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APPEAL MATRIX
ERISA MEDICARE MEDICAID
SC WORKERS COMPENSATION

ERISA –	**180 days, see discussion below.**
Non ERISA Plans –	**goes by terms of the Plan, see below**
Medicare – Original –	**120 days – see below**
Medicare Advantage –	**60 days – see below**
SC Workers Compensation –	**new procedure by Commission, see below**
Medicaid Original –	**30 days to request fair hearing**
Medicaid Managed Care, contracted –	**per terms of contract**
Medicaid Managed Care, non contracted –	**30 days to request fair hearing**

ERISA- any Plan sponsored by an employer whether insured or self insured EXCEPT church plans, governmental plans and workers compensation.

Within 180 days from the receipt of the Explanation of Benefits denying the claim. Plans may allow for not more than two levels of appeal at this stage. Appeal must be submitted to the "Plan". §2560.503.1(h)(ii)(1). If you are outsourcing at any stage, we recommend referral of the matter not later than after the first appeal, or not later than 120 days after the receipt of the first denial.

Administrative Remedies must be exhausted before suit can be filed in United States District Court. Suit must be filed within applicable statute of limitations (currently three years) after the final appeal denial.

As to claims procedures and the US Department Of Labor Employee Benefits Security Administration (US DOL EBSA) regulations in general, we highly recommend the Frequently Asked Questions section of their website at:
http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html

Other Non ERISA Plans

By the terms of the Plan, except the Patient Protection and Affordable Care Act (PPACA), requires non ERISA plans to follow any applicable law, such as state insurance regulations. Insurers must update these procedures when HHS issues new standards. (Act Sec. 1001(5) of the PPACA as amended by Act Sec. 10101 (g) adding PHSA sec 2719(a)(2)). State Health Plan

guidelines are particularly restrictive and specifically enforced. First appeal is to the State Health Plan, then to the Budget and Control Board. We recommend consulting your legal counsel if you are unsure of your appeal deadline. If you are outsourcing in general, refer not later than 30 days before the expiration of the deadline.

ORIGINAL MEDICARE

§ 405.942 Time frame for filing a request for a redetermination.

(a) *Time frame for filing a request.* Except as provided in paragraph (b) of this section, any request for redetermination must be filed within 120 calendar days from the date a party receives the notice of the initial determination.

(1) For purposes of this section, the date of receipt of the initial determination will be presumed to be 5 calendar days after the date of the notice of initial determination, unless there is evidence to the contrary.

(2) The request is considered as filed on the date it is received by the contractor.

(b) *Extending the time frame for filing a request. General rule.* If the 120 calendar day period in which to file a request for a redetermination has expired and a party shows good cause, the contractor may extend the time frame for filing a request for redetermination.

(1) *How to request an extension.* A party may file a request for an extension of time for filing a request for a redetermination with the contractor. The party should include any evidence supporting the request for extension. The request for redetermination extension must—

(i) Be in writing;

(ii) State why the request for redetermination was not filed within the required time frame; and

(iii) Meet the requirements of §405.944.

§ 405.944 Place and method of filing a request for a redetermination.

(a) *Filing location.* The request for redetermination must be filed with the contractor indicated on the notice of initial determination.

§ 405.960 Right to a reconsideration to a QIC. We recommend referral to us at this stage. A Subsequent lawsuit filed with the Administrative Law Judge will be based, in large part on the administrative record, as well as anything file with the Administrative Court.

A person or entity that is a party to a redetermination made by a contractor as described under §405.940 through §405.958, and is dissatisfied with that determination, may request a

reconsideration by a QIC in accordance with §405.962 through §405.966, regardless of the amount in controversy.

§ 405.962 Timeframe for filing a request for a reconsideration 180 days

(a) *Timeframe for filing a request.* Except as provided in paragraph (b) of this section and in §405.974(b)(1), regarding a request for QIC reconsideration of a contractor's dismissal of a redetermination request, any request for a reconsideration must be filed within 180 calendar days from the date the party receives the notice of the redetermination.

(1) For purposes of this section, the date of receipt of the redetermination will be presumed to be 5 calendar days after the date of the notice of redetermination, unless there is evidence to the contrary.

(2) For purposes of meeting the 180 calendar day filing deadline, the request is considered as filed on the date it is received by the QIC.

(b) *Extending the time for filing a request* —(1) *General rule.* A QIC may extend the 180 calendar day timeframe for filing a request for reconsideration for good cause.

§ 405.970 Timeframe for making reconsideration.

(a) *General rule.* Within 60 calendar days of the date the QIC receives a timely filed request for reconsideration or any additional time provided by paragraph (b) of this section, the QIC mails, or otherwise transmits to the parties at their last known addresses, written notice of—

(1) The reconsideration;

(2) Its inability to complete its review within 60 calendar days in accordance with paragraphs (c) through (e) of this section; or

(3) Dismissal.

§ 405.1014 Request for an ALJ hearing within 60 days of QIC's denial, dismissal, or failure to respond.

(a) *Content of the request.* The request for an ALJ hearing must be made in writing. The request must include all of the following—

(1) The name, address, and Medicare health insurance claim number of the beneficiary whose claim is being appealed.

(2) The name and address of the appellant, when the appellant is not the beneficiary.

(3) The name and address of the designated representatives if any.

(4) The document control number assigned to the appeal by the QIC, if any.

(5) The dates of service.

(6) The reasons the appellant disagrees with the QIC's reconsideration or other determination being appealed.

(7) A statement of any additional evidence to be submitted and the date it will be submitted.

