n04659

Medicare Provider Payment Dispute and Appeal Rights Process

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

To ensure that Network Health Insurance Corporation meets the Medicare requirements when a contracted or non-contracted provider disputes payment made by the health plan.

Policy Detail:

I. Network Health Insurance Corporation (NHIC) will review provider payment disputes where a provider contends that the amount paid by the Plan for a covered service is less than the amount that would have been paid under original Medicare.

II. Whereas contracted providers do not have appeal rights, they do have the right to file a payment dispute with the Plan.

III. Once the Plan makes its internal decision about an initial payment dispute filed by a contracted provider, the decision is final. CMS guidelines state contracted providers do not have appeal rights.

IV. The provider payment dispute process for non-contracted providers cannot be used to challenge payment denials by the Plan that result in zero payment being made to the non-contracted provider. These matters must be processed as appeals.

Procedure Detail:

Any provider filing a payment dispute or appeal requesting that the claims payment determination be reconsidered may do so by phone at 800-378-5234, or dependent upon complexity, in written format to:

Medicare Coding Specialist
Network Health Insurance Corp
1570 Midway Pl
Menasha, WI 54952

The following information is to be included in the letter:

A. Beneficiary Name and beneficiary ID
B. Date(s) of service for which the initial determination was issued
C. Which item(s), if any, and/or service(s) are at issue in the dispute/appeal
D. Amount reimbursed
E. Discrepancy of what the amount should be
F. Name and a signature of the party or representative of the party

Contracted Providers

I. If the denial code reflects a need for a correction, the provider must submit a corrected claim identifying the corrections.
   A. Disputes
      1. A dispute is when a contracted provider contends that the amount paid by the Plan for a covered service is less than the amount that would have been paid under original Medicare.
      2. Contracted providers have 120 calendar days from the initial payment

determination to file a payment dispute to Medicare Coding Specialist, Network Health, and 1570 Midway Place, Menasha, WI 54952.

3. The Plan then has 30 calendar days upon receipt to respond to a provider payment dispute.
4. Once the Plan makes its internal decision about an initial payment dispute filed by a contracted provider, the decision is final. CMS guidelines state contracted providers do not have appeals rights.

Non-Contracted Providers

I. If the denial code reflects a need for a correction, the provider must submit a corrected claim identifying the corrections.

A. Disputes

1. A dispute is when a non-contracted provider contends that the amount paid by the Plan for a covered service is less than the amount that would have been paid under original Medicare.
2. Non-Contracted providers have 120 calendar days from the initial payment determination to file a payment dispute to Medicare Coding Specialist, Network Health, 1570 Midway Place, Menasha, WI 54952.
3. The Plan then has 30 calendar days upon receipt to respond to a provider payment dispute.
4. Previous to February 1, 2014 a non-contracted provider had the right to request an independent decision from C2C. Due to budgetary constraints, CMS will no longer offer these services after January 31, 2014, CMS instructs providers to contact the MAO or other payer directly to dispute the payment.
5. Resubmissions must be sent in writing within 180 days of written notice from Network Health of its first payment review determination. The Plan will again review processing and render its decision which will be final.

B. Appeals

1. An appeal is a challenge of a payment denial by the Plan that results in zero payment made to the non-contracted provider.
2. Non-Contracted providers have 60 days from the initial determination date to file a payment appeal to Medicare Coding Specialist, Network Health, 1570 Midway Place, Menasha, WI 54952.
3. The Plan has 60 calendar days to review and respond to the provider.
4. Medicare Health Plans are required to conduct a thorough Plan level reconsideration prior to submitting a case to Maximus Federal Services for IRE level reconsideration. The Plan will facilitate an appeal request and forward it to the independent entity contracted by CMS called Maximus Federal Services if the denial is upheld.
5. When a non-contracted provider seeks a standard reconsidered determination for purposes of obtaining payment only, then the non-contracted provider must sign a waiver of liability, i.e., the non-contracted provider formally agrees to waive any right to payment from the enrollee for a service. When a non-contracted provider files a request for reconsideration of a denied claim but the provider does not submit the waiver of liability documentation upon the Medicare Health Plan's request, the Plan must make and document its reasonable efforts to secure the necessary waiver of liability form.
6. It is critical that every attempt is made to obtain the Waiver of Liability for the protection of the enrollee. A minimum of weekly contacts shall be made to secure the Waiver of Liability up to closure of appeal 60 day

timeframe. All attempts made must be documented to include date, time, method of contact and outcome.

7. If the Medicare Health Plan receives a reconsideration request without the required executed representative or waiver of liability document (or in which the required document is incomplete or erroneous), the Plan level reconsideration review will not begin.
8. If the Plan dismisses a reconsideration request a written notice of the dismissal will be sent to the provider at their last known address. The dismissal notice will state the reason for the dismissal and explain the right to for the provider to request an IRE review of the dismissal within 60 calendar days after receipt of the written notice of the Plan's dismissal. The provider request of an IRE review of a Plan's dismissal must be filed with the IRE.
9. The dismissal notice will explain that the request for review of the Plan's dismissal should be filed with the IRE at the following address:

    MAXIMUS Federal Services, Inc.
    Medicare Managed Care & PACE Reconsideration Project
    3750 Monroe Avenue, Suite
    702 Pittsford, NY 14534-1302
    Fax: 585-425-5292
10. Upon receipt of such request, the IRE will contact the Plan to obtain the case file.
11. If the IRE determines that the Plan's dismissal was in error, the IRE vacates the dismissal and remands the case to the Plan for reconsideration. The IRE's decision regarding a Plan's dismissal is binding and not subject to further review.

Regulatory Citations:

CMS Manual Publication 100-16 Chapter 13
CMS memo: Change in Part C Reconsideration Dismissal Procedures

Related Policies:

None

Related Documents:

Waiver_of_Liability_Statement.pdf

Origination Date:	Approval Date:	Next Review Date:
02/18/2010	01/29/2018	02/01/2019
Regulatory Body:	**Approving Committee:**	**Policy Entity:**
CMS	Vice President Council	NHIC
Policy Owner:	**Department of Ownership:**	**Revision Number:**
Jeanne Skinner	Operations	2
Revision Reason: 01/29/2018 – Consent 10/06/2016 – Transferred to new policy template.		