NON-CONTRACT PROVIDER DISPUTE AND APPEALS PROCESS

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

Generations Healthcare HMO’s 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), Generations Healthcare 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.

Generations Healthcare’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 Generations Healthcare.)*

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

**Dispute/PDR** – Any decision by Generations Healthcare (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
- Generations Healthcare 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 Generations Healthcare (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 Generations Healthcare 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 Generations Healthcare Claims Department for an **initial** Organization Determination and will **not** be processed as a dispute or appeal. New claims should be mailed to: Generations Healthcare CLAIMS, P.O. Box 741107, Houston, TX 77274.

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

**Addresses for Submitting a Non-Contract Provider Dispute or Appeal**

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

**Provider Disputes:**
Generations Healthcare HMO  
Provider Dispute Resolution  
P.O. Box 741107  
Houston, TX 77274-1107

**Provider Appeals:**
Generations Healthcare HMO  
Appeals Department  
P.O. Box 742608  
Houston, TX 77274

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 Generations Healthcare.

**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 Generations Healthcare.

Resolution Time Frame for Non-Contract Provider Disputes and Appeals

Generations Healthcare 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 Generations Healthcare via fax or mail within **120 calendar days** of written notice from Generations Healthcare. Refer to the Generations Healthcare website at www.GenerationsHealthcare.cc for forms.

The PDD request may only be filed if:
- The non-contract provider received an initial Dispute decision from Generations Healthcare; or
- Generations Healthcare did not finalize or respond to the non-contract provider’s Dispute within **30 calendar days**.

**Appeal/Reconsideration** – If Generations Healthcare upholds the initial claim decision, Medicare requires that Generations Healthcare 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

Y0067_PR_WOL_0512 IA 05/29/2012
## 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: Generations Healthcare – Provider Dispute Resolution  
P.O. Box 741107  
Houston, TX 77274-1107

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

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Provider Tax ID#/Medicare ID#:</th>
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</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
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<table>
<thead>
<tr>
<th>Provider Type:</th>
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<tbody>
<tr>
<td>MD</td>
</tr>
<tr>
<td>DME</td>
</tr>
<tr>
<td>Mental Hospital</td>
</tr>
<tr>
<td>Home Health</td>
</tr>
<tr>
<td>Hospital</td>
</tr>
<tr>
<td>ASC</td>
</tr>
<tr>
<td>SNF</td>
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<tr>
<td>Other</td>
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<table>
<thead>
<tr>
<th>Claim Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
</tr>
<tr>
<td>Multiple “LIKE” Claims (Please provide listing)</td>
</tr>
</tbody>
</table>

**Number of claims**

<table>
<thead>
<tr>
<th>*Patient Name:</th>
<th>*Date of Birth:</th>
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</table>

<table>
<thead>
<tr>
<th>*Health Plan ID #:</th>
<th>Patient Account Number:</th>
<th>Original Claim ID Number (if multiple cases provide separate listing):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>*Service From/To Date:</th>
<th>Original Claim Amount Billed:</th>
<th>Original Claim Amount Paid:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dispute Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim</td>
</tr>
<tr>
<td>Appeal of Medical Necessity</td>
</tr>
<tr>
<td>Requirement for Reimbursement of Overpayment</td>
</tr>
</tbody>
</table>

| Seeking Resolution of Billing Determination |
| Other |

<table>
<thead>
<tr>
<th>*Description of Dispute:</th>
</tr>
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<table>
<thead>
<tr>
<th>*Expected Outcome:</th>
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</table>

<table>
<thead>
<tr>
<th>Contact Name (Please Print)</th>
<th>Title</th>
<th>Phone Number</th>
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<table>
<thead>
<tr>
<th>Contact Name (Please Print)</th>
<th>Title</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

☐ Check if additional information is attached.
2nd Level Payment Dispute Decision (PDD) Request Form

Fill out all sections as required. Missing or incomplete information may result in your request being dismissed as invalid.

Provider/Supplier Contact Information

Provider name: ______________________________________________________________________________________

Provider correspondence street address: ____________________________________________________________________

City: ___________________________________________ State: __________________ Zip Code: ______________

Telephone number: ___________________________ E-mail address: ________________________________

Pricing Information

NPI number: ___________________________________________ Zip code where services were rendered: ______________

Physician specialty, if dispute is on a physician claim: ______________________________________________________

Plan name/number: ____________________________________________________________________________________

Provider is ___________________ deemed; or Provider is ______________ non-contracted

Reason for Payment Dispute – a description of the specific issue
(A separate attachment may be utilized if necessary)
______________________________________________________________________________________________

The following information MUST be submitted with this form:
1. Copy of the provider/supplier’s submitted claim with disputed portion identified
2. Copy of the MAO plan’s original payment determination
3. Copy of the MAO plan’s redetermination (dispute) payment decision
4. Copy of the relevant portion of Terms and Conditions or contract and any supporting documentation and correspondence that support your position that the plan’s payment is not correct (this may include interim rate letters and/or documentation reflecting payment from Original Medicare on similar or identical services)
5. Appointment of Provider Representative Authorization Statement, if applicable

Requester’s Information

Name: __________________________________________________________________________________________

Title and company name: ______________________________________________________________________________

Street address: __________________________________________ City: __________________ State: _____ Zip Code: ____________

Relationship to provider: ______________________________________________________________________________

Telephone number: ___________________________ E-mail address: ________________________________

Requester’s signature: __________________________________________ Date signed: ____________________________

For electronic submissions only, in lieu of a signature:

☐ By checking this box, I certify that I have proper authorization to submit this payment dispute on behalf of this provider.

Universal American Corp.
Attn: Second Level Dispute Processing
P.O. Box 56029
Houston, TX 77256

Universal American Corp. ("UAM") is the parent company of Today’s Options® PPO, Today’s Options® PFFS, TexanPlus® HMO, TexanPlus® HMO-POS, Generations Healthcare HMO, and Tribute® HMO SNP, which contract with the Centers for Medicare & Medicaid Services (CMS) to provide healthcare and prescription drug coverage to Medicare beneficiaries under the Medicare Advantage plans which they sponsor.

Y0067_2nd Level Provider Dispute Decision Form_0114_IA 02/06/14