MEDICARE ADVANTAGE PLANS PROVIDER DISPUTE

Effective January 1, 2010 Centers for Medicare & Medicaid Services (CMS) established an independent provider payment resolution process for disputes between non-contracted providers, Medicare Advantage Organizations, Cost plans, Medi-Medi Plans and the Program of All-Inclusive Care for the Elderly (Pace) Organizations

The provider payment dispute process cannot be used to challenge payment denials by organizations that result in zero payment being made to the non-contracted provider. Instead, these matters must be processed as appeals under 42 CFR Subpart M. In addition, the payment dispute process may not be used to resolve payment disputes between contracted network providers and organizations covered by this process.

As indicated above, first level Provider Payment Disputes applies to:

- Non-contracted providers contesting the amount paid by UC Davis Medical Group (UCDMG) for a covered service was less than the amount Original Medicare would have paid. Reimbursement for Medicare Advantage non-contracted claims will be not less than the Medicare Allowable amount.

- Instances where a non-contracted provider disagrees with the payer's decision to make payment on a more appropriate code (down coding).

When submitting a Payment Dispute to UCDMG, the provider must submit the Dispute in writing within 120 days after the notice of initial determination along with a Provider Payment Dispute form found on the UCDMG Managed Care website at www.ucdavis.edu/managedcare to:

UC Davis Managed Care Operations
P.O. Box 179001
Sacramento, CA
Attn: Medicare Advantage Provider Disputes
or fax to : (916) 734-9972

The Medicare Advantage Non-Contracted Provider Payment Dispute must be submitted in writing and include, at a minimum, the following information:

1) The beneficiary's name
2) UCDMG Medicare Advantage claim number
3) Specific services and items for which the reconsideration is requested and the specific dates of service.
4) The name and signature of the provider or the representative for the provider.
5) Description of how the payment redetermination was made by the provider ans supporting documentation.
6) Signed "Waiver of Liability".

If the provider does not file a dispute within 120 days after the initial determination, UCDMG may deny the dispute as untimely filed. UCDMG may allow an additional five calendar days for mail delivery and extend the time limit for filing a Provider Dispute if good cause is shown. The non-participating provider has up to 180 calendar days from the date of the dismissal notice to provide additional documentation in order to support a finding of good cause for late filing. If UCDMG upholds the dismissal, UCDMG will issue a letter or EOB/RA explaining that good cause has not been established.

If additional documentation is needed for review of the Provider Dispute, UC Davis Medical Group will request this information either by a phone or a written inquiry. If the additional information requested is not received within 14 calendars days, the Provider Dispute review will be based on the information in file. In the event that the documentation is received after the 14 calendar day deadline, UCDMG will consider the evidence before making and issuing the final determination.

UC Davis Medical Group will respond with a written decision on the Payment Dispute within 30 calendar days from the date the Payment Dispute was received.

The Provider Dispute Resolution:

1) Must be in writing
2) Include fax and rational pertaining to the resolution
3) Inform provider about their right to send Second Level Appeal to the Health Plan
4) The non-contracted provider may submit a second level writer request to the applicable health plan for a second level review, by email, fax or mail within 180 calendar days of written notice from the payer

Copy of all provider disputes and corresponding documentation must be kept for a period of not less than 10 years.

Second level appeal process

- Non-Contracted providers may submit a second level appeal request within 60 calendar days from the remittance notification date to the plan.

- Non-Contracted Providers must include a signed Waiver of Liability form holding the enrollee harmless regardless of the outcome of the appeal

- Non-Contracted Providers should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement

- Non-Contracted Providers must mail the reconsideration to the plan at Health Net of California, Inc. Medicare Claims PO Box 9030, Farmington, MO 63640-9030

- Providers that have exhausted the Plan's internal dispute process and who still maintain they have not been reimbursed fairly may file a complaint through 1-800-Medicare in addition to taking other action the provider deems appropriate. CMS does not offer advice to providers on their potential rights in a payment dispute. CMS is committed to ensuring that MAOs and other payers follow regulations at 42 CFR §§422.214, 417.559 and 422.520 when reimbursing non-contracted providers for services provided to Medicare beneficiaries. Non-contracted providers are required to accept as payment, in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.