TexanPlus® HMO/HMO-POS/HMO-SNP

A WellCare Company

Non-Contract Provider Dispute and Appeals Process

For Post-Service Claim Payment Issues Following an Initial Organization Determination

Y0067_CLAIMS_DisputeAppeals_Non-ContractProv_0114_IA 02/11/2014

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Introduction

TexanPlus® HMO/HMO-POS/HMO-SNP dispute and appeals processes ensure that non-contract provider disputes and appeals are handled in a fast, fair and cost-effective manner.

Whenever a non-contract provider claim is denied, contested or adjusted (claim not paid at 100% of billed charges), TexanPlus will inform the non-contract provider in writing of the availability of the claim Payment Dispute Resolution (PDR) process and/or claim payment Appeal (reconsideration) procedures.

TexanPlus's dispute and appeals process is available for use by non-contract providers who disagree with plan's initial Organization Determination.

(Please note: contract providers follow the contract provider's agreement/contract with TexanPlus.)

Determining Whether a Case Should be Submitted as a Dispute or an Appeal

Dispute/PDR – Any decision by TexanPlus (Organization Determination) that results in a **full or partial payment** to a non-contract provider when the non-contract provider disagrees with the decision in which:

- The amount paid for a Medicare-covered service is less than the amount that would have been paid under Original Medicare; or
- TexanPlus paid for a different service or more appropriate code than what was billed, often referred to as a down-coding of claims.

Examples include bundling issues, disputed rate of payment, and Diagnostic-Related Groups (DRG) payment disputes.

Appeal/Reconsideration – A formal complaint related to denial of a claim line or a claim by TexanPlus (adverse Organization Determination) and can be for:

- Denials that result in **zero payments**, at the line level or claim level, to the non-contract provider;
- Medical necessity determinations;
- Appeals for which no initial determination has been made; or
- Local and national coverage determinations.

Examples include benefit determinations, medical necessity issues, and coverage issues related to national and/or local coverage determination policies (NCDs/LCDs).

Submission Guidelines for Non-Contract Provider Disputes and Appeals

To avoid delays in processing, please note the following:

- Incomplete submissions will affect processing.
- You must submit supporting documentation.

For an appeal, the non-contract provider **must** sign and submit a Waiver of Liability (WOL) Statement before TexanPlus can begin processing the appeal. If a WOL is not received, the Plan will send a written notice to the non-contract provider indicating the reason(s) for the dismissal and explaining the right to request an IRE (independent review entity) review of the dismissal. The non-contract provider has 60 calendar days after receipt of the written notice to request an IRE review. The request should be submitted to: MAXIMUS Federal Services, Inc., Medicare Managed Care & PACE Reconsideration, Project 3750, Monroe Avenue, Suite 702, Pittsford, NY 14534-1302; Fax: 585-425-5292. A signed WOL is not needed for Payment Disputes.

- **Corrected or Rejected claims should not be submitted as a dispute or appeal.** They are considered a **new** claim and should be sent to TexanPlus Claims Department for an **initial** Organization Determination and will **not** be processed as a dispute or appeal. New claims should be mailed to: TexanPlus CLAIMS, P.O. Box 18500 Austin, TX 78760-8500.

Required Information

(see following page for required documentation)

Non-Contracted Provider Information:

- Non-Contracted Provider's Name
- Non-Contracted Provider's Tax ID #/Medicare ID #
- Non-Contract Provider's Address
- Non-Contract Provider Type (specify type – MD, Hospital, Ambulance, DME, etc.)
- Non-Contract Provider's Contact Name
- Non-Contract Provider's Contact Title
- Non-Contract Provider's Contact Phone #
- Non-Contract Provider's Contact Fax #

Member Information:

- Patient's Name (First, Middle, Last)
- Patient's Date of Birth
- Health Plan Name
- Patient's Account/ID #

Claim Information:

- Original Claim #
- Dates of Service (from/to)
- Original Claim Amount Billed
- Original Claim Amount Paid

DISPUTE/APPEAL TYPE	REQUIRED DOCUMENTATION
Rate/Fee Dispute – Dispute request for a claim that was paid or denied at an incorrect fee.	• Copy of Medicare fee schedule in effect during the dates of service • Copy of claim
Coding Edit Revise – Request for a claim that was denied or adjusted for CCI edit or bundling.	• Appropriate supporting documentation, e.g., OP report, path report • Letter stating rationale for complication • Copy of claim
Medical Necessity/Utilization Management Decision – Request for a claim that was denied on initial medical necessity review.	• Appropriate medical records, e.g., ER records, H&P, discharge summary (**Do not** send daily notes unless requested) • Rationale for service performed • Copy of claim

