



AUC CLAIMS DD TAG AGENDA

April 8, 2015

9:00 a.m. – 10:30 a.m.

Teleconference line: 1-712-832-8300

Participant passcode: 337213

WebEx instructions:

1. To start the WebEx session, go to: <https://health-state-mn-ustraining.webex.com>
2. Under "Attend a Session," click "Live Sessions"
3. Click on the session for "AUC Claims DD TAG"
4. Provide your name, email address, and the following password: Cdd2010! (Note: The exclamation mark at the end is part of the password.)
5. Click "Join now"

Meeting Objectives:

- Worker's Comp
- Determine if Reopening Claims Frequency Type Code Q should be included in 837 Companion Guide or should Best Practice be developed
- Attachments (Non MVA and Work Comp)

Agenda items

1. Meeting to order – Sue Lee
2. Anti-trust statement (<http://www.health.state.mn.us/auc/antitrust.pdf>)
3. Introductions - Please e-mail your attendance to susan.lee@allina.com
4. Discussion
 - a. Worker's Comp Update (Lisa Wichterman)
 - b. Reopening Claims Frequency Type Code (837I)
 - c. Attachments process
 - d. Lab Billing SBAR
 - e. Filing Appeals – AUC Appeal form instructions

5. Other Business

Next Meeting –

9:00 a.m. – 10:30 a.m.

Teleconference / WebEx only

This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), **Version 5010.**

1. Title of best practice:

Appeals - submitting an appeal by a provider to a Minnesota group purchaser

2. Who does the best practice apply to:

Providers and Group Purchasers

3. Narrative description as to what is being addressed by this best practice:

This document provides further instruction on how a provider should submit an appeal to a Minnesota group purchaser. It includes:

- This general instruction document
- The Common Appeal form
- Instructions for completing the Common Appeal form

4. The loops, segments and elements, etc. that the best practice applies to:

Not applicable.

5. Describe how to do the best practice:

According to the Minnesota Common Companion Guides for professional, dental and institutional claims, section 3.2.3, an appeal is defined as:

Provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted.

When a provider determines that an appeal needs to be sent, the provider should complete the Appeal Request Form using the instructions provided. Additional documentation should be sent as required by the group purchaser to support the appeal consideration; this documentation does not include resubmission of the claim. The Attachment Cover Sheet must not be sent with the Appeal Request Form.

Fee-for-service Medicaid does not accept the appeals form that corresponds to this Best Practice due to regulatory requirements (citation: 42 CFR 447). In these cases, the provider must submit a new or replacement claim with the necessary documentation as an attachment.

Visit our website at: <http://www.health.state.mn.us/auc/index.html>

Appeals - submitting an appeal by a provider to a Minnesota group purchaser

A copy of the Appeal Request Form and the appeal information should be retained by the provider for their records.

6. Examples to illustrate best practice:

Examples of Appeals include:

- Timely filing denial
- Payer allowance
- Incorrect benefit applied
- Eligibility issues
- Benefit Accumulation Errors
- Medical Policy / Medical Necessity
- Code Review

7. AUC approval date:

11-20-14

8. Last reviewed date:

08-06-14

AUC Appeal Request Form Instructions

Please also refer to the Appeals Best Practice on the AUC website at: <http://www.health.state.mn.us/auc/index.html> for additional information.

General Instructions:

The preferred method for completing this form is to type the information within the fields provided. If completed by hand, the information must be clearly printed within the fields provided using blue or black ink.

All fields on the AUC Appeal Request Form are required unless otherwise noted below.

A copy of the Appeal Request form and the attachment information should be retained for your records.

Fee-for-service Medicaid does not accept the appeals form that corresponds to this Best Practice due to regulatory requirements (citation: 42 CFR 447). In these cases, the provider must submit a new or replacement claim with the necessary documentation as an attachment.

Payer Name	Enter the name of the payer the appeal request is being made to.
Billing Provider Name	Enter your billing provider name. X12: Loop 2010AA, NM103, NM104 and NM105.
Billing Provider ID	Enter your NPI X12: NPI: Loop 2010AA, NM109 Atypical providers: Loop 2010BB, REF02.
Patient Account Number	Enter the patient's unique ID as assigned by the payer/group purchaser. For Version 5010 Use: Loop 2300, CLM01.
Patient Name	Enter the patient's name as reported on the claim. For Version 5010 Use: X12: Loop 2010CA, NM103, NM104, and NM105 or Loop 2010BA, NM103, NM104, and NM105. If both are populated within the claim, use Loop 2010CA, NM103, NM104, and NM105.
Patient ID#:	Enter the patient's unique identifier as assigned by the group purchaser. For Version 5010 Use: Loop 2010BA, NM109.
Date(s) of Service	Enter the date the service was provided in MMDDYY format.
Payer Claim Control Number	Use payer claim control number found in the 835 CLP07.
Property and Casualty or Workers Compensation Claim Number	This is also known as the event number. This field is only required for claims related to Property and Casualty or Workers Compensation.
Reason for Appeal Request	This is the reason the appeal is being requested.
Attachment(s)	Check appropriate box.
Contact Information	Enter the date the request is being completed, requester, contact phone number, contact email information and contact fax information. Include address where response should be sent.
Pages	Enter the total number of pages of your appeal information including the cover sheet.