Medicare Advantage Provider's
Frequently Asked Questions

Differentiating between a Dispute, Grievance and Appeal

Dispute: Occurs when a Provider disagrees with the Medicare Advantage (MA) Payment; involves issues *after* services have been rendered (handled by calling Provider Services – this should always be your first step for resolution).

Grievance: Concerns that do *not* involve an initial determination (i.e. Accessibility/Timeliness of appointments, Quality of Service, MA Staff, etc.)

Appeal: Written disputes or concerns about initial determinations; primarily concerns related to denial of services or payment for services.

Provider Appeals Questions and Answers

Q. When requesting a MA Provider Appeal on a claim submitted to the Local plan, should the appeal also be filed with the Local Plan?
A. No, the appeal should be submitted to the member's Home plan (address provided below).

Q. What is the appropriate address for submitting MA Provider Appeals?
A. All MA appeals (member and both contracted & non-contracted providers) should be submitted in writing to Medicare Advantage Appeals and Grievances and mail to:
4361 Irwin Simpson Rd.
Mailstop: OH0205-A537
Mason, OH 45040

Q. What is the timeframe providers have to submit an appeal?
A. Contracted providers have 180 calendar days from the remit date; Non-Contracted providers have 60 calendar days from the remit date.

Q. What should be included with the appeal?
A. This documentation should be included with the appeal.

- Waiver of Liability form (the provider is appealing/ non-contracted provider are required to use this form)
- Or, Appointment of Representative form (appealing on behalf of member)
- Member identifiable information
- A copy of the original claim, remittance notification showing the denial
- Any clinical records;
- Or, other documentation that supports the provider's argument for reimbursement.

Q. What is the turnaround timeframe allowed for processing a post-service provider appeal?
A. Both contracted and non-contracted is 60 calendar days from the receipt of the appeal.

Q. For non-contracted provider appeals, which form is required?

- A Waiver of Liability (WOL);or
- An Appointment of Representative (AOR)

A. Each form is dependent on the type of appeal as follows:

• Waiver of Liability – if the provider is appealing on their own behalf and agrees not to bill the member if we uphold our decision. This form is required for a non-contracted provider when submitting an appeal. The form is available at here.

• AOR – if the provider is appealing on behalf of the member. This form is available at: http://www.cms.gov/

Q. Is an AOR form required for a MA contracted provider?

A. Yes, if the provider is filing on behalf of the member and following conditions are *not* applicable:

- Requesting provider is the member's primary care physician.
- Requesting provider has seen member on more than one occasion (evidenced by multiple dates of service on the claims submitted , provider indicating in the request they saw member multiple times, or we (WLP) notes multiple claims on file).
- Request by phone (provider may be asked to confirm if member aware appeal requested.
- Provider submits written request (fax, letter, email) and the member is copied on the letter.
- We are able to call member to confirm they are aware the provider has filed appeal.
- This form is available at: http://www.cms.gov/

Q. If the appeal is upheld, will it be sent to an Independent Review Organization for review?

A. Yes, for both Non-contracted & Contracted Providers when filing an appeal on behalf of the member.

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