Payment Dispute Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider disagrees with the amount paid. To dispute a claim payment, submit a written request within 120 calendar days of the remittance notification date and include at a minimum:

_ A statement indicating factual or legal basis for the dispute
_ A copy of the original claim
_ A copy of the remittance notice showing the claim payment
_ Any additional information, clinical records or documentation to support the dispute

Mail the payment dispute to **Brown & Toland,** PO BOX 72710, Oakland, CA 94612-8910

Second Level Medicare Provider Dispute

Requests for a second level Medicare Provider Dispute must be submitted directly to the health plan within 180 calendar days.

Health Plan Addresses for 2nd Level PDRs:

Aetna Medicare Part C
Grievance and Appeal Unit
PO Box 14067
Lexington, KY 40512

Alignment Health Plan
P.O. Box 14012
Orange CA 92863

Blue Shield of California
Initial Appeal Resolution Office
P.O. Box 272620
Chico, CA 95927-2620

Health Net of California, Inc.
Medicare Claims
PO Box 9030
Farmington, MO 63640-9030

SCAN Health Plan
Attention: Claims-2nd Level Appeal
P.O. Box 22698, Long Beach, CA 90801-5698
Fax: 562-426-2150

Appeals Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination including issues related to bundling or downcoding of services. To appeal a claim denial, submit a written request within 60 calendar days of the remittance notification date and include at a minimum:

_ A statement indicating factual or legal basis for appeal
_ A signed Waiver of Liability form (you may obtain a copy on: to https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip)
_ A copy of the original claim
_ A copy of the remittance notice showing the claim denial
_ Any additional information, clinical records or documentation

Health Plan Addresses for Non-Contracted Appeal/Reconsideration:

Aetna Medicare Part C Grievance and Appeal Unit
PO Box 14067
Lexington, KY 40512

Alignment Health Plan
Attn: Appeals Dept
P.O. Box 14012
Orange, CA 92863

SCAN Non-Contracted Provider Appeal
PO Box 22698
Long Beach, CA 90801

Wellcare By Health Net
Provider Appeal
PO Box 3060
Farmington, MO 63640-3822

Anthem
Grievances and Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Rd.
Mason, OH 45040

Blue Shield of California
P.O. Box 272620
Chico, CA 95927-2620

For United Healthcare Medicare Advantage members only:

Appeals Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination including issues related to bundling or downcoding of services. To appeal a claim denial, submit a written request within 60 calendar days of the remittance notification date and include at a minimum:

_ A statement indicating factual or legal basis for appeal
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_ A copy of the original claim
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_ Any additional information, clinical records or documentation

Mail the appeal request to: UnitedHealthcare P.O. Box 6106, Cypress, CA 90630 MS: CA124-0157.

Payment Dispute Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted health care professionals may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider contends the amount paid by the Plan for a Medicare covered service is less than the amount that would have been paid under Original Medicare. To dispute a claim payment, submit a written request within 120 calendar days of the remittance notification date and include at a minimum:

_ A statement indicating factual or legal basis for the dispute
_ A copy of the original claim
_ A copy of the remittance notice showing the claim payment
_ Any additional information, clinical records or documentation to support the dispute

Mail the payment dispute to **Brown & Toland, PO Box 72710, Oakland, CA 94612-8910**.

If you have additional questions relating to a dispute decision made, you may contact us at:
Phone: 415-972-6002
Fax: 415-972-4431
Mail: PO Box 72710
Oakland, CA 94612-8930
Email: customerservice@btmg.com

Billing Alerts

Section 1905(n) of the Social Security Act prohibits a provider from billing an individual with coverage as a Qualified Medicare Beneficiary (QMB), with or without other Medicaid coverage, or someone receiving Supplemental Security Income benefits and Medicare for the Medicare deductible or coinsurance.

EXPLANATION OF PAYMENT (EOP)/PROVIDER REMITTANCE ADVISE (PRA)/REMITTANCE ADVISE (RA)
CA COMMERCIAL CLAIMS

1. Contracted Paid/Denied Claims:
   Under the Knox Keene Act, an eligible member to whom services were provided shall not be liable for any portion of the bill, except for applicable cost share, which may include deductible, co-insurance and/or copayments. The contracted provider should not bill the member or attempt to collect against the member, unless the member was not eligible at the time the services were rendered or non-emergency services were not authorized and/or directed by the participating medical group or primary care physician.

   Pursuant to the Knox Keene Act of the State of California, the enrollee to whom prior approved services were provided is not liable for any portion of the bill, except for co-payments, deductibles, other cost sharing components, or non-covered benefits as defined in the enrollee's Evidence of Coverage documents.

   In the event the member appeared eligible no more than 72 hours prior to services being rendered and an authorization or eligibility is provided that the specific provider relied upon to render services and the member later appears ineligible on date of services, Knox-Keene requires that the provider and member be held harmless and you cannot recover payment.

