

CMS Provider Payment Dispute Resolution Mechanism

The Centers for Medicare and Medicaid Services (CMS) established an independent provider payment dispute resolution process for disputes between non-contracted providers and all Medicare Advantage (MA) Organizations. Provider payment disputes subject to the independent review process include any decisions where a non-contracted provider contends that the amount paid by Brown & Toland for a covered service is less than the amount that would have been paid under original Medicare. Disputes subject to the resolution process also include instances where there is a disagreement between a non-contracted provider and BTHS about the plan's decision to pay for a different service than that billed, often referred to as down-coding claims. CMS' independent review of a provider payment dispute is available only after a provider has completed Brown & Toland Health Services' (BTHS) first-level appeals process and BTHS has informed the provider in writing that the payment dispute has been denied.

I. Claim Submission Instructions

- A. Sending Claims to Brown & Toland. Claims for services provided to members assigned to BTHS must be sent using one of the following routes:

Via Mail: Brown & Toland's Claims Department
P. O. Box 70190
Oakland, CA 94612-0190

Via Physical Delivery: Brown & Toland's Claims Department
1221 Broadway, Suite 700
Oakland, CA 94612

Via Clearinghouse: BTHS will accept electronic claims submitted through Change Healthcare.

For more information on Change Healthcare, please visit their website at changehealthcare.com or call at (888) 363-3361.

- B. Calling Brown & Toland Regarding Claims. For claim filing requirements or status inquiries, you may contact Brown & Toland's Customer Service Department by calling: **(415) 972-6002**.
- C. Claim Submission Requirements. The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by Brown & Toland:

i. Timely Claims Submission Policy

The following Medicare timely filing limitations will apply to all non-contracted providers submitting claims on behalf of a Brown & Toland senior member. For dates of service January 1 – September 30, the timely filing limit is December 31 of the following year. For dates of service October 1 to December 31, the timely filing limit is December 31 of the second year following the date of service.

ii. Billing & Coding Standards

Brown & Toland providers shall bill in a manner consistent with Brown & Toland standards, which include but are not limited to applying current Centers for Medicare & Medicaid Services (“CMS”), American Medical Association (“AMA”), and/or Current Procedural Terminology (“CPT”) guidelines to the codes on the claim.

The purpose of coding standards is to establish guidelines for Brown & Toland providers to use to ensure accurate reporting of services provided to Brown & Toland members. These standards apply to all Brown & Toland providers.

Submission of an appeal/dispute of a denied service shall include review of the claim in its entirety, when multiple services are on the claim.

If one or more of the other rendered – previously paid – service is deemed to be inappropriately coded (e.g. bundled, mutually exclusive, or service not rendered per documentation, etc.) as a result of new code(s) submitted, the entire claim shall be adjudicated based on the review.

- If the review findings result additional payment of the claim, the claim will be adjusted to reflect additional payment.
- If the review findings result in a potential overpayment, a refund request will be sent to the physician.

iii. Claim Form Requirements

BTHS providers must bill on the applicable HCFA 1500 and/or UB-04 (or equivalent) claim forms using standard CPT, ICD-9, HCPCS, and DSMIII coding methodologies for procedure codes and diagnosis codes. All codes must be current and valid as of the date of services billed. Please include a detailed description for all codes that do not have a standard description or are miscellaneous codes.

iv. Operative Report

BTHS providers must submit an Operative Report when billing for

codes that have not be pre-authorized by BTHS Referral Services. If BTHS Referral Services Department has authorized all codes on the claim, then providers do not need to automatically send an Operative Report with their claims.

v. Referral Forms

BTHS providers do not need to send copies of their BTHS referral forms to the Claims Department.

D. Claim Receipt Verification. Brown & Toland providers may verify that BTHS has received a claim by using one of the following methods:

- i. Electronic: Use BTCARE to look up claims status
- ii. Phone: Call Customer Service Department at (415) 972-6002
- iii. Email: Email Customer Service Department at customerservice@btmg.com

II. Brown & Toland First-Level Dispute Resolution Process for Non-Contracted Provider

A. Sending a Non-Contracted Provider Dispute to Brown & Toland. Non-Contracted provider disputes submitted to Brown & Toland must use the “Provider Dispute Resolution Form” which includes all of the information listed in Attachment A. The “Provider Dispute Resolution Form” also is available in the References & Forms section on brownandtoland.com, under Physician Links, Provider Dispute Resolution. All non-contracted provider disputes must be sent to the attention of the BTHS Customer Services Provider Dispute Unit (PDU) at the following:

Via Mail: BTHS Customer Services Provider Dispute Unit
P.O. Box 70190
Oakland, CA 94612-0190

Via Physical Delivery: BTHS Customer Service Provider Dispute Unit
1221 Broadway, Suite 700
Oakland, CA 94612

Via e-mail: customerservice@btmg.com

Via Fax: 415.972.6011

B. Definition of a Provider Dispute. A non-contracted provider dispute is a provider’s written notice to Brown & Toland challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) and may include one of the following instances:

- i. Decisions where a non-contracted provider contends that the amount paid by BTHS for a covered service is less than the amount that would

have been paid by Original Medicare, or;

- ii. Instances where there is a disagreement between a non- contracted provider and BTHS about BTHS' decision to make payment on a more appropriate code (down coding).

A CMS non-contracted provider dispute does not include the following types of disputes:

- Payment denials by payers that result in zero payments being made to a non-contracted provider.
- Payment disputes for contracted providers.
- Local and national coverage determinations.
- Medical necessity determinations
- Payment disputes for which no initial determination has been made.

C. Information to include in a Provider Dispute. Each non-contracted provider dispute must contain, at a minimum the following information: provider's name, provider's identification number, provider's contact information, and:

- i. A clear identification of the disputed item;
- ii. The claim number and the date of services of the claim; and
- iii. A clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial or adjustment or other action is incorrect.