Addresses for Submitting a Non-Contract Provider Dispute or Appeal

Non-contract providers must mail a written request to TexanPlus at:

Provider Disputes:

Provider Dispute Resolution
TexanPlus
P.O. Box 17900
Austin, TX 78760-7900

Provider Appeals:

Appeals Department
TexanPlus
P.O. Box 18200
Austin, TX 78760-8200

Clearly indicate whether you are submitting a dispute (when full or partial payment was made on the initial Organization Determination) or an appeal (when zero payment was initially made).

Deadlines for Submitting Non-Contract Provider Disputes and Appeals

Dispute/PDR – Non-contract providers have **120 calendar days** from the initial Organization Determination date (i.e., EOB/RA/determination letter) to file a written request for a dispute with TexanPlus.

Appeal/Reconsideration – Non-contract providers have **60 calendar days** from the initial adverse Organization Determination date (i.e. EOB/RA/determination letter) to file a written request for an appeal with TexanPlus.

Resolution Time Frame for Non-Contract Provider Disputes and Appeals

TexanPlus will resolve each non-contract provider claim payment dispute (PDR) within **30 calendar days** of receipt of the written request. Claim payment appeals will be resolved within **60 calendar days** of receipt.

Non-Contract Provider Second-Level Independent Review Entity Process

Dispute/PDR – The non-contacted provider may submit a second-level written request for an independent Payment Dispute Decision (PDD) from TexanPlus via fax or mail within **120 calendar days** of written notice from TexanPlus. Refer to the TexanPlus website at www.TexanPlus.com, www.TexanPlusDFW.com, www.TexanPlusPOS.com or www.TexanPlusSNP.com for forms.

The PDD request may only be filed if:

- The non-contract provider received an initial Dispute decision from TexanPlus; or
- TexanPlus did not finalize or respond to the non-contract provider's Dispute within **30 calendar days**.

Appeal/Reconsideration – If TexanPlus upholds the initial claim decision, Medicare requires that TexanPlus send all cases in which we have not changed our decision to an independent review entity. MAXIMUS Federal Services, Inc. is the independent review entity that Medicare uses to review cases to make sure that the correct decision was made.

After receiving the case file, MAXIMUS Federal Services, Inc. will contact the non-contract provider to advise where to send any additional information and about other rights that the non-contract provider may have.

WAIVER OF LIABILITY STATEMENT

_____
Medicare/HIC Number

_____
Enrollee's Name

_____
Provider

_____
Dates of Service

_____
Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further Appeal under 42 CFR 422.600.

_____
Signature

_____
Date

Provider Dispute Resolution Request Form

Instructions:
Please fully complete the form. Information with an asterisk (*) is required. Be specific when completing the Description of Dispute and Expected Outcome. Please provide supporting documentation to support your appeal.

Mail the completed form to: Provider Dispute Resolution
TexanPlus
P.O. Box 18500
Austin, TX 78760-8500

Or fax the complete form to: 1-877-656-1728

Provider Name:	Provider Tax ID#/Medicare ID#:
Address:	

Provider Type: ☐ MD ☐ Mental Hospital ☐ Hospital ☐ ASC ☐ SNF
☐ DME ☐ Home Health ☐ Rehab ☐ Ambulance
☐ Other _____ (Please specify)

Claim Information ☐ Single ☐ Multiple "LIKE" Claims (Please provide listing)
Number of claims _____

*Patient Name:		*Date of Birth:
*Health Plan ID #:	Patient Account Number:	Original Claim ID Number (if multiple cases provide separate listing):

*Service From/To Date:	Original Claim Amount Billed:	Original Claim Amount Paid:

Dispute Type:
☐ Claim
☐ Appeal of Medical Necessity
☐ Requirement for Reimbursement of Overpayment
☐ Seeking Resolution of Billing Determination
☐ Other

*Description of Dispute:

*Expected Outcome:

_____ (____)_____
Contact Name (Please Print)

_____ (____)_____
Contact Name (Please Print)

☐ Check if additional information is attached.