

NHIC - Medicare Provider Payment Dispute and Appeal Rights Process

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

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 or greater than the amount that would have been paid under original Medicare. Where as contracted providers do not have appeals rights, non-contracted providers do have the right to request an independent decision from CMS Payment Dispute Resolution contractor, First Coast Service Options, Inc.

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:

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

Medicare Coding Specialist

Network Health Insurance Corp

1570 Midway Pl

Menasha, WI 54952

The following information is to be included in the letter:

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

Once the plan makes its internal decision about an initial payment dispute filed by a contracted provider, the decision is final. Per CMS guidelines, contracted providers do not have appeals rights.

Once the plan makes its internal decision about an initial payment dispute filed by a non-contracted provider, the provider has the right to request an independent decision from CMS' Payment Dispute Resolution Contractor, First Coast Service Options, Inc. (FCSO). In addition, if the organization fails to make a decision in response to a non-contracted provider dispute request within 30 days from the date the dispute request was received by the organization, the provider

may request a Payment Dispute Decision (PDD) without having received an initial internal dispute decision by providing evidence to FCSO of the dispute it filed with the organization.

When a non-contracted physician or provider seeks a standard reconsidered determination for purposes of obtaining payment only, then the non-contracted physician or provider must sign a waiver of liability, i.e., the non-contracted physician or 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 Medicare health plan must make, and document, its reasonable efforts to secure the necessary waiver of liability form. The Medicare health plan should not undertake a review until or unless such form is obtained. The time frame for acting on a reconsideration request commences when the properly executed waiver of liability form is received. However, if the Medicare health plan does not receive the form by the conclusion of the appeal time frame, the Medicare health plan should forward the case to the independent review entity (IRE) with a request for dismissal. The Medicare health plan must comply with the IRE's Reconsideration Process Manual section on reconsiderations that fail to meet provider-as-party requirements.

A non-contracted provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the provider completes a waiver of liability statement, which provides that the provider will not bill the enrollee regardless of the outcome of the appeal. See Appendix 6.

If the Medicare health plan denies a request for payment from a non-contracted provider that is appealing on his or her own behalf, the Medicare health plan must notify the noncontracted provider of the specific reason for the denial and provide a description of the appeals process. The Medicare health plan must also explain that in the event that the non-contracted provider wishes to appeal, the non-contracted provider must sign a waiver of liability statement (see Appendix 6).

Regulatory Body: CMS

CMS 1/4/10 Memo CMS Manual Chapter 13