Appeal Submission Tips for Providers

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.

- To make an adjustment: Providers are encouraged to submit a corrected claim to the original claim through the clearinghouse, to make changes or corrections to this claim.

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. Sending an appeal is not changing anything about how the claim was originally billed, but requesting a different outcome on how the claim was processed as submitted.

Before sending an appeal or adjustment:

Review all applicable policies and make sure a corrected/adjusted claim is not required. When sending an appeal, make sure the documentation supports the services rendered and is specific. Also, make sure the appeal form is completely filled out and explains what is being appealed. To find which policies might apply, do a general "search" on Medica.com for the procedure code in question.

Here are a few common things to consider:

- Does the claim meet criteria for payment as billed, or does the coding need to be corrected?
- Are there affiliated **Coverage**/**Utilization Management** policies to follow?
- Are there affiliated **Reimbursement Policies** to follow?
- In-Network vs. Out Of Network guidelines to consider?
- Government vs. Non-Government guidelines to consider?
- Was the claim submitted within applicable **Timely Filing** guidelines?
- Any other considerations to review before submitting an adjusted claim or appeal?

Process at Medica when an appeal is received:

The appeal is reviewed and routed to the appropriate team based on the issue. Once a decision is reached, providers will receive notification.

If the claim decision is overturned, the claim will be reprocessed and the provider will receive a new Provider Remittance Advice which will explain the new processing.

If the claim decision is upheld, the provider will receive a letter explaining the decision and next steps.

Additional Resources

Medica Policies and Guidelines
Medica Appeals and Grievances e-Learning
Submitting an Appeal Micro-Training video
Medica Product Portfolio
Medica Timely Filing and Late Claims Policy
Medica Administrative Manual: Claim Adjustment/Appeal Guidelines

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