Appeal Form Completion

Page updated: September 2020

This section describes the instructions for completing an *Appeal Form* (90-1). An appeal is the final step in the administrative process and a method for Medi-Cal providers with a dispute to resolve problems related to their claims.

Appeal Form (90-1)

An appeal may be submitted using the *Appeal Form* (90-1). A sample completed *Appeal Form* (see Figure 1) and detailed instructions are on a following page.

Note: Do not submit an appeal if a claim is still in suspense.

Supporting Documentation for Appeals

Necessary documentation, such as those listed below, should be submitted with each appeal to help appeals examiners perform a thorough review of the case. All supporting documentation must be legible. A copy of any of the following attachments is acceptable:

- Claim†, corrected if necessary
- All *Remittance Advice Details* (RADs)
- *Explanation of Medicare Benefits* (EOMB) or *Medicare Remittance Notice* (MRN)
- Other Health Coverage (OHC) payments or denials
- All *Claims Inquiry Forms* (CIFs), *Claims Inquiry Acknowledgments, CIF Response Letters* or other dated correspondence to and from the California MMIS Fiscal Intermediary (FI) to document timely follow-up.
- *Treatment Authorization Request* (TAR)
- Service authorization request (SAR)
- Manufacturer's invoice or catalog page
- Report for "By Report" procedures
- Completed sterilization *Consent Form* (Form PM 330)

Appeals with *CMS-1500* claim form attached:

Use the new *CMS-1500* (02/12) version and complete the ICD indicator field.

‹‹Appeals with *UB-04* claim form attached:››

Insert the ICD indicator in the appropriate area of the diagnosis field and refer to the appropriate claim completion sections of the provider manual, to complete this requirement.

Supplemental Claims Payment Information (SCPI) electronic transmissions are intended for the purpose of an automated reconciliation of computer media records and are not acceptable forms of documentation for timeliness in appeals. Although the transmissions are from the state, the methods of creating paper facsimiles vary according to provider software and are not standard.

Over-One-Year Dates of Service

Appeals submitted for claims billing services rendered more than 13 months prior to the appeal date should include one of the following, if available, to show proof of recipient eligibility:

- Copy of the Internet eligibility response or state-approved vendor software screen print, with an Eligibility Verification Confirmation (EVC) number
- RAD showing payment for same recipient for the same month of service billed
- Copy of the original *Eligibility Letter of Authorization* (LOA) form (MC 180/MC 180-2)
- MEDS-generated *Eligibility Letter of Authorization* signed by an official of the county, (three pages, all three pages are required) or
- Copy of the original county-generated *Notification of Eligibility for Letter of Authorization*.

Requesting Claim Adjustments

When requesting a claim adjustment, submit a copy of the RAD on which the claim line was paid and all other pertinent attachments, including timeliness documentation.

Page updated: October 2022

Timeliness: 90-Day Deadline

Providers must submit an appeal in writing within 90 days of the action/inaction precipitating the complaint. Failure to submit an appeal within this 90-day time period will result in the appeal being denied. (See *California Code of Regulations*, Title 22, Section 51015.)

Timeliness Verification

The only acceptable documentation to verify timely submission of a claim is a copy of a RAD, *Claims Inquiry Response Letter, Claims Inquiry Acknowledgment*, or any dated correspondence from the California MMIS Fiscal Intermediary containing a Claims Control Number (CCN) or Correspondence Reference Number (CRN) with a Julian date falling within the six-month billing limit for the claim submission. A copy of the CIF without its accompanying *Claims Inquiry Acknowledgment* does not prove timely follow-up and may cause an appeal to be denied.

Page updated: March 2023

Where to Submit Appeals

Providers should mail appeals to the FI at the following address:

Attn: Appeals Unit
California MMIS Fiscal Intermediary
P.O. Box 15300
Sacramento, CA 95851-1300

FI Acknowledgement of Appeal

The FI will acknowledge each appeal within 15 days of receipt and make a decision within 45 days of receipt. If the FI is unable to make a decision within this time period, the appeal is referred to the professional review unit for an additional 30 days.

If the appealed claim is approved for reprocessing, it will appear on a future *Remittance Advice Details* (RAD). The reprocessed claim will continue to be subject to Medi-Cal policy and claims processing criteria and could be denied for a separate reason.

