Medicare Advantage (MA)

Provider Complaint Submission Form

Organizations representing Medicare providers and seeking assistance from CMS in resolving Medicare Advantage (MA) claims issues must complete this form by following the instructions below.

1. Please submit one form for each complainant/beneficiary, ensuring all information on the form is populated. **Each file must be password protected**.
2. Do not submit medical records – summarize specific issues.
3. Document all efforts to resolve the matter with the MA plan directly.
4. If these requirements are not met, CMS will return the case(s) for corrections. Failure to comply, may result in no complaint entry.

CMS will enter *complete* complaint forms into the Complaints Tracking Module (CTM), directing the MA to investigate the case. MAs have 30 days to work directly with the submitter(s) toward resolution. In general, CMS' role is to facilitate communication between the MA and the submitter. CMS does not determine medical necessity nor determine or resolve claim payments or payment disputes. CMS will identify and escalate repeated trends as warranted.

CMS has oversight of all MA plans nationally; however, all complaints are processed using one centralized email box (below) where password protected files should be sent.

MedicarePartCDQuestions@cms.hhs.gov

Upon entry of the complaint, CMS staff will provide the submitter with the complaint ID. If the issue remains unresolved after 30 days and attempts to resolve the matter with the MA plan have not been successful, then the submitter may contact CMS at the email listed above (include complaint ID).

POLICY RELATED QUESTIONS

Network adequacy policy questions should be sent to the Division of Medicare Advantage Operations (DMAO) at: https://dmao.lmi.org/dmaomailbox/

Utilization management or non-compliance in the area of claims processing approaches (PA, concurrent review, and retrospective reviews) including denied/downgraded payments are sent to the Medicare Parts C&D Oversight and Enforcement Group (MOEG) at: C/D Audit Mailbox (part_c_part_d_audit@cms.hhs.gov).

Appeals policy questions should be sent to the Division of Appeals Policy (DAP) at: https://appeals.lmi.org

Enrollment and eligibility policy questions should be sent to the Division of Enrollment and Eligibility Policy (DEEP) at: https://enrollment.lmi.org

For other policy related questions not listed here, please submit this provider form to the MedicarePartCDQuestions@cms.hhs.gov email requesting specific information needed.

WHAT IS A PROVIDER APPEAL COMPLAINT?

For these purposes, a provider appeal complaint is submitted by a contracted or non- contracted provider alleging an MA's failure to follow the applicable appeals process. A n appeal could include an MAO's denial of a specific line item within a claim, an MA's failure to notify the provider of the available appeal process or failure to act upon an appeal appropriately submitted by a provider.

CMS defines the non-contracted provider appeals process in the Medicare Managed Care Manual, Chapter 13. That process includes the requirement that the MA auto-forward adverse appeal decisions to the Independent Review Entity (IRE).

The MA is responsible for defining their appeals process for contracted providers as elaborated in the provider's contracts with the MA plan directly.

WHAT IS A CLAIMS PAYMENT DISPUTE?

For these purposes, a claims payment dispute is a provider's dispute over the *amount* that the MA paid for an approved service on a particular claim. An MA's decision to partially approve, down code, bundle services, or approve a service at a lower level of care than the service billed would be appealable by non-contracted providers. Reference: Administrative appeals process of Part 422, Subpart M (contracted providers would appeal in accordance with the terms of their contract with the MAO).

Information Required for All Complaints

- **1.1** Date of Submission to CMS
- **1.2** Submitting Entity (If the case is submitted by an organization *representing* a Medicare provider, submit evidence of the contractual relationship between the provider and the representative organization that documents the organization's authority to investigate the case on the provider's behalf. Likewise, if the submitting entity is representing a beneficiary(ies), submit an Appointment of Representative (AOR) form demonstrating the authority to investigate the case(s) on the beneficiary(ies) behalf.)
- **1.3** Complainant's Name, E-mail Address, Telephone Number
- **1.4** Beneficiary Name
- **1.5** Beneficiary HICN/MBN (Medicare Beneficiary Number)
- **1.6** Provider Name, Telephone number, E-mail address
- **1.7** Medicare Advantage Organization Name
- **1.8** Claim Number
- **1.9** Date(s) of Service
- **1.10** Was the Provider Contracted with the MAO on the Date of Service? *(Yes or No)*
- **1.11** Complaint Type *(Contract Provider Appeal, Non-Contract Provider Appeal, Contract Provider Payment Dispute, Non-Contract Provider Payment Dispute, Other)*
- **1.12** Did MAO communicate appeal rights to you in their contract or otherwise? (*Yes or No*)
- **1.13** Have you exhausted all appeal rights? *(Yes or No).*
- **1.14** Has the representing organization attempted to resolve the issue by working directly with the MAO? *(Yes or No or N/A)* If Yes, name the individual(s) at the MAO.

RESOURCES

Medicare Managed Care Manual, Chapter 13 – Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPP), (collectively referred to as Medicare Health Plans) [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf]

Federal Regulations - Title 42, Chapter IV, Subchapter B, Part 422, Subpart M-Grievances, Organization Determinations and Appeals http://www.ecfr.gov/cgi-bin/text-idx?SID=38e42d9c79ff304832eea49cfc1bf40c&mc=true&node=sp42.3.422.m&rgn=div6

CMS Appeals and Grievances Website - Medicare Managed Care Appeals & Grievances, https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html

APPEAL / CLAIM PAYMENT DISPUTE COVER SHEET

		Fill in required information below. Indicate option selection with "X."
1.1	Date of Submission to CMS	
1.2	Entity Submitting Complaint	___ Provider ___ Organization Representing Provider ____Appointment of Representative (attach form) ____Other (Summarize)
	Name of Organization Representing Provider	
1.3	Submitter's Name	
	E-mail Address	
	Telephone Number	
1.4	Beneficiary Name	
1.5	Beneficiary Health Insurance Claim Number (HICN) / Medicare Beneficiary Number (MBN)	
1.6	Provider Name, telephone number, E-Mail address	
1.7	Medicare Advantage Organization	
1.8	Claim Number	
1.9	Date(s) of Service	
1.10	Provider Contract Status	___ Provider Contracted with MAO during Date(s) of Service ___ Provider NOT Contracted with MAO during DOS
1.11	Complaint Type	___ Contracted Provider Appeal ___ Non-Contracted Provider Appeal ___ Contracted Provider Claims Payment Dispute ___ Non-Contracted Provider Claims Payment Dispute ___ Other
	Brief Summary of Complaint	
1.12	Did MAO communicate your appeal rights.	__Yes __No
1.13	Have you exhausted all appeals rights per the non-contracted provider appeals or per contract w/MAO	__Yes __No
1.14	Provider or their representative has Communicated with MAO in Attempt to Resolve Issue	___ Yes ___ No *(NOTE: CMS will only review this case if the provider has already attempted to resolve it by working directly with the MAO.)*
	If Yes, Name(s) of Individual(s) at MAO	