P.O. Box 240808
Anchorage, AK 99524-0808
(907) 644-6800
http://medicaidalaska.com

Appeal Process Information

First-Level Appeals

Regulation 7 AAC 105.270 stipulates the length of time a provider has to submit a first-level appeal. Most first-level appeals must be filed within **180 days** of the adverse decision. Providers may appeal a denied or reduced claim, non-certification of hospital admission or length of stay, denied or reduced prior authorization request, non-certification of a service that requires certification by a quality improvement organization, and denied enrollment and disenrollment. First-level appeals relating to disputed recoupment of an overpayment must be filed within **30 days** of the overpayment notice.

Type of First-Level Appeal	**Where Do I Send My First-Level Appeal?**

• Denied or reduced claim
• *Recoupment of overpayment request
• Denied or reduced prior authorization request for the following services
  ○ Durable medical equipment, prosthetic and orthotics; and selected pharmaceutical drugs
  ○ All non-emergent, medically necessary transportation and accommodation services
  ○ Selected professional services as indicated in the fee schedules
  ○ Services in excess of annual or periodic service limitations (vision, mental health, etc.)
  ○ All respiratory therapy, home healthcare services, private duty nursing, and hospice care
  ○ All outpatient Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) scans, and Emission Computerized Tomography (SPECT) scans
  ○ Chronic and Acute Medical Assistance (CAMA) program recipients requiring outpatient radiation and chemotherapy
  ○ Certain maternal/newborn admissions. Please refer to the chart found at http://hss.state.ak.us/dhcs/authorization.htm.
*Must be filed within 60 days of the overpayment notice
	Xerox
	Attn: Appeals
	P.O. Box 240808
	Anchorage, AK 99524-0808

Non-Certification of Selected Inpatient and/or Outpatient Procedures and Diagnoses • Regardless of length of stay. The *Select Diagnoses and Procedures PRE-CERTIFICATION List* may be obtained at • http://www.qualishealth.org/cm/alaska-medicaid/index.cfm. • Non-certification of an inpatient hospital stay that exceeded three (3) days • Denied or reduced prior authorization request for certain maternal/newborn admissions. Please refer to the chart found at http://hss.state.ak.us/dhcs/authorization_hcs.htm.	Qualis Health Attn: Care Management Dept/Appeal Review 10700 Meridian Ave. North, Suite 100 P.O. Box 33400 Seattle, WA 98133-0400 Phone: (800) 949-7536, extension 2024 Fax: (800) 826-3630

Type of First-Level Appeal	Where Do I Send My First-Level Appeal?
Residential and Psychiatric Treatment Admissions and Continued Stay Reviews • Psychiatric admissions and continued stays • Residential Psychiatric Treatment Center (RPTC) admissions and continued stays	Qualis Health P.O. Box 243609 Anchorage, AK 99524-3609 Phone: (907) 550-7620 Toll Free: (877) 200-9046 Fax: (907) 550-7621 Toll-Free Fax: (877) 200-9047
• Denied or reduced prior authorization request for substance abuse rehabilitation services in excess of annual or periodic service limitations	Dept. of Health and Social Services Division of Behavioral Health Attn: Claims Appeal Section 3601 C Street, Suite 878 Anchorage, AK 99503-5923

• Denied or reduced prior authorization request for the following services
  ○ Administrative wait and swing bed stays at acute care facilities
  ○ All Long Term Care (LTC) facility admissions and continued stays
  ○ Home and Community-Based Waiver services
• Personal Care Assistant (PCA) services
	Dept. of Health and Social Services
	Division of Senior and Disabilities Services
	Attn: Claims Appeal Section
	550 W. 8th Avenue
	Anchorage, AK 99501

• Denied enrollment or disenrollment	Refer to the address located on the *Department Addresses for Second Level Provider Appeals List* for the type of service you provide.

Second-Level Appeals

Regulation 7 AAC 105.280 stipulates where second-level appeals are sent. A second-level appeal must be filed within **60 days** of the first-level appeal decision and sent to the Department of Health and Social Services Office or Division indicated below for the type of service you provide.

Type of Second-Level Appeal	Where Do I Send My Second-Level Appeal?
• Inpatient Psychiatric and Residential Psychiatric Facility Services • Community Behavioral Health Services (treatment of mental health and/or substance use disorder) • Mental Health Physician Clinic Services	Dept. of Health and Social Services Division of Behavioral Health Attn: Claims Appeal Section 3601 C Street, Suite 878 Anchorage, AK 99503-5923
• Home and community based waiver services • Personal care assistant services • Skilled nursing facility • Intermediate care facility • Intermediate care facility for mentally retarded persons and persons with related conditions (ICF/MR)	Dept. of Health and Social Services Division of Senior and Disabilities Services Attn: Claims Appeal Section 550 W. 8th Avenue Anchorage, AK 99501
• Indian Health Services Hospital – inpatient and outpatient • Indian Health Services Clinic	Dept. of Health and Social Services Office of the Commissioner, Tribal Programs Attn: Claims Appeal Section P.O. Box 110601 Juneau, AK 99811-0601
• Behavioral Rehabilitation Services	Dept. of Health and Social Services Office of Children Services, Behavioral Rehab. Svcs. Attn: Claims Appeal Section P.O. Box 110630 Juneau, AK 99811-0630
• Targeted case management for children eligible under 7 AAC 23.080 (Infant Learning Program)	Dept. of Health and Social Services Office of Children Services, Infant Learning Program Attn: Claims Appeal Section P.O. Box 240249 Anchorage, AK 99524-0249