Appeal Response Letter

The FI will send a letter of explanation in response to each appeal. Providers who are dissatisfied with the decision may submit subsequent appeals. In these cases, indicate the reason for appealing the decision in the *Reason For Appeal* field (Box 13) of the *Appeal Form*, and attach a copy of the claim and any supporting documentation (including timeliness documentation).

‹‹**Note**: Providers also have access to electronic Appeal Response Letters through Medi-Cal Provider Portal.››

Judicial Remedy: One-Year Limit

Providers who are not satisfied with the FI's decision after completing the appeal process may seek relief by judicial remedy not later than one year after the appeal decision. Providers who elect to seek judicial relief may file a suit in a local court, naming the Department of Health Care Services (DHCS) as the defendant. (See *Welfare and Institutions Code,* Section 14104.5.)

Page updated: October 2022

DO NOT STAPLE IN BAR AREA

(1) APPEAL REFERENCE NUMBER

1

F.I. USE ONLY

FASTEN HERE

2

READ INSTRUCTIONS ON REVERSE PRIOR TO COMPLETING AND SIGNING THIS FORM. DO NOT TYPE/MARK IN SHADED AREAS.

APPEAL

(2) DOCUMENT NUMBER
GXXXXXXX

TYPEWRITER ALIGNMENT
ELITE PICA

TYPEWRITER ALIGNMENT
ELITE PICA

(3) PROVIDER NAME/ADDRESS

3

ABC PROVIDER
1234 MAIN STREET
ANYTOWN CA 958235555

(4) PROVIDER NO.

4

0123456789

(5) CLAIM TYPE
CHECK ONE BOX ONLY

5

01 PHARMACY
02 LTC
03 HOSPITAL INPATIENT
04 HOSPITAL OUTPATIENT/ CLINIC
05 PHYSICIAN/ ALLIED
07 VISION

(6) AS PROVIDED BY THE CALIFORNIA ADMINISTRATIVE CODE. TITLE 22, SECTION 51015 (b-d). I AM SUBMITTING AN APPEAL OF MY CLAIM AS DEFINED BELOW. ENCLOSED ARE ALL THE PERTINENT DOCUMENTS CORRESPONDING TO THIS APPEAL, INCLUDING COPIES OF THE CLAIM. EOB/RA, CIF's, MEDICARE EOMB/RA AND ANY PREVIOUS CORRESPONDENCE WITH THE MEDI-CAL FISCAL INTERMEDIARY.

6

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

7 (7) PATIENT'S NAME OR MEDICAL RECORD NO.: **DOE**

8 (8) PATIENT'S MEDI-CAL I.D. NO./SSN: **90000000A95001**

(9) DELETE		(10) CLAIM CONTROL NO.	(11) DATE OF SERVICE	(12) EOB/RA CODE
9	01	1234567890123	113007	010
	02	1234567890124	113007	072
	03	1234567890125	122107	401
	04			
	05			
	06			
	07			
	08			
	09			
	10			
	11			
	12			
	13			
	14			

10 11 12

(13) **REASON FOR APPEAL:** (ENCLOSED ALL SUPPORTING DOCUMENTS, INCLUDING CLAIM COPY)

1. PLEASE SEE ATTACHED REPORT. WE SUBMITTED A CIF BUT THE CLAIM WAS DENIED AGAIN FOR DOCUMENTATION. PLEASE RECONSIDER.

2. QUANTITY BILLED WAS 2, ONLY PAID 1. PLEASE ADJUST THIS UNDERPAYMENT.

3. BILLED IN ERROR. PLEASE RETRACT PAYMENT.

13

(14) COMMON APPEAL REASON
CHECK ONLY ONE (IF APPLICABLE)

14

- ELIGIBILITY (POE ATTACHED)
- TAR DENIAL (TAR ATTACHED)
- CROSSOVER (EOMB ATTACHED)
- ADJUSTMENT REQUEST (PAID WARRANT ATTACHED)

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

15

(15) *Jane Smith*
SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM

030108
DATE

FORM# 90-1 (3/07)

Figure 1: Sample Completed *Appeal Form* (90-1): Denial Resubmissions, Underpayment Reconsiderations and Overpayment Returns

Page updated: October 2022

Explanation of Form Items

Each numbered item below refers to an area on the *Appeal Form* shown on a previous page.

