



SECTION 07

Payment Integrity and Provider Disputes

IN THIS SECTION

- › Overview
- › Program Integrity
- › Payment Accuracy Reviews
- › Overpayment Recovery
- › Reopening and Revision of Claims Determinations
- › Provider Refunds
- › Payment Disputes
- › Payment Dispute Appeals
- › Dispute Resolution Timeframes
- › Provider Responsibilities

Overview

eternalHealth is committed to ensuring accurate claims payment and maintaining compliance with Centers for Medicare & Medicaid Services (CMS) requirements, applicable federal and state regulations, and provider contractual obligations. Payment Integrity activities are designed to identify billing inaccuracies, prevent improper payments, support regulatory compliance, and promote responsible stewardship of healthcare resources.

Participating providers are expected to cooperate with payment integrity reviews, overpayment investigations, audit activities, and dispute resolution processes.

Program Integrity

To support accurate claims adjudication and regulatory compliance, eternalHealth maintains a comprehensive Payment Integrity Program that includes both pre-payment and post-payment reviews.

Program Integrity activities may include:

- Claims reviews
- Coding validation
- Medical necessity reviews
- Documentation audits
- Coordination of Benefits verification
- Fraud, Waste, and Abuse investigations
- Retrospective payment reviews
- Overpayment identification and recovery activities

eternalHealth may utilize internal resources and contracted vendors to conduct these activities. Providers are expected to respond promptly to requests for medical records, billing documentation, and other information necessary to support review activities.

Payment Accuracy Reviews

Claims may be reviewed before or after payment to determine:

- Accuracy of coding and billing
- Medical necessity of services provided
- Compliance with Medicare coverage requirements
- Accuracy of reimbursement
- Compliance with provider contract provisions
- Appropriate use of modifiers and coding methodologies

As part of these reviews, providers may be asked to furnish:

- Medical records
- Treatment notes
- Operative reports
- Diagnostic testing results
- Authorization documentation
- Other supporting records relevant to the claim under review

Failure to provide requested documentation may result in payment adjustments, claim denials, or recovery actions, as permitted by applicable regulations and provider agreements.

Overpayment Recovery

eternalHealth complies with CMS requirements regarding identification, notification, and recovery of overpayments.

An overpayment may occur as a result of:

- Duplicate payments
- Data entry errors
- Incorrect coding
- Medical necessity determinations
- Eligibility errors
- Audit findings
- Coordination of Benefits updates
- Fraud, Waste, or Abuse investigations

When an overpayment is identified, eternalHealth may:

- Notify the provider in writing.
- Request repayment.
- Offset the amount against future claim payments.
- Initiate recovery activities through authorized vendors.
- Assess applicable interest when permitted by law.

Reopening and Revision of Claims Determinations

eternalHealth may reopen and revise a claim determination in accordance with CMS regulations and applicable Medicare reopening guidelines. Claims may be reopened:

- Within one (1) year of the original determination for any reason.
- Within four (4) years for good cause.
- At any time when fraud or similar fault is identified.

Provider Refunds

If a provider independently identifies an overpayment, the provider should promptly notify eternalHealth and return the overpaid amount.

Refund submissions should include:

- Member name
- Member ID number
- Date(s) of service
- Claim number
- Amount being refunded
- Explanation of the reason for the refund
- Applicable remittance advice or correspondence related to the claim

Timely reporting of overpayments supports compliance with federal Medicare program requirements and applicable provider contractual obligations.

Payment Disputes

Participating providers who disagree with a claim payment determination may submit a Payment Dispute for review.

Payment disputes must be submitted within one hundred eighty (180) calendar days from the provider's receipt of the applicable remittance advice.

A payment dispute should contain sufficient information to support review, including:

- | | | |
|-----------------------------|--------------------------------|--|
| • Provider name | • Service Date(s) | • Relevant medical records or supporting documentation |
| • Member name and member ID | • Explanation of the dispute | • Provider contact information and return address |
| • Claim number | • Applicable remittance advice | |

Additional information may be requested if necessary to complete the review.

Payment Dispute Submission Address

eternalHealth

Attn: Claims

PO Box 1263

Westborough, MA 01581

Payment Dispute Fax

Fax: 1-888-692-7270

Payment Dispute Appeals

If a provider disagrees with the outcome of an initial Payment Dispute determination, the provider may submit an appeal for secondary review.

Appeal requests should include:

- Payment dispute case number
- Original claim information
- Explanation of the basis for appeal
- Any additional supporting documentation
- Provider return address and contact information

Appeals should be submitted to the same mailing address or fax number used for payment disputes.

eternalHealth will review the appeal and issue a written determination consistent with applicable regulatory requirements and provider agreement provisions.

Dispute Resolution Timeframes

Upon receipt of a complete dispute submission, eternalHealth will review the dispute and provide a written determination.

First-Level Payment Disputes

- Resolution issued within sixty-five (65) calendar days of receipt.

Second-Level Payment Dispute Appeals

- Resolution issued within sixty-five (65) calendar days of receipt of the appeal request.

Providers should allow the full review period to expire before submitting duplicate requests regarding the same claim dispute.

Favorable Determinations

If a dispute or appeal is resolved in the provider's favor, eternalHealth will issue any additional payment, interest, or penalties required by law within applicable regulatory timeframes.

Provider Responsibilities

Participating providers are responsible for:

- Maintaining documentation supporting billed services.
- Cooperating with audit and payment integrity review requests.
- Responding timely to requests for records or information.
- Reporting identified overpayments.
- Retaining records necessary to support reimbursement.
- Submitting payment disputes within required timeframes.
- Complying with CMS, regulatory, and contractual requirements related to claims payment and reimbursement.

Failure to cooperate with payment integrity activities may result in delayed payments, audit findings, overpayment recoveries, corrective action plans, or other actions permitted under applicable regulations and provider agreements.