AmeriHealth NEW JERSEY

Medicare Non-Contracted Provider Payment Dispute Process

Medicare Advantage Organization

Filing a request for Payment Review Determination (PRD)

If you believe that the payment amount you received for treating our Medicare Advantage (MA) members is less than the expected payment, you have the right to dispute that payment by requesting a Payment Review Determination (PRD).

A written request for a Payment Review Determination along with any documentation and correspondence that support your position that the plan's reimbursement is not correct and a signed Waiver of Liability Statement must be submitted within 120 days from the initial MA payment to have your claim reconsidered.

Payment Review Determination can be received via fax **1-888-289-3008** or mailed to:

AmeriHealth New Jersey
Medicare Non-Contracted Provider Appeals Department
P.O. Box 13652
Philadelphia, PA 19101-3652

We will review your request and respond to you within 30 calendar days. If we agree with the reason for the dispute, we will adjust the claim and pay any additional money that is due. We will also inform you if the decision is to uphold the original payment. If you have questions about our Payment Review Determination, you may contact Provider Services at **1-888-YOUR-AH1 (1-888-968-7241).**

If you still believe our decision is incorrect, you may request a Payment Dispute Decision (PDD) by AmeriHealth New Jersey.

Filing a Request for a Payment Dispute Decision (PDD)

A request for a Payment Dispute Decision (PDD) must be submitted to the plan within 180 days of the Plan's Payment Review Determination (PRD) notification. The request must be in writing and should be made on a standard PDD form available at **www.amerihealthnj.com**.

A written request that is not made on the standard PDD form will be accepted if it contains all the required elements, as follows:

- Provider or Supplier Contact information including name and address.
- Pricing Information, including NPI number (and CCN / OSCAR number for institutional providers), ZIP Code where services were rendered,Physician Specialty, the name of the MAO that made the redetermination including the specific plan name, and whether the provider supplier is deemed or non-contracted.
- Reason for dispute; a description of the specific issue.
- Copy of the provider's submitted claim with disputed portion identified.
- Copy of the MA plan's original pricing determination.
- Copy of the MA plan's redetermination (dispute) pricing decision.
- Copy of the relevant portion of Terms and Conditions or contract and any supporting documentation and correspondence that support your position that the plan's reimbursement is not correct (this may include interim rate letters and/or documentation reflecting payment from Original Medicare on similar or identical services.)
- Appointment of Provider or Supplier Representative Authorization Statement, if applicable.
- The name and signature of the party or the representative of the party.

Decisions subject to the payment dispute process include any decisions where there is a dispute about the payment amount made by a MAO Plan to a non-contracted provider that is less than the rates of Original Medicare.

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Decisions not subject to the provider payment dispute process are:

- National Coverage Determinations (NCDs)
- Services denied for coverage issues such as Local Coverage Determinations (LCDs)
- Medical necessity determinations are not subject to the independent review process and should be sent to the appropriate Qualified Independent Contractor (QIC) for processing
- Disputes between a contracted network provider and the MA Plan are also not reviewed by CMS

Claim payment dispute decision requests may be submitted via the following ways:

- **Fax.** Fax electronic requests for payment dispute decisions to 1-888-289-3008.
- **Mail.** Providers can mail hard copy requests for payment dispute decisions to the following address:

  AmeriHealth New Jersey
  Medicare Non-Contracted Provider Appeals Department
  P.O. Box 13652
  Philadelphia, PA 19101-3652

Time Frame for Making a Payment Dispute Decision (PDD):
AmeriHealth New Jersey will issue a decision within 60 days after receiving a provider payment dispute appeal unless granted an exception by the plan. AmeriHealth New Jersey will notify all parties of its PDD or notify all parties that it has dismissed the request for a PDD.

Decision Letters:
The Payment Dispute Decision letter will include the facts of the appeal, arguments made for and against additional reimbursement, the adjudicator's decision, and the adjudicator's rationale, and notification to the parties of their right to request a debrief.

Common Abbreviations
CMS – Centers for Medicare and Medicaid Services
MAO – Medicare Advantage Organization
HMO – Health Maintenance Organization
PPO – Preferred Provider Organization
PDD – An Independent Payment Dispute Decision
PRD – Payment Review Determination

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Standard Definitions

Organization Determination: MAO Plan's original claim payment

Payment Dispute: Provider or Supplier disputes the MAO Plan's original claim payment (generally must be disputed within 120 days from the date payment is initially received by the provider or supplier)

Payment Review Determination (PRD): The first level payment dispute decision made by a MAO Plan (generally provided within 30 days from the time the payment dispute is first received by the plan)

Payment Dispute Decision (PDD): The second level decision regarding the Payment Dispute. This second level request must be disputed within 180 days of the MAO plan's Payment Review Determination (PRD) notification.

Request for Payment Dispute Decision: Provider's or Supplier's request for second level review of the MAO Plan's Payment Review Determination.

Medicare Advantage Organization (MAO) Plans: An entity contracted with CMS to provide Medicare Advantage insurance benefits to enrollees.

Non-Contracted Provider or Supplier: A provider or supplier who has rendered services to a MAO PFFS Plan enrollee on an emergency basis and did not review the PFFS Plan's Terms & Conditions before rendering services is referred to as a non-contracted provider or supplier. For all other MAO plans, a provider is considered non-contracted when there is not a signed contract/agreement between the provider and the specific MAO plan (HMO, PPO, etc). For example, a provider may be contracted under a MAO's HMO plan, but be considered non-contracted for services rendered to a PPO plan member.

Contracted Provider or Supplier: A contracted provider or supplier of services that files a claim for services or items furnished to the enrollee may not request an independent payment dispute decision since these disputes are considered to be matters of contract disputes.

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