CLAIM RECONSIDERATION PROCESS FOR MEDICARE ADVANTAGE PROVIDERS

Participating providers do not have appeal rights. However, any party to an organization determination (enrollee, enrollee representative, non-participating and participating providers) may request that an adverse organization determination be reconsidered on behalf of the member.[i]

Although participating providers do not have appeal rights they may be designated by the enrollee as a representative. The participating provider may submit an Appointment of Representative (AOR) form to MetroPlus as described in the Medicare Managed Care Manual, Chapter 13, Section 10.4.1[ii]. If the AOR form is complete and includes the rationale for the appeal and supporting documentation MetroPlus' Utilization Management department will process the reconsideration request for denied payments or claims within 60 calendar days from the initial adverse (claim) payment determination. [iii] For reconsiderations submitted either without an AOR form or with a defective AOR form MetroPlus will inform the enrollee and representative, in writing, that the reconsideration request will not be considered until the appropriate documentation is provided. MetroPlus will make at least (3) attempts either oral, by fax or by direct mail to obtain the missing information. All attempts will be documented but if the attempts do not secure the necessary documentation the case will be sent to the Independent Review Entity (IRE). MetroPlus will not undertake a review until or unless such documentation is obtained. Note the time frame for acting on a reconsideration request commences when the documentation is received by MetroPlus. If the representative does not provide appropriate documentation to MetroPlus within 60 days the case will be forwarded to the Independent Review Entity (IRE). MetroPlus will only consider appeals submitted according to the procedures set forth above. If a provider submits a request for appeal after the sixty (60) calendar day timeframe, the request will be dismissed and sent to the Independent Review Entity (IRE) for dismissal. Providers will not be paid for services, irrespective of the merits of the underlying dispute. In such cases, providers may not bill members for services rendered.

Non-Participating Providers who are dissatisfied with an adverse (claim/payment) determination made by MetroPlus, may submit a reconsideration on his or her own behalf only if the non-contract provider completes a waiver of liability statement, which confirms that the non-participating provider will hold the enrollee harmless regardless of the outcome of the appeal. [iv]. The non-participating provider must submit a written request (explaining why they disagree with MetroPlus' adverse determination) for review and reconsideration with all supporting documentation within sixty (60) calendar days from the initial denied date on the provider's Explanation of Payment (EOP).[v] Written requests, including attachments, must be mailed to the following location:

MetroPlus Health Plan

160 Water Street, 3rd Floor

New York, NY 10038

Attn: Claims Department – Correspondence Unit

In addition to the written reconsideration request and the Waiver of Liability the non-Participating provider must include a copy of the original claim or adverse determination, the remittance notification showing the denial, any clinical records and additional documentation that supports the reconsideration request.

MetroPlus will not consider reconsideration requests that are not submitted according to the procedures set forth above. If the provider submits a request for reconsideration after the sixty (60) calendar day time frame, the

request is deemed ineligible and will be forwarded to the Independent Review Entity (IRE) for dismissal.[vi] . MetroPlus must comply with the Independent Review Entity (IRE) Reconsideration Process Manual section on reconsiderations that fail to meet provider-as-party requirements[vii]. Providers will not be paid for any services, irrespective of the merits of the underlying dispute if the request is not timely filed. In such cases, providers may not bill members for services rendered.

Providers can view claims status on MetroPlus' website www.metroplus.org or providers may call Provider Services at 1-800-303-9626 Monday – Saturday; 8am – 8pm.

REGARDING THE PRACTICE OF BALANCE BILLING BY PARTICIPATING PROVIDERS

Participating providers are prohibited from seeking payment, from billing, or from accepting payment from any member for fees that are the legal obligation of MetroPlus Health Plan. [viii]

With the exception of deductibles, copayments, or coinsurance, all payments for services provided to MetroPlus members constitute payment in full, and provider's may not balance-bill members for the difference between their actual charges and the reimbursed amounts. Any such billing is a violation of the provider's contract with MetroPlus and applicable New York State law. Where appropriate, MetroPlus will refer providers who willfully or repeatedly bill members to the relevant regulatory agency for further action.

Additionally, per requirements set forth by the Centers for Medicare & Medicaid services (CMS), dual-eligible members will not be held responsible for any cost-sharing for Medicare services then the state is responsible for paying those amounts. Providers must accept MetroPlus' payment as payment in full or bill the appropriate state source (i.e. Medicaid FFS).

OTHER IMPORTAINT INFORMATION

The Explanation of Payment (EOP) details the adjudication of the claims describing the amounts paid or denied and indicating the determinations made on each claim. Therefore, it is important that you review and reconcile your accounts promptly upon receipt. If there is a change in your practice (i.e. address, tax ID#), please notify MetroPlus as soon as possible and submit a W-9, as appropriate.

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[i] Medicare Managed Care Manual, Chapter 13, Section 60 – Appeals, 60.1 - Parties to the Organization Determination for Purposes of an Appeal, (Rev. 105, Issued: 04-20-12)

[ii] Medicare Managed Care Manual, Chapter 13, Section 10.4 – Representatives 10.4.1 - Representatives Filing on Behalf of Enrollees & Section 70. Reconsideration- 70.2 - How to Request a Standard Reconsideration (Rev. 105, Issued: 04-20-12),

[iii] Medicare Managed Care Manual, Chapter 13, Section 70- 70.7.3 - Standard Reconsideration of a Request for Payment (Rev. 105, Issued: 04-20-12)

[iv] Medicare Managed Care Manual, Chapter 13, Section 60 - 60.1.1 - Non-contract Provider Appeals (Rev. 105, Issued: 04-20-12.

[v] Medicare Managed Care Manual, Chapter 13, Section 60 - 60.1.1 - Non-contract Provider Appeals (Rev. 105, Issued: 04-20-12.

[vi] Medicare Managed Care Manual, Chapter 13, Section 60 - 60.1.1 - Non-contract Provider Appeals (Rev. 105, Issued: 04-20-12.

[vii] Medicare Managed Care Manual, Chapter 13, Section 60 - 60.1.1 - Non-contract Provider Appeals (Rev. 105, Issued: 04-20-12.

[viii] (422.100(b)(1)(v)).; (422.504(g)(1)(ii));