2. Non-Contracted (This is being sent to the provider and **NOT** the member) (these are all **non-ER** services)
   a. Paid Claims:
      For dates of services on or after July 1, 2017; non-contracted providers may **NOT** balance bill a member for non-emergency services when covered services are rendered in a Participating Facility. **Brown & Toland** has many participating specialists and regional facilities available. In the event **Brown & Toland** elects to use a non-participating Facility and **Brown & Toland** does not enter into a Letter of Agreement that protects the member, all authorized services for non-emergency providers shall be paid at usual and customary rates established by **Brown & Toland** minus the member's applicable cost-sharing.

   b. Denied Claims:
      You may file a written appeal to: **Brown & Toland, PO Box 72710, Oakland, CA 94612-8910** with a clear & concise reason for questioning/disputing the denial decision.

3. PDR Process (Contracted & Non-Contracted **Emergency Services** Claims)
   Under AB1455 if you feel there is an error in payment, you may dispute in writing to **Brown & Toland, PO Box 72710, Oakland, CA 94612-8910**. A complete description of the dispute process can be found at **https://www.brownandtoland.com/cms-physician-dispute-resolution**.

   Pursuant to California Code of Regulations Title 28, Sections 1300.71 and 1300.71.38, a provider may file a written dispute to: **Brown & Toland, PO Box 72710, Oakland, CA 94612-8910** to challenge, appeal, or request for a reconsideration on a claim(s) that has been denied, adjusted, or contested.

   Provider Disputes must be filed to **Brown & Toland** within 365 days from the last date of written notification that led to the dispute. For instructions and forms for submitting a dispute, go to our website at **https://www.brownandtoland.com/cms-physician-dispute-resolution** or contact our Customer Service Department at **415-972-6002**.

   The dispute request must include the following information:
   1. Name address and phone number of the provider of service;
   2. Provider's tax id number
   3. Patient name
   4. Insurer's information
   5. Date of service
   6. A complete and accurate explanation of the issue supporting documentation including copies of claims, claim number, medical records, or supporting documentation to challenge reports, as necessary, from the initial adverse determination.

4. **Non-Emergency Services Independent Dispute Resolution Process (AB 72 IDRP)**
The law requires that the Department of Managed Health Care conduct an independent dispute resolution process (AB 72 IDRP) that allows a non-contracting provider who rendered services at, or as a result of services at, a contracting health facility, or a payor, to dispute whether payment of the specified rate was appropriate. Once a non-contracting provider or payor submits an AB 72 IDRP Application, the opposing party is required by law to participate in the AB 72 IDRP. AB 72 does not apply to emergency services and care.

Eligible Claims

Eligible claim disputes are those disputes that are subject to DMHC jurisdiction and meet **all** of the following criteria:

- The disputed claim must be for services rendered on or after July 1, 2017.
- The disputed claim must be for non-emergency services. If there is an unresolved dispute as to whether the health care service(s) at issue is non-emergent, the claim does not qualify for the AB 72 IDRP.
- The disputed claim must be for covered services provided at a contracting health facility, or provided as a result of covered services at a contracting health facility, by a non-contracting individual health professional.
- The non-contracting provider has completed the health plan or payor's Provider Dispute Resolution (PDR) process within the last 365 days.
- The non-contracting provider is not a dentist.
- The payor is not a Medi-Cal managed health care service plan or any other entity that enters into a contract with the State Department of Health Care Services

For more information or to submit a dispute under the IDRP process, please go the California Department of Managed Health Care's website at:

https://www.dmhc.ca.gov/fileacomplaint/providercomplaintagainstaplan/nonemergencyservicesindependentdisputeresolutionprocess.aspx

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Brown & Toland adjudicates claims based on industry accepted billing procedures such as Medicare Guidelines and Correct Coding Initiative and based on rates, provided by written contract, that Brown & Toland has with the provider rendering the authorized services. Please note that Brown & Toland is authorizing the specific service and not necessarily the CPT Code(s) submitted with such service authorization request. Brown & Toland reserves the right to adjust payment to correct for any mistakes or deviations from the coding and billing guidelines within each claim. The information provided herein does not constitute legal advice and is for informational purposes only.

****SECTION 1379 OF THE CALIFORNIA HEALTH AND SAFETY CODE PROHIBITS BILLING OF HMO MEMBERS FOR COVERED SERVICES*****For claim questions or adjustment requests, please contact Brown & Toland Customer Service at 800-225-5637 or customerservice@btmg.com. Providers have a right to file a formal dispute with Brown & Toland regarding a claim or contract. For instructions on submitting a formal dispute with Brown & Toland, please refer to the Provider Notice posted on www.brownandtoland.com or contact Brown & Toland Customer Service.