
Appeal Process Overview

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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. An appeal may be submitted for unsatisfactory responses to the processing, payment and resubmission of a claim or a claim inquiry. The California MMIS Fiscal Intermediary reviews each case individually using the documents presented by a provider to render a fair decision.

«Electronic Claim Resubmission May Avoid Appeal

Before preparing a paper appeal for a claim adjustment or reconsideration, providers may want to consider if their claim issue might be resolved by electronically voiding and resubmitting the claim. Information about claim voids and resubmission is available in the Part 1, *Electronic Methods for Eligibility Transaction and Claim Submissions* provider manual section under the heading, “Electronic Claims Resubmission: 837I and 837P.” Electronic claim resubmission is not available for pharmacy claims.»

Preparing an Appeal

Providers who seek an appeal must initiate action by submitting a complaint in writing that identifies the claim and describes the disputed action or inaction. The simplest way is to use an *Appeal Form* (90-1) to identify the disputed claim.

The FI accepts appeals related to claims processing issues only. Appeals for Medi-Cal-related items that do not pertain to claims processing (such as recipient eligibility, *Treatment Authorization Request* (TAR) approval and provider enrollment) must be submitted to the appropriate State or county department. Refer to the appropriate section for information.

Refer to the *Appeal Form Completion* section in the Part 2 manual for *Appeal Form* (90-1) completion instructions.

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* [CCR], Title 22, Section 51015.)

Where to Submit Appeals

Providers should mail appeals to:

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

Acknowledgement of Appeal

The CA-MMIS FI will acknowledge each written complaint 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.

Reprocessed Claims Appear on RAD

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.

Claims Appeal Status

Providers may determine the status of an appealed claim by means of the Provider Telecommunications Network (PTN) or the Medi-Cal website. Refer to the *Provider Telecommunications Network* (PTN) section in this manual for details about using this provider service to access the status of an appealed claim.

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.

Judicial Remedy One-Year Limit

Providers who are not satisfied with the decision after completing the appeal process may seek relief by judicial remedy **no 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* [W&I Code], Section 14104.5.)

<<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.
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