Non-Contracted Care Provider Dispute and Appeal Rights

For Medicare Advantage Health Benefit Plans

The Centers for Medicare & Medicaid Services (CMS) has a specific dispute process when a non-contracted care provider disagrees with a claim payment made by a Medicare health plan. We've gathered information about the process, along with some definitions and instructions from CMS, to help you better understand the next steps.

Requirements and Review Process: Claim Payment Dispute

If the non-contracted Medicare health plan care provider disagrees with either the amount we paid on a claim for a member enrolled in a UnitedHealthcare Medicare Advantage health benefit plan, or our decision to pay for different service or level than was billed, the care provider has 120 calendar days from the initial payment determination date to file a written **claim payment dispute.**

What's a Claim Payment Dispute?

When a non-contracted Medicare health plan care provider believes that the amount paid by the Medicare health plan for a Medicare covered service is less than the amount that would have been paid under Original Medicare, the care provider can dispute the payment amount. These disputes can also include instances where there is a disagreement between a non-contracted care provider and the Medicare health plan about the plan's decision to pay for a different service or pay at a different level of service than was originally billed. The disagreement of a claim payment may be due to:

- Bundling issues
- Rate of payment
- Diagnosis-Related Group (DRG) payment dispute
- Down-coding of claims

Submitting a Claim Payment Dispute

Please use our claim payment dispute form at **UHCprovider.com/plans** > Choose your state > Medicare > Select plan name > Tools & Resources > Medicare Advantage Non-Contracted Provider Claim Payment Dispute Request Form.

The dispute has to be submitted in writing, so please send the form and all supporting documentation to the address listed on your Provider Remittance Advice (PRA). UnitedHealthcare has 30 calendar days to review and respond to payment disputes after we receive your form.

Requirements and Review Process: Payment Reconsideration

If you disagree with a denied claim payment, you have 60 calendar days from the initial denial date to file a written **payment reconsideration (this is the first step in the Medicare Appeal process)**.

What's a Payment Reconsideration?

This is a challenge to a denial by the Medicare health plan of benefits or payment that results in no payment being made to the non-contracted Medicare health plan care provider. The first level of the Medicare appeal process is referred to as the reconsideration level. Benefits or payment may be denied due to:

- Benefit determinations
- Medical necessity issues
- Coverage issues related to National Coverage Determinations (NCDs)/Local Coverage Determinations (LCDs)

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Submitting a Payment Reconsideration

The request for a payment reconsideration must be submitted in writing to the address listed on your PRA, along with any supporting documentation and a completed Waiver of Liability (WOL).Without a completed WOL, the request will be dismissed and will send instructions on how to request a review of a dismissed reconsideration.

The plan has 60 calendar days to review and respond after receiving a completed reconsideration request. If the plan upholds all or part of the initial payment determination, the plan must forward the case to the CMS Independent Review Entity (IRE) for a second level review. The IRE will review the case and send a resolution to the care provider and the plan.

We're Here to Help

If you have questions, please call Provider Services at **877-842-3210.** Thank you.

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