PHYSICIANS CHOICE
medical group

M E M O R A N D U M

Date: January 17, 2022

To: **All Providers / Physicians Choice Medical Group of San Luis Obispo & Physicians Choice Medical Group of Santa Maria**

From: Barbara Cheever, Vice President of Operations

RE: **PDRs (aka Claim Appeals)**

I would like to take a moment to discuss claim appeals. Every payor including Medicare has a claim appeal process. To file a claim appeal, you must file a PDR (Provider Dispute Resolution). **The PDR form is available on our website (www.physicianschoicemedicalgroup.com).**

When submitting a PDR, it is very critical that you state the reason for your appeal and provide supporting documentation. Allow me to clarify. I will use timely filing as my first example. Physicians Choice Medical Group processes all claims received within 45 days. All claims received are processed regardless if the claim is a duplicate or if the claim was paid a zero amount. Providers are responsible to review claims to ensure the claim has been received. Providers should be reviewing claims monthly. This will allow the provider to resubmit any claim not showing. All claims received will appear on your RA. If you submitted a claim and it didn't show up within 45 days, review the claim to ensure the information is correct and it was not rejected by your clearing house, then rebill it!

Appeals for timely filing must include proof of timely filing. **Proof of timely filing for electronic claims is a copy of the transmittal form confirming transmission to Identity MSO. Without the submittal report there is no proof of timely filing and the claim is not eligible for payment.** If you have a copy of the submittal confirmation which reflects Office Ally accepted the claim include this information on your appeal so it can be verified. Without a clear explanation or understanding of your appeal, there is no ability to reverse the original claim decision.

Next, allow me to address claims appeals due to lack of authorization, or level of care. In your appeal you state why services were provided without authorization. Again, it is important you provide the reason for your appeal and provide supporting documentation. Without a clear explanation or understanding of your appeal, there is no ability to reverse the original claim decision.

Having said that, I would like to remind our specialists unauthorized non-emergent services may not be eligible for payment. We recommend providers verify services are authorized before patients are scheduled for services. This will help eliminate claim denials.

Should you have any question, please contact me directly at (805) 725-5430.