Highmark Medicare Services - Section 1011

Ask the Contractor Teleconference

Understanding the Section 1011

Dispute Resolution Request Process

2pm – 3pm Eastern Time

April 20, 2011

Dial-in number: 1-888-276-8689

Pass code: 1920282

Section 1011 Dispute Resolution Process Topics

I. Section 1011 Dispute Resolution Process

II. Types of Dispute Resolution Requests

III. Filing a Dispute Resolution Request

IV. Dispute Decision Notification

V. Timing and Calculation of Payments

VI. Dispute Resolution Inquiries

I. Section 1011 Dispute Resolution Process

The Section 1011 dispute resolution process gives providers an opportunity to seek further clarification regarding Section 1011 payment decisions, medical review decisions, and compliance review decisions. A provider may submit a dispute resolution request when they disagree with the initial decision and have information to support their position. The dispute will be adjudicated by a member of the Section 1011 contractor staff at Highmark Medicare Services (HMS), and the provider will be notified of the outcome of the review. In situations where the outcome is favorable to the provider, additional payment may be due. This training module will discuss specifics of the process and provide helpful tips for providers who wish to file Section 1011 disputes.

Background

The Section 1011 Final Policy states on page 66, "While we are not adopting a formal appeals process, we believe that providers should have an avenue to address payment disputes. Accordingly, we are adopting an informal appeals process to resolve payment disputes. In order to ensure timely and accurate payments to all providers, an informal appeals process will allow providers an opportunity to seek clarification of payment decisions while significantly reducing the time that it takes to resolve payment disputes."

II. Types of Dispute Resolution Requests

There are two categories of Dispute Resolution Requests: Non-Allowable and Allowable. The charts below describe the situations that result in each category.

Non- allowable Dispute Resolution Types

A dispute request will be dismissed and found non-allowable if the request is found to be: untimely, a duplicate to another request, incomplete, or is withdrawn. The chart below provides a description of the reasons a dispute would be found non-allowable.

Non-Allowable Dispute Type	*Description*
Untimely	request is not received within the allowed 45-day timeframe to file a dispute
Duplicate Request	request is for a service that has already been disputed
Incomplete	dispute request form is incomplete or incorrect
Withdrawn	per the provider's request, the dispute is withdrawn

Allowable Dispute Resolution Types

An allowable dispute request is processed and results in one of three types of dispute decisions. The types are: "Upheld", "Full Reversal", and "Partial Reversal".

Allowable Dispute Decisions	*Description*
Upheld	uphold the original payment decision
Full Reversal	fully reverse the payment decision
Partial Reversal	partially reverse the payment decision

The dispute decisions described above result in the following effects on payment requests:

- Upheld: The documentation submitted with the Dispute Resolution Request did not support the disputed items and no payment will be made.

  Example: The provider billed for services rendered to a patient who was seen for an emergency condition and the payment request was selected for a Medical and Compliance Review. The payment request was denied by the Medical Review department as "patient not eligible". A dispute was filed within 45 days with a completed PPD form. However, the notes in the patient's medical chart indicated that the patient was a full time student in the USA. Therefore, the patient was not an undocumented alien and the original decision was upheld. In this case, no payment is made.

- Full Reversal: The documentation submitted supported payment for the disputed items. The original decision will be fully reversed and payment will be made in the next quarterly cycle.

  Example: The provider billed for a service that was selected for a Medical and Compliance Review. The documentation requested for the review was never received by HMS. The services were therefore denied. Within 45 days of the denial, the provider filed a Dispute Resolution Request with all the documentation attached which supported the services rendered, and also included a completed and signed PPD form. HMS reviewed the dispute, and with the needed information now included, the services rendered and patient eligibility were able to be verified and it was determined payment for these services could be made with the next quarterly payment.

- Partial Reversal: The documentation submitted partially supports the disputed items and will partially reverse the original decision. An additional payment will be made in the next quarterly cycle.

  Example: A payment request was originally submitted for an inpatient stay of five days and was not paid. A Dispute Resolution Request was filed within 40 days and included documentation that showed the patient was stabilized in two days. Upon review, it was determined that the patient was stabilized within two days. The stay was down coded to two days. Therefore, the dispute is found to be partially favorable. Partial payment (for 2 of the 5 days) will be made in the next quarterly cycle.

III. Filing a Dispute Resolution Request

Allowable disputes must be mailed timely, include a completed and signed Dispute Resolution Request Form, and contain all needed supporting documentation.

Timeframe for Filing a Dispute

Dispute Resolution Requests must be received EITHER within 45 calendar days after the quarterly payment date of the quarter for which the disputed payment request was billed OR no later than 45 calendar days from the date of a Section 1011 Medical Review or Compliance Review denial letter.

Example of untimely dispute:
On April 30, 2011, HMS receives a dispute on a payment request with a date of service of May 4, 2010. The payment request was denied February 25, 2011. The Dispute Resolution Request outcome is dismissed due to being filed untimely. The Dispute Resolution Request for dates of service 04/01/10 to 06/30/10 must be received by April 11, 2011. Note: If a Medical Review/Compliance Review denial letter was generated, the dispute must be received within 45 calendar days from the denial letter date.

