# Frequently Asked Questions About Provider Appeal and Dispute Rights

We have expanded the information on the Evidence of Payment (EOP) pertaining to Provider Appeal and Dispute rights and adjustment request process. We have provided a list of frequently asked questions (FAQs) and responses below. If you cannot find your question below, please contact our Provider call center at the phone number at the end of this FAQ.

**Q: What I can do if my claim is denied?**

A: When a claim is denied for lack of documentation, you must request reconsideration of adjustment with the corrected information or documents supporting the case. When he is rejected for another reason, you should also request reconsideration Adjustment and if you disagree with the determination, then you can apply Appeal.

**Q: I am a contracted Provider and my claim has been partially or fully denied. What can I do?**

**A:** A Participating Provider holds a contract with the Plan to provide care to Members who are enrolled in a Medicare Advantage Health Maintenance Organization (HMO).
Any Payment Disputes for a Contracted or Participating Provider are dictated under the Terms of the contract that the Provider holds with the Plan. If there are any questions around the specifics of those provisions within your contract or if you believe you have not been given the appropriate Dispute or Appeal rights on an overpayment, please contact your Provider Relations Representative or Provider Relations call center directly at 1-866-676-6060, Monday through Friday from 7:00 am to 7:00 pm.

**Q: I am a Non-contracted and a claim I submitted has been partially or fully denied (e.g. zero payment, some service denied in paid claim). What can I do?**

**A:** For a Non-contracted Provider, Payment Dispute as well as Appeal rights are available to a Provider who does not have a contract with the Plan, but who provides care to a Plan Member.

**Non-contracted Zero or partially Payment Appeal Process (Not underpayment) -** CMS guidance provides that non-contracted Providers have Appeal rights which include the CMS Independent Review Entity (IRE) process. A Provider has the right to an Appeal when **a denial of a service rendered occurs**, or upon receipt of an initial claim or Revised Payment Determination **which results in a zero payment or partially payment to the Provider**.

Timeframes for filing a Reconsideration request are limited. A Reconsideration request must be filed within sixty (60) calendar days from the date of the notice of non-payment or Revised Payment Determination is initially received by the Provider. Non-contracted and Providers may Appeal an initial claim decision or revised payment determination provided they formally waive any right to payment from the patient. To process an Appeal request, the **Provider must submit a completed and signed Waiver of Liability (WOL) form noting the specific claim(s) in question**, along with all supporting documentation needed to support the Appeal to the Plan. In filing an Appeal with the Plan, please include a completed Waiver of Liability form as well as relevant supporting documentation to the address provided below, or you can fax the completed and signed Waiver of Liability form, as well as all supporting documentation for the Appeal directly to 1-787-625-3375.

Written requests for an Appeal, as well as all supporting documentation can be mailed directly to the Plan at:

MMM Holdings, LLC
PO BOX 71114
San Juan PR, 00936-8014

Also you can send your appeal, documents and additional supporting evidence for an appeal to us via email.

What you need to do

- Inlcude the Non-contracted Provider Payment Dispute Form or Appeal letter
- Form 1500 or UB-04
- Waiver of Liability Statement Request
- Explanation of Payments
- Medical Record
- Maximum email size: 10 MB
- Acceptable file types: PDF

Send the email to Appeals&GrievanceNotifications@mmmhc.com

**Please indicate within the documentation that an Appeal is being requested.** As a reminder, a completed and signed WOL form must accompany all Appeal requests in order for Reconsideration to be completed by the Plan.

In accordance with CMS regulations, if the completed and signed WOL form is not received within sixty (60) days of receipt of an Appeal, a dismissal notice letter will be sent to you with right to request a IRE Maximus Federal Service, Inc. re-evaluation of the Appeal. You may obtain a blank WOL form in the Appendix section of the Provider manual at http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices.html It is also

important to note that by signing the WOL form you are not waiving your rights to payment from MMM, Holdings, LLC. if the Appeal determination is favorable.

Following review of your Appeal, should the Plan uphold its original decision to deny payment for the services rendered, the Plan is required to automatically forward all adverse or unfavorable decisions to Maximus for an independent review of that decision. They will notify you and the Plan directly of their decision.

**Q: I am a Non-contracted and I do not believe that the claim was paid properly (i.e. underpayment). What can I do?**

**A:** Non-contracted have the right to file a Payment Dispute as a result of a reduction in payment on an initial claim or upon receipt of a Revised Payment Determination. Payment Disputes are where a Non-contracted Provider contends that the amount paid by the Plan for a covered service is less than the amount that would have been paid under Original Medicare.

Non-contracted have *120 calendar days* from the initial claim payment or Revised Payment Determination to file a written request for a Payment Dispute with the Plan. The Plan is required to resolve each non-contracted Provider Claim Payment Dispute within *30 calendar days* of receipt of the written request.
Written requests for a Payment Dispute, as well as all supporting documentation may be faxed to 1-787-625-3375 or mailed directly to the Plan at the address provided above. Please note within the documentation that a Payment Dispute is being requested.

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Toll free to call Provider Call Center: 1-866-676-6060