Non-contracted care provider dispute and appeal rights

For Medicare Advantage health benefit plans

Overview

The Centers for Medicare & Medicaid Services (CMS) has a specific dispute process when a non-contracted care provider disagrees with a claim payment made by a Medicare health plan. We've gathered information about the process, along with some definitions and instructions from CMS, to help you better understand the next steps.

Requirements and review process: Claim payment dispute

If the non-contracted Medicare health plan care provider disagrees with the amount we paid on a claim for a member enrolled in a UnitedHealthcare Medicare Advantage health benefit plan, the care provider has 120 calendar days from the initial payment determination date to file a written claim payment dispute.

What's a claim payment dispute?

When a non-contracted Medicare health plan care provider believes that the amount paid by the Medicare health plan for a Medicare covered service is less than the amount that would have been paid under Original Medicare, the care provider can dispute the payment amount.

Submitting a claim payment dispute

Online: Go to **UHCprovider.com** > Select Sign In at the top-right corner. Sign in to the portal with your One Healthcare ID and password. In the menu, click Claims & Payments > Look up a Claim to search by the claim number and click Act on Claim. If you're a new user and don't have a One Healthcare ID, visit **UHCprovider.com/access** to get started.

Mail: Please send your request, along with any supporting documentation, to the address listed on your provider remittance advice (PRA).

UnitedHealthcare has 30 calendar days to review and respond after receiving a payment dispute request.

Requirements and review process: Payment reconsideration

If you disagree with a denied claim or our decision to pay for a different service or different level of service than was originally billed, you have 60 calendar days from the initial denial date to file a written payment reconsideration (this is the first step in the Medicare Appeal process).

What's a payment reconsideration?

This is a challenge to a denial or decision to pay for a different service or pay at a different level of service than was originally billed by the Medicare health plan. The first level of the Medicare appeal process is referred to as the reconsideration level or Level 1 appeal. Benefits or payment may be denied due to:

- Benefit determinations
- Medical necessity issues
- Coverage issues related to National Coverage Determinations (NCDs)/Local Coverage Determinations (LCDs)

Submitting a payment reconsideration

Online: Go to **UHCprovider.com** > Select Sign In at the top-right corner. Sign in to the portal with your One Healthcare ID and password. In the menu, click Claims & Payments > Look up a Claim to search by the claim number and click Act on Claim. If you're a new user and don't have a One Healthcare ID, visit **UHCprovider.com/access** to get started.

Mail: Please send your request, along with any supporting documentation and a completed **Waiver of Liability (WOL)** to the address listed on your provider remittance advice (PRA). The WOL is available at UHCprovider.com > Claims and Payments > **Waiver of Liability Form for UnitedHealthcare Medicare Advantage**.

UnitedHealthcare has 60 calendar days to review and respond after receiving a completed reconsideration request and a valid WOL. If the plan upholds all or part of the initial payment determination, the plan must forward the case to the CMS Independent Review Entity (IRE) for a second-level review. The IRE will review the case and send a resolution to the care provider and the plan.

We're here to help

If you have questions, please call Provider Services at **877-842-3210**. Thank you.

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