Filling Deadline Chart

Quarter	Begin Date	End Date	Payment Date	Disputes Due
Q3, FY 2010	04/01/2010	06/30/2010	02/25/2011	04/11/2011
Q4, FY2010	07/01/2010	09/30/2010	05/27/2011	07/11/2011
Q1, FY 2011	10/01/2010	12/31/2010	08/29/2011	10/13/2011
Q2, FY 2011	01/01/2011	03/31/2011	11/25/2011	01/09/2012
Q3, FY 2011	04/01/2011	06/30/2011	02/24/2012	04/09/2012
Q4, FY 2011	07/01/2011	09/30/2011	05/29/2012	07/13/2012

Address information

Providers must submit a written request for dispute resolutions using the Section 1011 Dispute Resolution Request – Form CMS-20042 and all supporting documentation.
Dispute resolution requests must be mailed to the following address:

Highmark Medicare Services
Attn: Section 1011 Dispute Resolution
P.O. Box 890121
Camp Hill, PA 17089-0121

NOTE: Dispute Resolution Requests will not be accepted via fax or e-mail.

Required Information on Form

Information required on the Dispute Resolution Request Form includes the following:

- Provider's name
- Section 1011 Provider Identification Number (PIN)
- Patient Identifier Number (HIC)
- Document Control Number (DCN)
- Full Date Range of Service
- Specific date(s) of items in dispute
- Original amount submitted for reimbursement
- Denied service and reason for dispute
- Requester's contact information, including name, title, e-mail address, mailing address, telephone number
- Signature
- Date signed
- Letter of representation (if submitter is an entity other than the provider)

Required Additional Documentation

In addition to the form, you must include **all** appropriate documentation to support the dispute such as Medical Records, Progress Notes, Provider Payment Determination (PPD) form, etc. Dispute resolution requests that are found to be incomplete or incorrect will be dismissed and the entire dispute including any records will be returned via the United States Postal Service. Section 1011 does not maintain a copy of the initial request.

> ***NOTE:*** If the dispute is contesting the findings of a previously conducted Medical/Compliance Review, HMS will have access to the medical records that were submitted for that review, so you only need to submit documentation that was NOT previously submitted and that supports ***stabilization of the emergent condition***. If a PPD was submitted with the medical review documentation and the patient was found to be "Eligible", you do not need to resubmit the PPD with the patient records for a dispute. The review determination letter that we send after the initial review specifies the results of both Compliance Review and Medical Review, so you will know if we have determined that the patient is "Not Eligible".
>
> If the dispute is contesting the findings of a previously conducted Compliance Review, you will need to send either an updated PPD form or an explanation beyond what is reported on the form as to why you feel the patient is eligible.

IV. Dispute Decision Notification

Providers will be notified of all dispute decisions within 45 calendar days of the receipt of the dispute. Providers will receive the decision via e-mail with the exception of incomplete/incorrect dispute requests and un-deliverable emails. In these cases, notifications are mailed via United States Postal Service.

The dispute decision notification will identify the following items, assuming they were on the dispute resolution request:

- Case Number - number is assigned by Section 1011 and should be used as a reference when calling to discuss a dispute request
- Document Control Number of the Section 1011 Payment Request - assigned by HMS
- Patient Identification Number - submitted by the provider on the payment request
- Full dates of service - reported by the provider on original payment request
- Items/services and amounts disputed by the provider - as listed on the Dispute Resolution Request form
- Payment dispute decision – decision types are: Upheld, Full Reversal, Partial Reversal, Dismissed, Withdrawn
- Reason for the decision – as explained on the notification

V. Timing and Calculation of Payments

Payments due as a result of a full or a partial reversal decision on a disputed payment request that has been already processed must be paid in the quarterly payment cycle following the original date of service. In some cases, this payment amount will be offset by other withholdings in the coming quarter. In cases where there is no withholding due, HMS Section 1011 must adjust the dates of service originally submitted to reflect dates of service falling within the current quarterly payment cycle. These payments are subject to the rates and pro-rata reduction applicable to the quarter in which the resolved dispute is paid. If the state is 'spent down' at the time of the resolved dispute decision, no additional payment can be made. If the payment falls in the quarter when a state's allocation becomes spent down, the payment amount may be reduced due to a pro-rata reduction.

If a Dispute Resolution Request is processed as a result of a Medical Review or Compliance Review on a payment request for dates of service for which no quarterly payment has yet been issued, the original payment request will be adjusted according to the resolution decision. In these cases, the payment will be made on the appropriate quarterly payment date for the dates of service billed.

VI. Dispute Resolution Inquiries

Status of a Dispute Resolution Request

HMS Section 1011 does not send an acknowledgement of receipt for a dispute request. Providers may address questions regarding dispute status to Section 1011's Customer Service Center at (866) 860-1011 Monday through Friday between 8:00 am and 4:30 pm ET.

Understanding a Dispute Decision

Per the Final Policy, there is no appeal of a dispute decision in Section 1011. However, if you have questions regarding dispute decisions please call or contact us at:

Highmark Medicare Services
Attention: Section 1011 Dispute Resolution Inquiry
PO Box 890121
Camp Hill, PA 17089-0121

- When calling Section 1011's Customer Service Center at (866) 860-1011 (Monday through Friday between 8:00 am and 4:30 pm ET), be sure to have the case number in the upper right corner of your decision letter ready.
- When writing regarding a specific dispute, please indicate the case number located in the upper right corner of your letter to assist us with your inquiry.

NOTE: Although you may be notified of your dispute decision by email, questions regarding the decision will not be accepted via direct email to the Dispute Resolution Representative who handled the case.