

SECTION J APPEALS

AAHP PROVIDER RECONSIDERATION/RE-DETERMINATIONS (Collectively “Appeals”)

CLAIMS CUSTOMER SERVICE:

- AAHP encourages providers to contact Claims Customer Service at 602-824-3900 or 1-888-864-1114 for assistance with questions or issues surrounding claim payment, partial payment, or non-payment. As a reminder, please submit all claims within 180 days for both contracted and non-contracted providers. A provider may dispute any claim payment, payment reduction or claim denial, by filing an appeal.

APPEALS:

- If you would like to file an appeal request, such as in response to a claim payment, payment reduction or claim denial by AAHP, please submit the request in writing within 60 days from the date of the remittance advice or notice of adverse action. Be sure to include a cover letter explaining the basis for the appeal along with any required documentation to support the request, such as medical records. Failure to timely request an appeal is deemed a waiver of all rights to review.
- Providers may submit appeal requests by mail to:

Abrazo Advantage Health Plan
Attn: Provider Appeals Unit
7878 North 16th Street, Suite 105
Phoenix, Arizona 85020

Fax requests to AAHP at: 602-674-6673 or 1-866-832-5469 if outside of Maricopa County

- AAHP acknowledges any appeal request received within five (5) business days of receipt. The appeal is reviewed and a decision rendered within 30 days of receipt. AAHP may request an extension of up to 14 days, if needed.
- If AAHP approves the reconsideration request, the provider receives a corrected payment and remittance advice. However, if AAHP upholds its original decision (e.g. denial) on any claim for medical services, it forwards the file automatically to the CMS designated Independent Review Entity (IRE) to review your case. The IRE is contracted with the federal government and is not part of AAHP. AAHP tells you in writing whenever your appeal is sent to the IRE for review.

PROVIDER APPEALING ON BEHALF OF A MEMBER:

- If AAHP denies services for a member in whole or part, a provider can file an appeal on behalf of a Member within 60 days of the original denial notice.
- A provider who elects to use this option needs to complete an *Appointment of Representative* form (AOR) as required by CMS.
- Please copy the AOR form (see the following pages) or visit the AAHP (www.abrazoadvantage.com) or CMS

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(<http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>) website to print and/or download this form.

- The AOR must be signed by both the provider and the Member and must accompany the appeal request.
- Send completed AOR forms to the above AAHP mailing address and/or fax number.
- Completion of an AOR allows the provider to act on the Member's behalf during the appeal process. The provider has all of the rights and responsibilities of an enrollee, or party, in obtaining an organization determination or in dealing with any of the levels of the appeal process.

APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY

MEDICARE NUMBER

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the beneficiary:

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF BENEFICIARY

DATE

STREET ADDRESS

PHONE NUMBER (AREA CODE)

CITY

STATE

ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE

DATE

STREET ADDRESS

PHONE NUMBER (AREA CODE)

CITY

STATE

ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation.

(Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue **must** complete this section.)

I waive my right to charge and collect a fee for representing _____
before the Secretary of the Department of Health and Human Services.

SIGNATURE

DATE

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE

DATE

CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.



Abrazo Advantage Health Plan (HMO)

PROVIDER RECONSIDERATION ("APPEAL") FORM (Rev 1/2010)

AAHP Guidelines:

All standard provider appeals regarding claim payment, partial payment or non-payment must be submitted within 60 calendar days from the date of the notice of determination (i.e. remittance advice or notice of adverse action).

Requests for appeal should include:

1. A completed Provider Reconsideration form OR a cover letter detailing the factual and legal basis for the dispute. (Complete one form for each disputed claim).
2. A copy of the original claim and remittance advice.
3. A signed and dated Waiver of Liability Statement form. **Non-contracted providers must complete a Waiver of Liability Statement to provide that the provider will not bill the member regardless of the outcome of the appeal. AAHP is not obligated to conduct the appeal until the waiver is received (see 42 CFR §422.600). If the waiver is not received at the conclusion of the appeal timeframe (60 days) the appeal case is forwarded to an Independent Review Entity (IRE) with a request for dismissal. The IRE is contracted with the Centers for Medicare & Medicaid (CMS) and is not part of AAHP.
4. Supporting documentation when the claim involves a clinical component (denied inpatient days, bundling issues, or services denied for lack of prior authorization). Documentation includes medical records, operative reports, etc.
5. Mail the completed form(s) and documentation to:

Abrazo Advantage Health Plan
Attn: Provider Appeals
7878 N. 16th St. #105
Phoenix, AZ 85020
Or by fax to: (602) 674-6673

6. Appeals are acknowledged within five (5) business days. A written decision is mailed within sixty (60) calendar days from receipt.
Note: When AAHP upholds its original decision in full or in part, the case file is forwarded to the IRE. The IRE reviews the case and makes a final determination on the appeal. In some cases, the provider may need to file an Independent Payment Dispute Resolution (PDD) directly with the IRE. Please refer to the resolution letter upon receipt to determine which appeal process is applicable.

Date Submitted:	Contact Name:		
Contact Phone Number:	Contact Fax Number:		
Provider of Disputed Service:			Provider F#:
Member Name:	Member Date of Birth:	Member ID#:	

CLAIM INFORMATION

Claim Number (s)	Date(s) of Service	CPT / HCPCS / Revenue Code	Modifier (if applicable)	Amount Billed	Amount Paid
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$

REASON FOR DISPUTE (check appropriate box)

<input type="checkbox"/> Claim Bundling	<input type="checkbox"/> Additional Bed Days
<input type="checkbox"/> Prior Authorization Issue	<input type="checkbox"/> Tier Level
<input type="checkbox"/> Timeliness of Claim	<input type="checkbox"/> Non-Covered Benefit
<input type="checkbox"/> Corrected Claim (re: ICD-9, CPT, HCPCS, Revenue Code, Modifier, Missing Documentation, etc)	<input type="checkbox"/> Medical Necessity
<input type="checkbox"/> Incorrect Reimbursement	<input type="checkbox"/> Ineligible Member
<input type="checkbox"/> Other Insurance / Missing EOB	<input type="checkbox"/> Provider Eligibility
<input type="checkbox"/> Other (specify):	

Reason/Supporting Information for Appeal:
