INSTRUCTIONS FOR ORGANIZATIONS REPRESENTING PROVIDERS TO SUBMIT PROVIDER COMPLAINTS RELATED TO MEDICARE ADVANTAGE ORGANIZATION (MAO) APPEALS ISSUES OR CLAIMS PAYMENT DISPUTES TO CMS

Organizations representing Medicare providers and seeking assistance from CMS in resolving Medicare Advantage (MA) claims issues **must adhere to the following instructions and complete the attached Appeal / Claim Payment Dispute Cover Sheet for each complaint** (i.e., one cover sheet for each beneficiary case). CMS will act upon the case if (and only if):

1. The representing organization submits the cover sheet and documentation requested on the cover sheet;
2. The representing organization refrains from submitting documentation **not** listed on the cover sheet (especially medical records); and
3. The representing organization indicates prior communication with the MAO in attempt to resolve the issue.

If the representing organization meets the above requirements, CMS staff will enter the complaint into CMS' Complaints Tracking Module (CTM) and direct the MAO to investigate the case within thirty days and work directly with the provider toward resolution. If the representing organization does not meet the above submission requirements, CMS will return the case(s) for correction before taking further action.

In general, CMS' role in these matters is to facilitate communication between the MAO and the provider. ***It is <u>not</u> CMS' role to determine medical necessity for an appeal case nor to determine appropriate claims payment amounts for payment disputes.*** Should CMS identify a trend in provider complaints, staff will investigate the matter further and work with the MAO to address the broader issue.

CMS allocates its MAO oversight responsibilities across all ten of the Agency's regional locations, but now receives and processes all inquiries and complaints via one centralized email box. Providers / representing organizations can submit complaints in ***password protected files*** to the appropriate Drug and Health Plan Operations (DHPO) mailbox location listed below:

MedicarePartCDQuestions@cms.hhs.gov

Upon receipt of the complaint, CMS staff will input the issue into the CTM and respond back to the representing organization with the complaint ID (for future reference). To follow up on a complaint after submission, the representing organization should communicate directly with the MA plan. If the MA plan is not responsive, then the representing organization may contact the CMS office that received the complaint (using the appropriate DHPO e-mail address) to inquire about the complaint status.

WHAT IS A PROVIDER APPEAL COMPLAINT?

For these purposes, a provider appeal complaint is a complaint submitted by a contracted or non-contracted provider alleging an MAO's failure to follow the applicable appeals process. Note that an appeal could include an MAO's denial of a specific line item within a claim. Examples of non-compliance could include an MAO's failure to notify the provider of the available appeal process or failure to act upon an appeal appropriately submitted by a provider.

CMS defines the non-contracted provider appeals process in the Medicare Managed Care Manual, Chapter 13. That process includes the requirement that the MAO auto-forward adverse appeal decisions to the Independent Review Entity (IRE).

The MAO is responsible for defining and adhering to an appeals process for contracted providers as elaborated in the provider's contracts with the MAO.

WHAT IS A CLAIMS PAYMENT DISPUTE?

For these purposes, a claims payment dispute is a provider's dispute over the *amount* that the MAO paid for an approved service on a particular claim. An MAO's decision to partially approve, downcode, or bundle services or approve a service at a lower level of care than the service billed would be appealable by non-contracted providers under the administrative appeals process of Part 422, Subpart M (contracted providers would appeal in accordance with the terms of their contract with the MAO).

DOCUMENTATION SUBMISSION REQUIREMENTS

For each complaint, the representing organization must complete the attached cover sheet, indicating the information below, and submit documentation specifically indicated on that sheet. ***Do NOT submit any additional documentation outside of the items requested on the cover sheet.*** CMS may return the complaint for correction if the representing organization submits unnecessary information (e.g., medical records) outside of what the cover sheet identifies.

