SAMRA PLASTIC & RECONSTRUCTIVE SURGERY
733 N. Beers St., Suite U1
Holmdel, NJ 07733
W (201) 977-4323 F (201) 616-7929

REQUEST FOR INTERNAL FIRST LEVEL APPEAL/SECOND LOOK FROM DENIAL, REDUCTION, AND/OR NON-PAYMENT

February 21, 2019

Cigna HealthCare-National Appeals Unit/NAO
PO Box 188011
Chattanooga, TN 37422

Patient: [redacted]
Member ID #: U6877930902
Provider Tax ID: 20-4377711
Date of service: 12/27/2018

Dear Appeals Representative,

Regarding the above captioned matter, kindly accept this letter as our formal request for internal appeal/second look. Please re-review all records, reports and documentation we have previously supplied in our prior notices, pre-certification requests, appeals and billing.

We hereby appeal any and all denials, reductions, and non-payments of services. All the services requested and/or provided are medically necessary. All fees billed are our usual, customary and reasonable and are based on the Optum Health (Formerly Ingenix) Fee Analyzer. At this reasonable rate all fees should be paid at 100% of billed charges to avoid charging your member the remainder. Any charges eligible for a 50% reduction should be paid at 50% of our billed charge.

We are requesting this claim be reviewed with all attached medical documents. This claim had a charge amount of $21,240.00 and we received a payment of $2,475.03. CPT 13132 was underpaid. This member's plan pays at 80% of UCR. Please review all attached medical notes and reprocesses this claim accordingly. Also note Dr. Salem Samra is a non par provider and should be paid at full usual and customary charges.

As stated above our fees are usual and customary based on *Optum* and are expected to be paid at 100% of billed charges. Any balance not covered by the insurance company will be billed to the member with a 1.5% monthly interest.

In furtherance of its request for benefits on behalf o[redacted] Salem Samra **FORMALLY REQUESTS** that you provide the following documents immediately:

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- The name, address and contact information of any other party of interest, including but not limited to the Plan Administrator, Claims Administrator, any named or un-named fiduciaries, Third-Party Administrator, additional Insurance Companies involved in the claims process, and any other entities involved in the claims process;
- A true and exact copy of the applicable Health Insurance Policy, Summary Plan Description, and Plan for the time period at issue;
- The Plan Name, Plan Sponsor (including its name and address for service of Complaint);
- Plan Claim Appeal Procedure, including all deadlines for filing appeals;
- Explanation of Benefits, or Adverse Benefit Determination, legal process;
- The specific reason(s) for your denial of the full amount of the claim submitted;
- Reference to the specific Plan provisions on which your determination was based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- The methodology by which you computed the Usual and Customary Rate, including copies of all specific rules, guidelines, protocols, or other similar criteria on which you relied in making this benefit determination;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances;
- Copies of representative documents (with private information redacted to comply with privacy laws) showing payments made by the Plan to this healthcare provider and similar healthcare providers for comparable services as an in network service;
- Copies of representative documents (with private information redacted to comply with privacy laws) showing payments made by the Plan to this healthcare provider and similar healthcare providers for comparable services as an out of network service;
- The name of the publication, database, documentation, Medicare guidelines etc., of all documents and databases used in computing the Usual and Customary Rate, and copies of all such documents;
- Provide copies of any and all algorithm, formula, procedure or fee schedule used to derive the customary and reasonable reimbursement rate in this matter;
- Copies of any and all documentation, including but not limited to manuals, statutes, rules, regulations, books and/or industry standards which refer to, reflect or otherwise relate to the computation of reimbursement for the date of service in question.

This request for documents is pursuant to United States Department of Labor regulations requiring Plans to make disclosure of its claims procedures. See 29 C.F.R. 2560.503-1. **The Plan is required to provide this requested documentation upon request and free of charge.**

This request also comports with U.S. Department of Labor regulations that provide, "[a] Plan's claims procedures may not preclude an authorized representative (including a health care provider) from acting on behalf of a Claimant..." As the authorized representative of Dr. Salem Samra, the Plan is required by law to provide this documentation to us forthwith.

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Kindly note, an enrollee/beneficiary may file suit against a Plan Administrator who fails to comply with the enrollee's/beneficiary's request for documentation purporting to support the Plan's benefit determinations. Section 502(a)(1)(A) of ERISA and its implementing regulations require the Plan Administrator to provide these documents upon request to the enrollee/beneficiary no more than thirty (30) days after such request has been made. The Plan Administrator may be held liable for up to $110.00 per day for each day he/she fails to provide this required disclosure of documentation to the enrollee/beneficiary. **As set forth above, this is a formal request for disclosure of documents pursuant to Department of Labor regulations, for the purpose of enabling us to evaluate whether the Plan has properly exercised its discretion in its benefit determination.**

If this appeal requires additional documentation pursuant to [redacted]plan or policy, kindly advise the undersigned via letter or facsimile.

Should you have any questions, feel free to contact me.

I look forward to your prompt attention to this matter.