Type of Second-Level Appeal	Where Do I Send My Second-Level Appeal?
• Ambulatory Surgery Center • Chiropractic Services • Dental Care • Dietician Services • Direct-entry midwife services • Durable medical equipment and supplies, respiratory therapy services, and prosthetic devices • Early periodic screening, diagnosis, and treatment (EPSDT) services • End stage renal disease (dialysis) clinic • Family planning • Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) • Home health care • Hospice • Hospital – inpatient and outpatient • IHS Clinic • IHS hospital – inpatient and outpatient • Laboratory and Imaging • Nutrition services • Occupational therapy • Pharmacy • Physical therapy • Physician, advanced nurse practitioner, and physician assistant services • Physician clinic • Podiatry services • Private duty nursing • Psychologist services • School-based services • Speech, hearing and language • Transportation (emergent and non-emergent) and accommodation services • Vision care services	Department of Health & Social Services Division of Health Care Services Attn: Claims Appeal Section 4501 Business Park Boulevard, Bld. L Anchorage, AK 99503-7167

The following definitions and explanations may prove helpful to Alaska Medical Assistance providers requesting review of a denied or reduced claim and/or prior authorization request.

Claim. (1) a bill for services, (2) a line item of service, or (3) all services for one recipient within a bill.

Clean claim. One that can be processed without obtaining additional information from the provider of the service or from a third party.

Timely filing of claims. Claims must be submitted no later than 12 months from the date services were rendered to the recipient. This applies to all claims including those that must first be filed with a third party carrier.

Good cause. Xerox will find *good cause* for a provider's failure to submit a claim before the billing deadline if the failure to submit the claim resulted from a condition that was beyond the provider's control or was caused by a condition that the provider could not reasonably be expected to prevent. Good cause examples are weather conditions causing mail delays or a disaster such as a fire, flood, or earthquake. A good cause example **does not** include provider staffing deficiencies.

Regulation 7 AAC 105.270 stipulates the length of time a provider has to submit a first-level appeal. Current regulation 7 AAC 145.005(c) stipulates the 12-month timely filing period from the date the services were rendered for a claim to be considered filed timely.

The majority of first-level appeals must be filed within **180 days** of the adverse decision date indicated on the remittance advice for a claim.

Failure to Timely File. An appeal based on the provider's failure to file the claim before the billing deadline must be submitted no later than 180 days after the date on the remittance advice on the claim. If it is determined that the provider's claim was not filed within the required time limit, the appeal will be denied. However, if it is determined that (1) the department committed an error on the claim previously submitted by the provider for the same service to the same recipient on the same day; or (2) the claim was timely filed but not processed; or (3) the provider is able to prove good cause for failure to submit the claim before the billing deadline, then the appeal will be approved.

Non-Certification of Hospital Admission or LOS. A provider may request a first-level appeal of a non-certification of hospital admission or length of stay that requires prior approval by Qualis Health. The provider must submit the appeal to Qualis Health no later than 180 days after the date of the non-certification of the hospital admission or length of stay notice.

In the event of the above-mentioned circumstance, the provider must submit the following items:

- Written request for a first-level appeal that specifies the basis upon which the decision is challenged including any supporting documentation
- Complete copy of the recipient's medical records that support the hospital admission or length of stay and any other supporting documentation
- Copy of the original non-certification notice and attachments.

Denied or Reduced Prior Authorization. A provider may request a first-level appeal of a decision that denies or reduces prior authorization if, no later than 180 days after the date of that decision, the provider submits a written request for an appeal to a contractor or state agency. The appeal must specify the basis upon which the decision is challenged and include any supporting documentation. These types of appeals do not include prior authorizations for services that require certification by Qualis Health.

Non-Certification of a Service. A provider may request a first-level appeal of a non-certification decision regarding a service that requires certification by Qualis Health in order to obtain prior authorization. The provider must submit the appeal to Qualis Health no later than 180 days after the date of the non-certification decision. The appeal must include the basis upon which the decision is challenged and include any supporting documentation.

Denied Enrollment or Disenrollment. A provider who has been denied enrollment or who is disenrolled from the Alaska Medical Assistance program for a reason other than stated in 7 AAC 105.400 (grounds for sanctioning providers) may appeal the denial or disenrollment. To appeal, the provider must submit a written request that specifies the basis upon which the decision is challenged and include any supporting documentation. The provider must submit the appeal to the appropriate fiscal intermediary or state office no later than 180 days after the date of the decision to deny. The decision for this type of appeal is a final administrative decision and the department shall notify the provider of their right to appeal to the Superior Court under the Alaska Rules of Appellate Procedure.

Recoupment of Overpayment Notice. A provider may request a first-level appeal of a recoupment or an overpayment notice. This must be a written request, submitted to Xerox no later than **60 days** after the date of the notice. The request must specify the basis upon which the notice of recoupment is challenged. Included with the written request must be a copy of the recoupment notice and any supporting documentation.

Any appeal submitted after the allowed time period will not be considered.