Item	Description
1	**Appeal Reference Number.** For FI use only.
2	**Document Number**. The pre-imprinted number identifying the *Appeal Form*. This number can be used when requesting information about the status of an appeal.
3	**Provider Name/Address**. Enter the following information: Provider Name, Street Address, City, State, and ZIP code.
4	**Provider Number (*required field*).** Enter the provider number. Without the correct provider number, appeal acknowledgement may be delayed.
5	**Claim Type (*required field*)**. Enter an "X" in the box indicating the claim type. Only one box may be checked.
6	**Statement of Appeal**. For information purposes only.
7	**Patient's Name or Medical Record Number**. Enter up to the first 10 letters of the patient's last name or the first 10 characters of the patient's medical record number.
8	**Patient's Medi-Cal ID Number/SSN (*required field*).** Enter the recipient ID number that appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card.
9	**Delete.** If an error is made, enter an "X" in this box to delete the corresponding line. When Box 9 is marked "X", the information on the line will be "ignored" by the system and will not be processed as an appeal line. Enter the correct billing information on another line.
10	**Claim Control Number (*required field if appealing a previously adjudicated claim*).** Enter the 13-digit number assigned by the FI to the claim line in question. (This number is found on the *Remittance Advice Details* [RAD]). This field is not required when appealing a non-adjudicated claim (for example, a "traced" claim that could not be located).
11	**Date of Service**. In six-digit format (MMDDYY) enter the date the service was rendered. For claims billed in a "from-through" format, you must enter the "from" date of service.
12	**RAD Code or EOB/RA Code**. When appealing an adjudicated claim, enter the RAD message code for the claim line (for example, 010, 072, 401).

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Item	Description
13	**Reason for Appeal**. Indicate the reason for filing an appeal. Be as specific as possible. Include all supporting documentation to help examiners properly research the complaint.
14	**Common Appeal Reason**. Check one of these boxes if applicable. Include a copy of the claim and supporting documentation (for example, TAR, EOMB). This box is for convenience only. Leave Box 13 blank if this box is used.
15	**Signature**. The provider or an authorized representative must sign the *Appeal Form.*

Completion

Complete the fields on the *Appeal Form* (90-1) according to the type of inquiry, as described in the following paragraphs. Resubmission, underpayment and overpayment requests for the same recipient may be combined on one form. However, each appeal should include only one recipient. Use the correct recipient Medi-Cal ID number on the appeal.

Required Fields

Always complete Boxes 3, 4, 5, 7, 8, 10, 11 and 12. These are required fields for all inquiry types. Boxes 4, 5, 8 and 10 (*Provider Number, Claim Type, Patient's Medi-Cal I.D. Number/SSN* and *Claim Control Number*) must be completed to process the appeal. If these fields are left blank, providers may receive an appeal rejection letter requesting resubmission of a corrected Appeal Form and all supporting documentation and proof of timely follow-up and submission.

Note: The correct recipient ID number must be entered in Box 8 (*Patient's Medi-Cal I.D. No./SSN*) even if the RAD reflects an incorrect recipient ID number.

Appealing a Denial

If appealing a denial, enter the denial code from the RAD in Box 12.

Underpayment and Overpayment Adjustments

If requesting reconsideration of an underpayment or overpayment, enter the payment code from the RAD in Box 12. (See *Figure 1* on a previous page.)

If requesting an adjustment, attach a legible copy of the original claim form, corrected if necessary, and a copy of the corresponding paid RAD. If requesting an overpayment adjustment because the patient named is not a provider's patient, attach only a copy of the paid RAD.

Appealing National Correct Coding Initiative (NCCI) Denials

Claims that fail federally mandated Medicaid NCCI edits will be denied and returned to the provider, who must submit an appeal for reconsideration of payment. Appeals for claims that fail due to NCCI edits are submitted primarily the same way as appeals for claims that fail due to standard Medi-Cal edits. Providers should pay special attention to correct use of modifiers on corrected claims and supporting documentation for appeals of NCCI-edit denials.