Sincerely,

Mayra Torres
Billing Dept. Representative on behalf of Dr. Salem Samra

Cigna

Submit to: Cigna HealthCare – National Appeals Unit/NAO
If by mail, at: PO Box 188011, Chattanooga, TN 37422

If by courier service, at: Cigna National Appeals (#188011) c/o of ACS
5810 Brainerd Rd, Chattanooga, TN 37411

If by Fax, to: 1.877.815.4827

YOU MUST COMPLETE A SEPARATE APPLICATION FOR EACH CLAIM APPEALED
SIGNATURE MUST BE COMPLETE AND LEGIBLE. THIS FORM MUST BE DATED.

A. Health Care Professional Information

1. **Health Care Professional Name:** [redacted], MD
2. **TIN/NPI:** [redacted]
3. **Health Care Professional Group (if applicable):** [redacted] Reconstructive Surgery
4. **Contact Name:** [redacted]
5. **Title:** Medical Biller
6. **Contact Address:** 733 N. Beers St., Suite U1 Holmdel, NJ 07733
7. **Phone:** 855-777-1056 ext 211
8. **Fax:** 201-616-7929
9. **Email:** mtorres@strategicpsonline.com

B. Patient Information

1. **Patient Name:** [redacted]
2. **Ins. ID:** [redacted]
3. **Did You Attach a copy of** (check the appropriate response):
   a. The assignment of benefits? ☒ Yes ☐ No ☐ NA
   b. The **Consent to Representation in Appeals of Utilization Management Determinations and Authorization to Release of Medical Records for UM Appeal and Arbitration of Claims?** (Consent form is **required for review of medical records** if the matter goes to arbitration.) ☒ Yes ☐ No

C. Claim Information

1. **Claim Number** (if known): 7681900593056
2. **Date of Service:** 12/27/2018
3. **Authorization Number:**
4. **Claim filing method** (check only one):
   a. ☒ electronic (**submit** a copy of the electronic acceptance report from Our clearinghouse or Us)
   b. ☐ facsimile (**submit** a copy of the fax transmittal)
   c. ☐ paper claim by mail or courier service (**submit** a copy of the delivery confirmation evidence)
5. **Check the reason(s) why you are filing this appeal** (**check all that apply and be specific about billing codes and reason for dispute**):
   a. ☐ Action has not been taken on this claim
   b. ☐ Dispute of a denied claim → provide **date of denial**: ____/____/____
   c. ☐ Claim was paid but not in a timely manner (provide more information):
      ☐ Yes ☐ No Additional information was requested? If yes, date: ____/____/____
      ☐ Yes ☐ No Additional information provided? If yes, date: ____/____/____
      ☐ Yes ☐ No Prompt Payment Interest paid correctly?
   d. ☒ Claim was paid, but the amount paid is in dispute
   e. ☒ Codes in dispute 13132 / / / / / / /
   f. ☐ Dispute of an overpayment or the amount of overpayment (Attach a copy of overpayment request)
   g. ☐ Dispute of carrier's offset amount against this claim (Attach a copy of A/R)

D. Reason for Appeal (Required)

Submitting this low payment appeal for the CPT 13132. This member's plan pays at 80% of Usual & Customary Rates.

Cigna	Submit to: Cigna HealthCare – National Appeals Unit/NAO If by mail, at: PO Box 188011, Chattanooga, TN 37422 If by courier service, at: Cigna National Appeals (#188011) c/o of ACS 5810 Brainerd Rd, Chattanooga, TN 37411 If by Fax, to: 1.877.815.4827
Health Care Professional Nam[redacted]	Contact Number: 855-777-1056
Member Name [redacted]	DOS: 12/27/18

You may provide additional information in an attachment to explain why you are disputing Our handling of the claim. You must be specific about billing codes and reason for dispute.

The following should be submitted with your appeal (copies only):

- The relevant claim form
- The relevant Explanation(s) of Benefits or Remittance Advice
- A statement specifying the line items that you are appealing
- Copies of any overpayment requests or A/R notice
- Information We previously requested that you have not yet submitted, if available
- Itemization of the health care professional contract provisions you believe We are not complying with, including a copy of the pertinent section of your contract
- Pertinent correspondence between you and Us on this matter
- A description of pertinent communications between you and Us on this matter that were not in writing
- Relevant sections of the National Correct Coding Initiative (NCCI) or other coding support you relied upon IF the dispute concerns the disposition of billing codes
- Other documents you may believe support your position in this dispute (this may include medical records)

Attachments: ☒ **Yes** ☐ **No**

Signature: Maura Jones Date: 02 / 21 /2019

Important to Note

In order to ensure your Internal Payment Appeal is eligible to meet processing requirements for the External Binding Arbitration Program

- **The Internal Appeal Form must be sent to the address posted on Our website;**
- **The Internal Appeal Form must have a complete signature (first and last name);**
- **The Internal Appeal Form Must be Dated;**
- **There is a signed and dated Consent to Representation in Appeals of UM Determinations and Authorization for release of Medical records in UM Appeals and Independent Arbitration of Claims Form**