D. Requesting Additional Documentation for Review of the Provider Dispute. If BTHS determines that the information submitted in the provider dispute is incomplete, BTHS may contact the provider by telephone or in writing to request the additional information. If the additional information that was requested is not received within 14 calendar days from the date of the request, BTHS will conduct its review of the provider dispute based on the information in the file. In the event that the documentation is received after the 14 calendar day deadline, BTHS will consider the evidence before making and issuing the final determination. BTHS must resolve the provider dispute within 30 calendar days from the date of receipt.

E. Time Period for Submission of Provider Disputes.

- i. Non-Contracted provider disputes must be received by Brown & Toland within 120 days from Brown & Toland's action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute.
- ii. If the provider dispute was not received within 120 days from BTHS' action that led to the dispute, BTHS will dismiss the provider dispute and send a letter to the provider indicating that the provider dispute is denied due to late filing.
- iii. Resolution shall explain the reason for dismissal and the provider or supplier has up to 180 calendar days from the date of the dismissal notice

to provide additional documentation for good cause.

- F. Extension of Time Limit for Filing a CMS Provider Dispute for Good Cause.
- i. If a provider or supplier submits evidence within 180 calendar days of dismissal that supports a finding of good cause for late filing, BTHS makes a favorable good cause determination and issues a redetermination.
 - ii. If BTHS does not find good cause, the dismissal remains in effect and BTHS issues a letter or Explanation of Benefits/Remittance Advice (EOB/RA) explaining that good cause has not been established.

- G. Processing Complete Provider Disputes. The BTHS Provide Dispute Unit (PDU) will resolve the provider dispute and issue a written determination within 30 calendar days of BTHS' receipt of the provider dispute as follows:
- i. If BTHS determines that the original denial decision is to be overturned, it will send a written decision letter to the provider informing him/her that the original claim determination is overturned.
 - ii. If BTHS determines that the original denial decision is to be upheld, BTHS will send a written decision letter to the provider informing him/her that the original claim determination is upheld.
 - iii. BTHS' decision on the payment dispute will be completed within 30 calendar days from the date the provider dispute is first received by BTHS. The written decision letter will include the following information:
 1. Facts and rationale pertaining to the resolution
- H. Contact Brown & Toland Regarding Non-Contracted Provider Disputes. All inquiries regarding the status of a non-contracted provider dispute or about filing a non-contracted provider dispute must be directed to Customer Service Provider Dispute Unit at: 415.972.6002.
- I. Instructions for Filing Substantially Similar Non-Contracted Provider Disputes. Substantially similar multiple claims, billing or non-contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:
- Please use the "Provider Dispute Resolution Form." (Please refer to Attachment A.) Please check the "Multiple 'LIKE' Claims" box in the Claim Information section and complete the spreadsheet. The "Provider Dispute Resolution Form" is also available in the References & Forms section at brownandtoland.com, under Physician Links, Provider Dispute Resolution.
- J. Past Due Payments. If the non-contracted provider dispute or amended non-contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, Brown & Toland will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within thirty (30) calendar days of first level receive date.
- K. Root Cause Analysis: Upheld and Overturned PDR decisions are tracked via CSM (Customer Service Module). If the root cause of an Overturned PDR decision is identified as system related, the Claims Appeals Team shall work with the appropriate departments (Business Application Configuration or IT) to ensure that the system is updated accurately to prevent future errors which could result in incorrect payments or non-payment of services.

IV. **Attachment A**

BROWN & TOLAND PROVIDER DISPUTE RESOLUTION REQUEST FORM

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS	
<ul style="list-style-type: none"> Please complete the form below. Fields with an asterisk (*) are required. Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME. Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed. For standard questions and claims adjustments, you may call Brown & Toland Customer Service at (415) 972-6002. Mail the completed form to: <div style="margin-left: 100px;"> Brown & Toland Customer Service Provider Dispute Unit P. O. Box 70190 Oakland, CA 94612-0190 </div> 	
Fax the completed form to:	<div style="margin-left: 100px;"> (415) 972-6011 </div>

*PROVIDER NAME:	*PROVIDER TAX ID # / Medicare ID #:
PROVIDER ADDRESS:	

PROVIDER TYPE

<input type="checkbox"/> MD	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Hospital	<input type="checkbox"/> ASC	<input type="checkbox"/> SNF
<input type="checkbox"/> DME	<input type="checkbox"/> Rehab	<input type="checkbox"/> Home Health	<input type="checkbox"/> Ambulance	
<input type="checkbox"/> Other _____ (please specify type of "other")				

*** CLAIM INFORMATION** Single Multiple "LIKE" Claims (complete attached spreadsheet) *Number of claims:* _____

* Patient Name:	* Date of Birth
* Health Plan ID Number:	Patient Account Number:
* Service "From/To" Date:	Original Claim ID Number: (required for claims disputes)
Original Claim Amount Billed:	Original Amount Paid:

DISPUTE TYPE	
<input type="checkbox"/> Claim	<input type="checkbox"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Brown & Toland Request For Reimbursement Of Overpayment	<input type="checkbox"/> Other:

* DESCRIPTION OF DISPUTE (Please attach additional information as needed):



EXPECTED OUTCOME:

_____	_____ () _____
Contact Name (please print)	Title Phone Number
_____	_____ () _____
Signature of Disputing Party	Date Fax Number

BROWN & TOLAND PROVIDER DISPUTE RESOLUTION REQUEST FORM
 (For use with multiple “LIKE” claims)

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
 (Please do not staple additional information)

This form is available in electronic format at www.browndtoland.com/cms-physician-dispute-resolution