Appeals and Administrative Review

CSHCN Services Program Provider Manual

January 2023

TEXAS
Health and Human
Services

APPEALS AND ADMINISTRATIVE REVIEW

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7.1 Appeals

An appeal is a request for reconsideration of a previous denial.

Providers may request an appeal if a denial is received for any of the following:

- Authorization or prior authorizations
- Claims
- Provider enrollment

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for additional information regarding the appeals process for authorization and prior authorization denials.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for additional information.

Section 2.1.4, "Provider Enrollment Determinations" in Chapter 2, "Provider Enrollment and Responsibilities" for additional information.

7.2 Authorization and Prior Authorization Denials

Authorization or prior authorization requests that do not contain all of the information necessary for the program to make a determination are denied.

Refer to: Section 4.5, "Authorization and Prior Authorization Denials" in Chapter 4, "Prior Authorizations and Authorizations" for information about reasons for denials.

7.2.1 Administrative Review for Authorization or Prior Authorization Denials

A provider or client who has received a denied authorization or prior authorization may submit a request for an administrative review to the CSHCN Services Program if they are dissatisfied with TMHP's decision to deny the authorization or prior authorization.

All providers and clients must submit requests for an administrative review within 30 days of the date TMHP denied the authorization or prior authorization. Requests for an administrative review and all supporting documentation must be submitted by mail or fax to:

CSHCN Services Program–Administrative Review
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

Additional information requested by the CSHCN Services Program must be returned to the Program within 30 calendar days of the date of the letter from the CSHCN Services Program. If the information is not received within 30 calendar days, the case is closed.

7.2.2 Fair Hearing Requests for Authorizations or Prior Authorizations

After an administrative review, providers or clients may request a fair hearing if they are dissatisfied with the CSHCN Services Program's decision and the supporting reason.

The fair hearing is the final appeal process and is described in the *Texas Administrative Code* (TAC) Title 25, Part 1, Chapter 1, Subchapter C (www.sos.state.tx.us). The fair hearing process is conducted by the Office of General Counsel at DSHS.

Providers or clients may choose to represent themselves, or have legal counsel or another spokesperson, at the hearing. If providers or clients are unable to attend the hearing in person, they may request arrangements to attend by teleconference.

Fair hearing requests must be submitted in writing to the CSHCN Services Program within 20 days of the date of the administrative review decision notice. The request should state the reasons for the disagreement and include any documents or other proof that help support those reasons. Providers and clients who fail to request a fair hearing within the 20-day period are presumed to have waived their right to request a fair hearing, and the CSHCN Services Program will take final action.

Mail or fax fair hearing requests to:

CSHCN Services Program-Fair Hearing
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

7.3 * Claim Appeals

Providers may use three methods to appeal claims to TMHP:

- Automated Inquiry System (AIS)
- Electronic
- Paper

TMHP must receive all appeals of denied claims and requests for adjustments on paid claims within 120 days of the date of disposition of the Remittance and Status (R&S) Report on which that claim appears. If the 120-day appeal deadline falls on a weekend or holiday, the deadline is extended to the next business day.

Refer to: ***[Revised]*** 2022 Authorization Filing Deadline Calendar

[Revised] 2023 Authorization Filing Deadline Calendar

All appeals must be sent to TMHP as a first-level appeal. A first-level appeal is a provider's initial appeal of a claim that has been denied or adjusted by TMHP. This appeal is submitted by the provider directly to TMHP for adjudication and must contain all required information to be considered.

7.3.1 Electronic Appeal Submission

Providers can use TexMedConnect or vendor software to submit files directly to TMHP or they may use a billing agent (i.e., billing companies or clearinghouses) that submits files on the provider's behalf.

TMHP Electronic Data Interchange (EDI) accepts the *Health Insurance Portability and Accountability Act* (HIPAA) standard American National Standards Institute (ANSI) ASC X12 837 format.

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for additional information regarding electronic transactions.

Zero-paid claims that appear in the "Claims - Paid or Denied" section of the R&S Report and the allowed charge and the paid amount are $0, may be resubmitted as electronic appeals. Zero-paid claims that are still within the 95-day filing deadline should be submitted as new day claims, which process faster than appeals.

For more information, contact the TMHP EDI Help Desk at 1-888-863-3638, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time.

