CLAIMS PAYMENT RECONSIDERATION OR APPEALS – MEDICARE

At times, a provider may be dissatisfied with MetroPlus Health Plan's decision regarding a claim determination for reasons including, but are not limited to:

- incorrectly processed or denied claims;
- untimely submission of claims;
- failure to obtain prior authorization.

Participating Providers (INN) do not have payment reconsideration or appeal rights. However, INN providers may request that a claim determination be reconsidered on behalf of the member. To request for a reconsideration on behalf of a member, INN providers must be designated by the member as a representative by submitting an Appointment of Representative (AOR) form and submit a **written** request with all supporting documentation to MetroPlus Health Plan within sixty **(60)** calendar days from the paid date on the provider's Explanation of Payment (EOP).

Non-Participating Providers (OON) who are dissatisfied with an adverse claim determination made by MetroPlus Health Plan, may submit a reconsideration/appeal on his or her own behalf only if the OON provider provides a Waiver of Liability (WOL) statement, which confirms that the OON provider will hold the member harmless regardless of the outcome of the appeal. The OON provider must submit a **written** request for reconsideration with a WOL and all supporting documentation within sixty **(60)** calendar days from the initial denied date on the provider's Explanation of Payment (EOP).

All requests for payment reconsideration should include the following information:

- a written statement explaining why you disagree with MetroPlus Health Plan's determination as to the amount or denial of payment;
- a copy of the original claim;
- a copy of the EOP;
- an AOR form (INN) or a WOL statement (OON); and
- supporting documentation.

All requests, including attachments, must be mailed to the following location:

MetroPlus Health Plan
Attn: Claims Department – Correspondence Unit
160 Water Street 3rd FL
New York, NY 10038

Examples of information or supporting documentation that should be submitted with the requests for reconsideration include:

- Provider's identification number (NPI and / or TIN).
- Provider's name, address, and contact number.
- Member's name and MetroPlus member identification number.
- MetroPlus claim number.
- Date(s) of service.
- Evidence of prior authorization issued by MetroPlus Utilization Management.
- Evidence of timely filing.

MetroPlus Health Plan will process all requests for reconsideration/appeal and issue a written explanation that the claim has been reprocessed or the initial denial has been upheld within sixty **(60)** calendar days from the date of receipt of the provider's request for reconsideration/appeal. If the initial denial is upheld, MetroPlus Health Plan will send the case to the Independent Review Entity (IRE).

MetroPlus Health Plan will not consider reconsideration/appeal requests that are not submitted or appealed according to the procedures set forth above. If a provider submits a request for reconsideration/appeal after the sixty **(60)** calendar day timeframe or if the required information is not submitted within the sixty **(60)** calendar day timeframe, the request is deemed ineligible and will be dismissed. 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 Health Plan's website at **www.metroplus.org** or providers may call Provider Services at **1-866-986-0356**, **Monday to Friday**, **9:00am – 5:00pm**.

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.

Except for deductibles, copayments, or coinsurance, all payments for services provided to MetroPlus Health Plan members constitute payment in full, and participating providers 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 Health Plan and applicable New York State law. Where appropriate, MetroPlus Health Plan 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 when the state is responsible for paying those amounts. Providers must accept MetroPlus Health Plan's payment as payment in full or bill the appropriate state agency. For example, participating providers should bill Fee-for-Service (FFS) Medicaid, for Medicare dual eligible individuals whose entitlement status is Full Medicaid, QMB+ or SLMB+ (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#, telephone #, participation), please notify MetroPlus Health Plan as soon as possible and submit a W-9, as appropriate.