

One Call Medical, Inc. Neurodiagnostic Medical Claim Appeal

Date of Appeal: _____ **Patient Name:** _____
Date of Service: _____ **Patient Social Security #:** _____
Date of Check: _____ [Appeals cannot exceed contract limit of 180 days]
Submitted by: _____ **Phone:** _____
Mailing address for results of appeal:

First Appeal **Second Appeal [2nd Level Appeal requires medical justification from physician.]**

CPT Codes and units being appealed: _____

Amount of reimbursement being appealed: _____

Detailed Explanation (Must include MEDICAL JUSTIFICATION and supporting documentation such things as HCFAs or bills, authorizations, prescriptions, and any corrected medical reports.):

This section for OCM internal use only – Please do not write below this line

Outcome: **Approved** **Denied** **Partial Allowance**

Reason for approval:

- Medical Justification submitted
 - Additional documentation submitted
 - Corrected report submitted
 - Amplitudes submitted
 - Nerve conduction numerical data submitted
 - Detailed list of muscles submitted
 - OCM data entry error
 - Not considered previously
 - Not billed previously
 - Incorrect bill review
 - Other: _____
- _____
- _____

Reason for denial:

- No medical justification submitted
 - No additional documentation submitted
 - Not authorized
 - Incorrect coding
 - Excessive NCS per AANEM guidelines & OCM policies
 - 95900 is included in reimbursement for 95903
 - Less than 5 muscles studied per limb is a limited study
 - Documentation does not support level of service
 - Review of Systems required but not documented
 - Exam is problem focused, not detailed
 - Physical examination required but not documented
 - Supplies/reports are included per contract
 - Appeal exceeds contract limit of 180 days
 - Other: _____
- _____

Nurse Reviewer, Clinical Services
Date:

Director, Clinical Services
Date:

John E. Robinton, M.D.
Medical Director
Date:

Medical Advisory Board
Date:

Documentation in Phoenix Date: **Initials:**

Documentation in SS Date: **Initials:**

Action Request to Finance Date: **Initials:**

Notification to Provider Date: **Initials:**

Action Request to Finance: