TexanPlus® HMO/HMO-POS/HMO-SNP

A WellCare Company

Provider Appeal and Dispute Rights

Frequently Asked Questions

TexanPlus® has expanded the information on the Explanation of Payment (EOP) pertaining to Provider Appeal and Dispute rights. A list of frequently asked questions (FAQ) and responses has been provided below. Please contact your Provider Relations Representative at the phone number listed at the end of this FAQ if you have other questions or would like to discuss any of these FAQs.

Q: What is a rejected claim?

A: A rejected claim is a submitted claim that cannot be processed (unclean) due to missing or invalid information required by the payer (Plan). An "unclean" claim may include, but is not limited to:

- Lack of required documentation
- Any required fields where information is missing or incomplete
- Invalid, incorrect or expired codes (e.g., the use of single-digit instead of double-digit place-of-service codes)

Q: How can I tell that a claim I submitted has been rejected?

A: Rejected claims are identifiable by the term **"REJECTED"** within the associated EOP message description. This can be at a billed line item level or at the claim level.

Q: How can I get a "REJECTED" claim reprocessed?

A: Rejected claims must follow the Centers for Medicare & Medicaid Services (CMS) clean claim guidelines (available in the Medicare Claims Processing Manual, Chapter 1: link to http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf and do not have Appeal rights. The claim(s) should be corrected and resubmitted, within your respective contracts or plan's filing time limits, to the address below:

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

Q: What is a denied claim?

A: A denied claim is one that has been processed but the Plan has determined that all or some portion of the claim is not payable. No payment is applied to the denied claim item. Denied claims cannot be resubmitted for payment, but may be appealed to the Plan at the address shown below, since they are the result of official payment determinations made by the Plan.

Q: I am a contracted Provider and my claim has been partially or fully denied. What can I do?

A: A provider who has a network participating provider contract with the Plan to provide care to Members who are enrolled in a Medicare Advantage Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) and/or a Network Private Fee-for-Service (PFFS) plan is governed by the terms of that provider contract.

Any Payment Disputes for a Contracted and/or Participating Provider are provided under the terms of the contract that the Provider has with the Plan. If you have any questions about the specifics of those provisions within your contract or if you believe you have not been given the appropriate Dispute or Appeal rights regarding a denial, an overpayment or an underpayment, please contact your Provider Relations Representative (or Provider Relations) directly.

Q: I am a non-contracted or deemed Provider and a claim I submitted has been denied in full (i.e., zero payment). What can I do?

A: Payment Appeal rights are available to a Provider who does not have a contract with the Plan, but who provides care to a Plan Member.

Non-contracted or Deemed Provider Zero Payment Appeal Process - CMS guidance provides that non-contracted and deemed Providers have Appeal rights, which includes the CMS Independent Review Entity (IRE) process. A Provider has the right to an Appeal when a **denial of a service rendered** occurs, or upon receipt of an initial claim or Revised Payment Determination **that results in a zero payment** to the Provider.

Time frames for filing a Reconsideration request are limited. A Reconsideration request must be filed within sixty (60) calendar days from the date that the notice of non-payment or Revised Payment Determination is initially received by the Provider. Non-contracted and deemed Providers may Appeal an initial claim decision or revised payment determination, provided they formally waive any right to payment from the patient. When filing an Appeal request, the Provider must submit a completed and signed Waiver of Liability (WOL) form noting the specific claim(s) in question, along with all supporting documentation needed to support the Appeal, to the Plan. When filing an Appeal with the Plan, please include a completed Waiver of Liability form, as well as relevant supporting documentation, to the address provided below; or fax the completed and signed Waiver of Liability form, as well as all supporting documentation for the Appeal, directly to 1-800-817-3516.

Written requests for an Appeal, as well as all supporting documentation, can be mailed directly to the Plan at:

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

Please note, within the documentation submitted, that an Appeal is being requested. As a reminder, a completed and signed WOL form must accompany all Appeal requests in order for the Plan to complete the Reconsideration process. It is also important to note that by signing the WOL form, you are not waiving your rights to payment from the Plan if the Appeal determination is favorable.

In accordance with CMS regulations, if the completed and signed WOL form is not received within 60 days of receipt of an Appeal, you will receive a notice of dismissal. You may obtain a blank WOL form in the Appendix section of your Provider manual at www.UniversalAmerican.com.

Following review of your Appeal, should the Plan uphold its original decision to deny payment for the services rendered, the Plan is required to automatically forward all adverse or unfavorable decisions to Maximus, the CMS Independent Review Entity (IRE), for an independent review of that decision. Maximus will notify you and the Plan directly of their decision.

Q: I am a non-contracted or deemed Provider and I do not believe that the claim was paid properly (i.e., partial payment or underpayment). What can I do?

A: Payment Dispute rights are available to a Provider who does not have a contract with the Plan, but who provides care to a Plan Member.

Non-contracted or deemed Providers have the right to file a Payment Dispute as a result of a reduction in payment on an initial claim or upon receipt of a Revised Payment Determination. The Payment Dispute process includes Plan decisions in which a non-contracted Provider feels that the amount paid by the Plan for a covered service is less than the amount that would have been paid under Original Medicare.

Non-contracted or Deemed Providers have 120 calendar days from the initial claim payment or Revised Payment Determination to file a written request for a Payment Dispute with the Plan. The Plan is required to resolve each non-contracted Provider Claim Payment Dispute within 30 calendar days of receipt of the written request.

Written requests for a Payment Dispute, as well as all supporting documentation, may be faxed to 1-877-656-1728 or mailed directly to the Plan at the address provided above. **Please note, within the documentation submitted, that a Payment Dispute is being requested.**

Upon receipt of the Plan's decision, if you disagree with the decision made you may request a Second Level Dispute review by providing such to Universal American, Attn: Second Level Dispute Processing by faxing to 1-855-486-4341, or mail to Universal American, Attn: Second Level Dispute processing, P.O. Box 18688, Austin, TX 78760-8688, within 120 calendar days of written notice from the Plan. Please refer to the Universal American website www.UniversalAmerican.com for forms, time frames and instructions.

For more information, please call Provider Services at 1-888-800-0760 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 711) 7 days a week.