

**MEDICAID PROVIDER APPEALS SUMMARY
SEPTEMBER 2005
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES**

** This document provides a summary of the North Dakota Department of Human Services' Medicaid provider appeal process. It is not intended to be legal advice. This information is subject to change. **

1. Who Can Appeal?

A Medicaid provider can appeal a denial or reduction in the level of service payment. A "provider" means an individual, entity, or facility that furnishes medical or remedial services or supplies pursuant to a provider agreement with the North Dakota Department of Human Services. (See North Dakota Century Code section 50-24.1-24(1)).

2. What Can Be Appealed?

A denial of payment by the Department can be appealed. A reduction in the level of service payment can also be appealed. The denial or reduction in payment must be for a service provided to an individual who was eligible for Medicaid at the time the service was provided. A provider may not appeal the rate paid for a particular service. (See N.D.C.C. section 50-24.1-24(2)).

3. When Must An Appeal Be Filed?

A Medicaid provider must appeal within 30 days of the date of the Department's notice of denial or reduction in level of service (remittance advice). (See N.D.C.C. section 50-24.1-24(2)).

4. How Is an Appeal Filed?

A Medicaid provider must file a written notice of appeal with the Department that includes a statement of each disputed item and the reason or basis for the dispute. (See N.D.C.C. section 50-24.1-24(2)). Provider appeals should be sent to:

ND Department of Human Services
Appeals Supervisor
State Capitol – Judicial Wing
600 E. Boulevard Ave.
Bismarck, ND 58505

5. What Happens After a Provider Files An Appeal?

Within 30 days of requesting an appeal, the provider must submit to the Department all documents, written statements, exhibits, and other written information that support the appeal. The provider should include a copy of the denial notice (remittance advice). The provider must also provide a computation and the dollar amount of the provider's claim for each disputed item. (See N.D.C.C. section 50-24.1-24(3)). The Department has developed a form that can be used by providers when submitting an appeal.

6. Who Will Review the Provider's Appeal?

The Department will review the appeal and make a determination as to whether the provider's claim has been substantiated and the claim should be paid as requested by the provider. The Department must assign to the appeal someone other than an employee who was involved in the initial denial of the claim. (See N.D.C.C. section 50-24.1-24(4)).

7. Can the Provider Talk to the Department About the Appeal?

Yes. A provider who has filed a timely appeal may contact the Department for an informal conference regarding the appeal anytime before the Department has issued its final decision. (See N.D.C.C. section 50-24.1-24(4)).

8. When Must the Department Issue a Decision?

The Department must issue its final decision within 75 days of receipt of the provider's appeal. The decision must explain the facts and authority that support the decision. (See N.D.C.C. section 50-24.1-24(5)).

9. Does a Provider Have Any Further Appeal Rights?

Yes. A provider can appeal the Department's final decision to the district court. The district court can review the Department's final decision and the judgment of the district court can be further appealed to the North Dakota supreme court. (See N.D.C.C. section 50-24.1-24(5)). There are certain deadlines that must be met in order to file an appeal with the district court and supreme court.