7.3.1.1 Advantages of Electronic Appeal Submission

- Increased accuracy potentially improves cash flow
- Audit trails can be maintained through print and download capabilities

- Appeal submission fields can be automatically filled in with Electronic Remittance and Status (ER&S) Report information, reducing data entry time
- Acceptance or rejection reports received for appeals submissions

7.3.1.2 Disallowed Electronic Appeals

The following claims may not be appealed electronically, and providers must appeal these denials on paper:

- Claims that require supporting documentation (e.g., operative report, medical records)
- Claims listed as *pending* or in *process* with explanation of pending status (EOPS) messages
- Claims denied as past *filing deadline*, except when retroactive eligibility deadlines apply
- Claims denied as past the *payment deadline*
- Inpatient Hospital claims that require supporting documentation
- Third-party liability (TPL) and other insurance
- Claims billed for additional days or units not included in the original claim

7.3.1.3 Electronic Rejections

TMHP EDI transactions that fail HIPAA edits are rejected, and the submitter receives a 277CA claim response file which replaced the TMHP EDI Rejected Transaction Report. The 277CA claims response file lists activity by submitter, provider, and payer.

The 277CA claims response file includes member identifier, patient last name and first initial, patient control number (PCN), type of bill or place of service, charge, transaction from and to dates, receipt date, rejection code, and rejection description.

Providers must send the batch ID, PCN, date of service, transaction from and to dates, receipt date, and rejection codes from the 277CA claims response file to TMHP when appealing denied claims.

The batch ID is located in the file name of the returned 277CA claims response, and not within the file. Providers must include the batch ID in all electronic response files submitted to TMHP for appeals to denied claims. Handwritten batch IDs are not acceptable for submission to TMHP. Providers who cannot identify or retrieve the batch ID from the 277CA claims response file name should contact the clearinghouse or vendor to have the filename included in the response document. If not, the provider must request a copy of the response file that contains the filename from the clearinghouse.

Providers who receive a rejection on the 277CA claims response file may resubmit an electronic claim within 95 days of the date of service.

A paper appeal may also be submitted with a copy of the response document within 120 days of the 277CA claims response file rejection to meet the filing deadline. A copy of the electronic response file rejection to include the batch ID must accompany each corrected claim that is submitted on paper.

7.3.2 AIS Claim Correction and Resubmission (Appeals)

Telephone resubmissions or appeals may be entered through AIS using the keypad of a touch tone telephone. Providers may submit up to 3 field corrections per claim and 15 appeals per call. If invalid information is entered three times during any step, the call is transferred to a contact center representative for assistance.

For more information about how to correct and resubmit claims using AIS, providers can call 1-800-568-2413.

Providers may submit appeals through AIS to correct claims that were denied for the following:

- Beginning date of service

- Billing, performing, or referring provider identification numbers
- Client number
- Date of birth
- Date of onset
- Ending date of service
- Place of service (POS)
- Prior authorization number (PAN)
- Quantity billed
- X-ray date
- Type of service (TOS)

The following may not be appealed through AIS, and providers must appeal these denied claims on paper:

- Incomplete claims listed on the R&S Report in the "Claims - Paid or Denied" section
- Claims listed on the R&S Report with $0 allowed and $0 paid
- Claims that require supporting documentation (e.g., operative report, medical records)
- Procedure code, modifier, or diagnosis code
- Claims listed as *pending* or *in process* with Explanation of Pending Status (EOPS) messages
- Claims denied as *past filing deadline* except when retroactive eligibility deadlines apply
- Claims denied as *past the payment deadline*
- Inpatient hospital claims that require supporting documentation
- Third-Party Liability (TPL) and other insurance

7.3.3 Paper Appeals

If a claim cannot be appealed electronically or by using AIS, providers may appeal the claim on paper by completing the following:

1) Submit a copy of the R&S page on which the claim is paid or denied or other official notification from TMHP (i.e., TMHP letters attached to returned claims).
2) Submit one copy of the R&S Report page for each claim appealed.
3) Circle only one claim per R&S page.
4) Indicate the reason for the appeal.
5) If applicable, indicate the incorrect information and provide the correct information that should be used to appeal the claim.
6) Attach a copy of any supporting documentation that is necessary or requested by TMHP. Supporting documentation must be on a separate page.