(b) *When and where to file.* The request for an ALJ hearing after a QIC reconsideration must be filed—

(1) Within 60 calendar days from the date the party receives notice of the QIC's reconsideration;

(2) With the entity specified in the QIC's reconsideration. The appellant must also send a copy of the request for hearing to the other parties. Failure to do so will toll the ALJ's 90 calendar day adjudication deadline until all parties to the QIC reconsideration receive notice of the requested ALJ hearing. If the request for hearing is timely filed with an entity other than the entity specified in the QIC's reconsideration, the deadline specified in §405.1016 for deciding the appeal begins on the date the entity specified in the QIC's reconsideration receives the request for hearing. If the request for hearing is filed with an entity, other than the entity specified in the QIC's reconsideration, the ALJ hearing office must notify the appellant of the date of receipt of the request and the commencement of the 90 calendar day adjudication time frame.

MEDICARE ADVANTAGE PLANS

The Appeal deadline for a Medicare Advantage Plan is 60 days, rather than 120. If a contracted Plan, you seem to have the same appeal rights under Original Medicare, and appeals from a denial of redetermination would go to the QIC

For non contracted plans, where there is a dispute over the amount of payment, appeals may be sent by the Plan to a Payment Dispute Resolution Contractor. However, it appears that an appeal must be made for reconsideration to the QIC, prior to filing a suit with the ALJ.

S.C. WORKERS COMPENSATION

The Commission has updated its Medical Bill Dispute/Appeal process from the 2006 manual with the following changes, taken directly from its website. We recommend referral at or before the time of petitioning the Commission for intervention.

Payment Dispute Resolution Process

State of South Carolina law (42-9-360(d)) provides that "Payment to an authorized health care provider for services shall be made in a timely manner but no later than thirty days from the date the authorized health care provider tenders request for payment to the employer's representative,

unless the commission has received a request to review the medical bill."

In cases in which a medical provider has not received full payment for Workers' Compensation services pursuant to the South Carolina Workers' Compensation Act (when such payment is not adjusted through contractual agreements in place between the parties), the medical provider may observe the following procedure.

1. If, following the earlier of the expiration of the initial 30-day billing period, or the receipt of a partial payment for services billed, the medical service provider believes they are entitled to additional payment under the Workers' Compensation Act (WCA), the medical service provider shall issue a written "2nd notice for payment" (sample form letters available here). The Commission encourages the provider to tender a "2nd Notice" via "receipt confirmed" means (ie: certified mail; commercial delivery carrier; etc.).
2. If, 30 days following the issuance of a "2nd notice for payment," the medical services provider has:
   a. received no response from the payer, the provider may submit a petition (petition available here) and supporting documentation to the Medical Services Division stating that:
      i. the payer has not responded to the "2nd Notice";
      ii. the provider is entitled to the lesser of the billed payment amount or the SCWCC Maximum Allowable Payment; and
      iii. the provider desires the SCWCC to issue a finding supporting payment from the payer.
   b. not received full payment, the provider may petition the South Carolina Workers' Compensation Commission Medical Services Division to review the case and issue a determination (petition available here). Supporting documentation as defined within the petition document must be provided to the SCWCC at the time of submission.
3. Upon receipt and review of the provider's petition, the SCWCC may (if the provided information warrants) initiate an information discovery process. During this process, the SCWCC shall issue a "Notice of Dispute" to the payer, the employer and the provider, and shall include copies of all documentation provided to the SCWCC concerning the case. The payer shall have 30 days from the issuance of the "Notice of Dispute" to respond to the SCWCC.
   a. In cases in which the provider alleges that the payer has not responded to the "2nd Notice", the SCWCC shall issue a notice of dispute and request that the payer provide

evidence that it did respond in writing (as evidenced by certified mail receipt) to the "2nd Notice" within the 30-day period described in section 2 above.

b. In cases in which the provider confirms that payer has provided written response to the "2nd Notice", payer shall provide to the SCWCC documentation justifying its nonpayment or partial payment of provider's bill.

4. Within 21 days of the earlier of the expiration of the "notice of dispute" period or the payer's response to the "notice of dispute", the SCWCC shall issue its determination of the case. If such determination instructions specific action to be taken by the parties to the case, such action must be completed within 14 days of the issuance of the SCWCC's determination.
5. If action has not been completed within the 14-day period, the SCWCC may bind the case for docketing to be heard before the Commission. Once docketed, applicable adjudication fees will apply. At hearing, additional fines/penalties may be imposed.
6. Please note: The Payment Dispute Resolution Process is not designed to permit the intentional delay of payment of provider service fees. Medical Bill Review entities which are found to have withheld payment on non-substantiated grounds may be subject to administrative fines and penalties up to the suspension and/or revocation of their approval to conduct South Carolina Workers' Compensation Medical Bill Review services.

Medical Bill Dispute Form

MEDICAID

For "conventional Medicaid" You have thirty days after receiving remittance denying the claim to request an appeal, called a "Fair hearing" before the Division of Appeals at DHHS. http://www.scdhhs.gov/openpublic/insidedhhs/bureaus/BureauofFiscalAffairs/Appeals.asp Because of the very short time frame, you have to be careful about trying to resolve the claim after receipt of remittance but before filing an appeal, as those thirty days pass quickly.

MANAGED CARE MEDICAID – SCDHHS interprets federal regulations to state that if you are a contracted provider, your rights are limited to the contract. If a non contracted provider, you must have patient consent to file an appeal. If you are non contracted and missed your thirty day window, appeal options are limited.