Additional NCCI appeal information is included in the Part 2 *Correct Coding Initiative*: *National* section. The manual section includes links to a federally maintained Centers for Medicare & Medicaid Centers (CMS) website with NCCI information about denials and appeals.

Correcting NDC/UPN Information for Physician-Administered Drug or Disposable Medical Supply Claims

To correct the National Drug Code (NDC) and/or Universal Product Number (UPN) information previously submitted on a claim form, complete the required fields identified above. Enter the corrected NDC/UPN information (Product ID Qualifier, Product ID, Unit of Measure Qualifier or NDC/UPN Quantity) in the *Reason for Appeal* field (Box 13).

Common Appeal Reasons

If filing an appeal for one of the reasons listed in Box 14, mark the appropriate box and submit the required documentation along with a copy of the claim. This box is for convenience and, if applicable, can be used instead of Box 13. However, all other items must be completed. (See *Figure 2* on a following page.)

Signatures

Sign and date the bottom of the form. All appeals must be signed by the provider or an authorized representative. Appeals submitted without a signature will be returned to the provider.

Submission

Submit the original *Appeal Form* and all attachments to the CA-MMIS FI.

(1) APPEAL REFERENCE NUMBER
F.I. USE ONLY

DO NOT STAPLE IN BAR AREA

FASTEN HERE

APPEAL

READ INSTRUCTIONS ON REVERSE PRIOR TO COMPLETING AND SIGNING THIS FORM. DO NOT TYPE/MARK IN SHADED AREAS.

(2) DOCUMENT NUMBER
GXXXXXXX

TYPEWRITER ALIGNMENT ELITE PICA

(3) PROVIDER NAME/ADDRESS
ABC PROVIDER
1234 MAIN STREET
ANYTOWN CA 958235555

(4) PROVIDER NO.
0123456789

(5) CLAIM TYPE
CHECK ONE BOX ONLY
01 PHARMACY
02 LTC
03 HOSPITAL INPATIENT
04 HOSPITAL OUTPATIENT/ CLINIC
05 PHYSICIAN/ ALLIED
07 VISION

(6) AS PROVIDED BY THE CALIFORNIA ADMINISTRATIVE CODE. TITLE 22, SECTION 51015 (b-d). I AM SUBMITTING AN APPEAL OF MY CLAIM AS DEFINED BELOW. ENCLOSED ARE ALL THE PERTINENT DOCUMENTS CORRESPONDING TO THIS APPEAL, INCLUDING COPIES OF THE CLAIM. EOB/RA, CIF's, MEDICARE EOMB/RA AND ANY PREVIOUS CORRESPONDENCE WITH THE MEDI-CAL FISCAL INTERMEDIARY.

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

(7) PATIENT'S NAME OR MEDICAL RECORD NO.: DOE
(8) PATIENT'S MEDI-CAL I.D. NO./SSN: 90000000A95001

(9) DELETE		(10) CLAIM CONTROL NO.	(11) DATE OF SERVICE	(12) EOB/RA CODE
	01	1234567890123	113007	002
	02			
	03			
	04			
	05			
	06			
	07			
	08			
	09			
	10			
	11			
	12			
	13			
	14			

(13) **REASON FOR APPEAL:** (ENCLOSED ALL SUPPORTING DOCUMENTS, INCLUDING CLAIM COPY)

(14) COMMON APPEAL REASON
CHECK ONLY ONE (IF APPLICABLE)

- [X] ELIGIBILITY (POE ATTACHED)
- [ ] TAR DENIAL (TAR ATTACHED)
- [ ] CROSSOVER (EOMB ATTACHED)
- [ ] ADJUSTMENT REQUEST (PAID WARRANT ATTACHED)

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

(15) Jane Smith
SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

030108
DATE

FORM# 90-1 (3/07)

Figure 2. Sample Completed *Appeal Form* (90-1): Common Appeal Reasons.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
†	An appeal received on or after October 1, 2015, by the FI will require an ICD indicator of “0,” on the claim attached to it if the attached claim is submitted with an ICD-10-CM diagnosis code. If the ICD indicator is not on the claim, the appeal will be rejected.