Information Required for All Complaints

1.1 Date of Submission to CMS

1.2 Submitting Entity (If the case is submitted by an organization *representing* a Medicare provider, submit evidence of the contractual relationship between the provider and the representative organization that documents the organization's authority to investigate the case on the provider's behalf.)

1.3 Complainant's Name, E-mail Address, Telephone Number

1.4 Beneficiary Name

1.5 Beneficiary HICN/MBN (Medicare Beneficiary Number)

1.6 Provider Name

1.7 Medicare Advantage Organization Name

1.8 Claim Number

1.9 Date(s) of Service
1.10 Was the Provider Contracted with the MAO on the Date of Service? *(Yes or No)*
1.11 Complaint Type *(Contract Provider Appeal, Non-Contract Provider Appeal, Contract Provider Payment Dispute, Non-Contract Provider Payment Dispute, Other)*
1.12 Did MAO communicate appeal rights to you in their contract or otherwise? (*Yes or No*)
1.13 Have you exhausted all appeal rights? *(Yes or No).*
1.14 Has the representing organization attempted to resolve the issue by working directly with the MAO? *(Yes or No or N/A)* If Yes, name the individual(s) at the MAO.

RESOURCES

Medicare Managed Care Manual, Chapter 13 – Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPP), (collectively referred to as Medicare Health Plans) [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf]

Federal Regulations - Title 42, Chapter IV, Subchapter B, Part 422, Subpart M-Grievances, Organization Determinations and Appeals http://www.ecfr.gov/cgi-bin/text-idx?SID=38e42d9c79ff304832eea49cfc1bf40c&mc=true&node=sp42.3.422.m&rgn=div6

CMS Appeals and Grievances Website - Medicare Managed Care Appeals & Grievances, https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html

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APPEAL / CLAIM PAYMENT DISPUTE COVER SHEET

Fill in the required information for each separate beneficiary case and submit the cover sheet for each case you submit. ***Do NOT submit any information outside what the cover sheet requests.*** The MAO will gather whatever additional information it needs during its efforts to investigate and resolve the case.

		Fill in required information below. Indicate option selection with "X."
1.1	Date of Submission to CMS	
1.2	Entity Submitting Complaint	___ Provider ___ Organization Representing Provider *(If indicated, complete the field below and submit evidence of the contractual relationship between the provider and the representing organization substantiating the organization's authority to investigate the case on behalf of the provider.)*
	Name of Organization Representing Provider	
1.3	Submitter's Name	
	E-mail Address	
	Telephone Number	
1.4	Beneficiary Name	
1.5	Beneficiary Health Insurance Claim Number (HICN) / Medicare Beneficiary Number (MBN)	
1.6	Provider Name	
1.7	Medicare Advantage Organization	
1.8	Claim Number	
1.9	Date(s) of Service	
1.10	Provider Contract Status	___ Provider Contracted with MAO during Date(s) of Service ___ Provider NOT Contracted with MAO during DOS
1.11	Complaint Type	___ Contracted Provider Appeal ___ Non-Contracted Provider Appeal ___ Contracted Provider Claims Payment Dispute ___ Non-Contracted Provider Claims Payment Dispute ___ Other
	Brief Summary of Complaint	
1.12	Did MAO communicate your appeal rights.	__Yes __No
1.13	Have you exhausted all appeals rights per the non-contracted provider appeals or per contract w/MAO	__Yes __No
1.14	Provider has Communicated with MAO in Attempt to Resolve Issue	___ Yes ___ No *(NOTE: CMS will only review this case if the provider has already attempted to resolve it by working directly with the MAO.)*

	If Yes, Name(s) of Individual(s) at MAO	

1.13	Organization Representing Provider has Communicated with MAO in Attempt to Resolve Issue	___ Yes ___ No *(NOTE: CMS will only review this case if the intervening organization has already attempted to resolve it by working directly with the MAO.)* ___ N/A (No intervening organization involved.)
	If Yes, Name(s) of Individual(s) at MAO.	