Note: *Completed claim forms are not required to be submitted with paper appeals. Providers who submit paper appeals must clearly document on the R&S Report what information is being appealed and must identify the claim being appealed.*

Reminder: *Do not copy supporting documentation on the opposite side of the R&S Report.*

Paper appeals must be submitted to the following address:

Texas Medicaid & Healthcare Partnership
Attn: CSHCN Services Program Appeals, MC-A11
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

Providers may not request reconsideration or appeal of the following:

- Claims appearing in the "Pending Claims" section of the R&S Report. Providers cannot resubmit or appeal a claim that has not appeared as a paid or denied claim.
- Incomplete claims appearing in the "Claims - Paid or Denied" section of the R&S Report. Incomplete claims appear with one or more EOB code(s). Providers must correct the information and submit a new claim with the R&S Report within 120 days of the date on the R&S Report.

Important: *It is strongly recommended that providers who submit paper appeals retain a copy of the documentation they send. It also is recommended that paper documentation be sent by certified mail with a return receipt requested. This documentation and a detailed list of the claims that were enclosed provides proof that the claims were received by TMHP. This is particularly important if it is necessary to prove that the 120-day appeals deadline has been met. If a certified receipt is provided as proof, the certified receipt number must be indicated on the detailed list. The provider may need to keep such proof for all claims submissions, if their enrollment is pending.*

7.3.3.1 Total Billed Amount Changes

Appeals must be submitted on paper if the total billed amount is changed. Electronic appeals of this kind will be denied for timely filing if it is submitted more than 95 days after the original date of service.

To resubmit a claim with a new total billed amount, the claim may be submitted electronically as a new day claim. The new day claim must be within 95 days of the filing deadline. If a claim is submitted after the 95-day filing deadline, it will be denied for timely filing.

7.3.4 Appeals Submitted Incorrectly

If an incomplete appeal is received, it is returned to the sender with further appeal instructions and a request for more information. Documentation (either by letter or fax) that does not clearly indicate the reason for submission is returned to the sender for clarification.

If TMHP identifies a pattern of ineffective use of the appeals process, the provider may be referred to a provider relations representative for assistance.

The provider may also initiate contact with a provider relations representative for assistance.

Refer to: Section 1.1.5, "TMHP Regional Representatives" in Chapter 1, "TMHP and HHSC Contact Information" for contact information.

7.3.5 Administrative Review for Claims

To complete the TMHP appeals process:

a) The claim must have been denied or adjusted by TMHP, and

b) The claim must have been appealed as a first-level appeal to TMHP, and

c) The first level appeal must have been denied again for the same reasons by TMHP.

After the TMHP appeals process has been exhausted, the provider must submit a request for administrative review within 30 days of the date TMHP denied the appeal in order for the claim to be considered for payment.

Requests for an administrative review and all supporting documentation must be submitted by mail or fax to:

CSHCN Services Program–Administrative Review
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

TMHP may be required to gather information related to the original claim and the first-level appeal. The CSHCN Services Program is the sole adjudicator of the administrative review.

Refer to: Section 4.5.3, "Administrative Review for Authorization and Prior Authorization Denials" in Chapter 4, "Prior Authorizations and Authorizations."

7.3.5.1 Administrative Review Requirements

An administrative review is a request for a review as defined in 26 TAC §351.10 and §351.13.

An administrative review must be:

- Submitted in writing to CSHCN Services Program Administrative Review by the provider who delivered the service or received claim reimbursement or claim denial for the service.
- Received by CSHCN Services Program Administrative Review after the appeals process with TMHP has been exhausted, and must contain evidence of appeal dispositions from TMHP:
  - All correspondence and documentation from the provider to TMHP, including copies of supporting documentation that was submitted during the appeal process.
  - All correspondence from TMHP to the provider.
- Received by CSHCN Services Program within 30 days of the date of disposition by TMHP as evidenced by the R&S sent to provider.
- Complete and contain all of the information necessary for consideration and determination by CSHCN Services Program Administrative Review, including:
  - A written explanation that specifies the reason for the request for review.
  - Supporting documentation for the request.
  - All R&S Reports that identify the claims and services in question.
  - Identification of the incorrect information and the corrected information used to appeal the claim.
  - A copy of the original claim, if it is available. Claim copies are helpful when the administrative review involves medical policy or procedure coding issues.
  - A corrected, signed claim.
  - A copy of supporting medical documentation requested by TMHP.
  - Provider's internal notes and logs, when pertinent (cannot be used as proof of timely filing).
  - Memos from the state or TMHP indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the review.
  - Other documents, such as receipts (e.g., certified mail along with a detailed listing of the claims enclosed), in-service notes, minutes from meetings, etc., if relevant. Receipts can be helpful when late filing is an issue.

