errors are identified, then the claim will need to either be resubmitted or adjusted to reflect the correct information for proper adjudication. Please note: Only paid claims can be adjusted.

    - If CHAMPS shows incorrect coverage, then a request needs to be submitted to update the system using the online form Update Other Insurance Now

Professional Providers

- When reviewing the Professional claim, please reference the Professional Provider Tip for Common Denials

- If the Professional claim/service line denied for Prior Authorization, reference the Medicaid Code and Rate Reference Tool within CHAMPS External Links to identify which service requires a PA.

Inpatient/Outpatient Providers

- When reviewing the Inpatient/Outpatient claim, please reference the Hospital Provider Tip for Common Claim Denials

- If you feel the Inpatient/Outpatient claim paid incorrectly, please reference the Provider Tips below for assistance on pricing hospital claims, to determine how reimbursement was calculated. Inpatient Claims Outpatient Claims

- If the Inpatient claim has denied for a PACER/Prior Authorization, please review the Provider Tips for PACER requirement and/or ICD-10 Surgical Code requirement

    - If the Outpatient claim/service line denied for Prior Authorization, reference the Medicaid Code and Rate Reference Tool within CHAMPS External Links to identify which service requires a PA. You must work with the MDHHS Program Review Division to obtain PA under the facility NPI.

If after the information above has been reviewed and you disagree with the outcome, please contact Provider Support to have the issue/claim reviewed. Providers can contact the Provider Helpline at 1-800-292-2550 or via email ProviderSupport@Michigan.gov

- When emailing Provider Support, please review the link Contact Provider Support and provide the appropriate completed template.

    For Claim inquiries include:
    Provider representative name and contact information:
    Provider NPI:
    Beneficiary ID:
    TCN(s):
    Date of Service (DOS):
    Procedure Code(s):
    CARC and RARC:
    A brief description of the issue:

- If providing additional documentation (RA, EOB, Medical Documents, etc.), please upload the information to the **DMP** and reference the Document ID# in the email. Please do not send attachments with the email.

    - For additional information on how to use the DMP, please reference the Provider Tip: Document Management Portal (DMP)

Once Provider Support reviews and responds to your inquiry and the provider would like to continue with the formal appeal process, click on the following link for more information: Michigan Office of Administrative Hearings and Rules for Michigan Department of Health and Human Services