Providers that have submitted their claims electronically can provide proof of timely filing by submitting a copy of an electronic claims report that includes the following information:

- Client name or CSHCN Services Program client identification number (patient control number [PCN])
- DOS
- Total charges
- Batch identification number (Batch ID) (in correct format)

Note: *Only reports that were accepted or rejected by TMHP will be honored. The claim filed (client name or PCN, DOS, and total charges) should match the information on the batch report.*

Providers must adhere to all filing and appeal deadlines for an administrative review to be considered by the CSHCN Services Program. The filing and appeal deadlines are described in 26 TAC §351.10 and §351.13 and in this manual.

Refer to: Section 5.1.8 *, "Claims Filing Deadlines" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for additional information.

Additional information requested by the CSHCN Services Program must be returned to the Program within 30 calendar days of the date of the letter from the CSHCN Services Program. If the information is not received within 30 calendar days, the case is closed.

7.3.6 Fair Hearing for Claims

After an administrative review, providers may request a fair hearing if they are dissatisfied with the CSHCN Services Program's decision and the supporting reason.

The fair hearing is the final appeal process and is described in the 25 TAC, Part 1, Chapter 1, Subchapter C (www.sos.state.tx.us). The fair hearing process is conducted by the Office of General Counsel at DSHS.

Providers may choose to represent themselves or have legal counsel or another spokesperson at the hearing. If providers are unable to attend the hearing in person, they may request arrangements to attend by teleconference.

Fair hearing requests must be submitted in writing to the CSHCN Services Program within 20 calendar days of the date of the administrative review decision notice. The request should state the reasons for the disagreement and include any documents or other proof that help support those reasons. Providers who fail to request a fair hearing within the 20-day period are presumed to have waived their right to a fair hearing, and the CSHCN Services Program will take final action.

Mail or fax fair hearing requests to:

CSHCN Services Program-Fair Hearing
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

Note: *Weekends and holidays must be included in the count to determine the 20-day deadline.*

7.3.7 National Correct Coding Initiative (NCCI) Claims Appeals

Claims or procedure codes that have been denied based on NCCI guidelines may be appealed with an appropriate modifier or documentation of medical necessity. If the submitted procedure code is denied because NCCI guidelines indicate the code is included in another procedure, the claim may be appealed with a modifier if applicable. If a modifier does not apply but medical necessity can be proven, the provider must submit documentation of medical necessity that indicates both services were necessary on the same date of service. For guideline exceptions that may be appealed, providers may refer to the

Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals. Providers must follow the current standard appeals process when appealing claims to TMHP.

7.4 Provider Enrollment Appeals

The CSHCN Services Program may deny, modify, suspend, or terminate a provider's approval to participate for the reasons listed in the CSHCN Services Program Rules in 26 TAC §351.6(b)(1) through (2) at www.sos.texas.gov/tac/index.shtml.

Before taking action to deny, modify, suspend, or terminate the approval of a provider, the CSHCN Services Program shall give the provider written notice of an opportunity to request an administrative review of the proposed action.

The administrative review process is outlined in the notice sent to the provider. A written request for an administrative review must be received within 30 calendar days of the date of the notice. If a written request for an administrative review is not received by the CSHCN Services Program by this date, the program's decision is final and cannot be appealed.

Requests for an administrative review and all supporting documentation must be submitted by mail or fax to:

CSHCN Services Program–Administrative Review
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

In addition, a fair hearing is available to any provider for the resolution of conflict between the CSHCN Services Program and the provider.

Fair hearing requests must be submitted in writing to the CSHCN Services Program within 20 days of the date of the administrative review decision notice. The request should state the reasons for the disagreement and include any documents or other proof that help support those reasons. Providers who fail to request a fair hearing within the 20-day period are presumed to have waived their right to a fair hearing, and the CSHCN Services Program will take final action.

Mail or fax fair hearing requests to:

CSHCN Services Program-Fair Hearing
MC-1938
PO Box 149030
Austin, TX 78714-99347
Fax: 1-512-776-7238

7.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

7.6 Authorization and Filing Deadline Calendars

Refer to: 2021 Authorization Filing Deadline Calendar

2022 Authorization Filing Deadline Calendar