Upper Peninsula Health Plan
Policy & Procedure

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Subject: Medicare Provider Appeals **Revised:**

Authorized By: _____ **Date:** _____ **Title: CEO**

Product Type(s): ☐ **All Products** ☐ Medicaid ☐ Healthy Michigan Plan
☒ Medicare ☐ MIChild ☐ MI Health Link

Purpose

To establish an efficient, consistent, systematic, and fair method of managing and resolving provider appeals. The following policy and procedure shall be maintained in compliance with the Upper Peninsula Health Plan (UPHP) Medicare contract with the Centers for Medicare & Medicaid Services (CMS).

Definitions

Administrative Law Judge Hearing: Third level of the appeals process. Reviews a decision made by the Independent Review Entity (IRE) and the amount in controversy meets the appropriate threshold.

Amount In Controversy (AIC): The threshold dollar amount remaining in dispute that is required for a Level 3 and Level 5 appeal. The AIC increases annually by a percentage increase tied to a consumer price index. The AIC is determined annually and published in the Federal Register prior to the end of each calendar year.

Contract Provider: A provider or supplier that has an executed contract to provide services and supplies to members of the Upper Peninsula Health Plan.

Inquiry: Any oral or written request to a Medicare health plan, provider, or facility, without an expression of dissatisfaction. Inquiries are routine questions about benefits and do not automatically invoke the grievance or organization determination process.

Independent Review Entity: Second level of the appeals process. An independent entity contracted by CMS to review Medicare health plans' adverse reconsiderations of organization determinations.

Judicial Review: Fifth level of the appeals process if the Medicare Appeals Council adopted, modified, or reversed the Administrative Law Judge (ALJ) decision and the amount in controversy meets the appropriate threshold.

Medicare Appeal Council: Fourth level of the appeals process that reviews a decision made by an Administrative Law Judge.

Non-Contract Provider: A provider or supplier that does not have an executed contract to provide services and supplies to members of the Upper Peninsula Health Plan.

Organization Determination: UPHP response to a request for coverage (payment or provision) of an item or service- including auto-adjudicated claims, prior authorization requests, and requests to continue previously authorized ongoing courses of treatment. It includes requests from both contract and non-contract providers.

Provider Appeal: A dispute of payment from UPHP in which the member is not at financial risk.

Reconsideration: A plan's review of an adverse or partially favorable organization determination

Reopening: Remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

Waiver of Liability: Required form a non-contract provider must sign to initiate an appeal with UPHP requesting payment which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal.

Policy

When a provider disagrees with a determination made by Upper Peninsula Health Plan (UPHP) regarding payment for Medicare covered services, they may file an appeal in writing to UPHP, 60 calendars days from the remittance notification date. UPHP may allow more time to file the appeal if the provider provides good reason for missing the timeframe. UPHP will issue its reconsidered determination in writing and be mailed no later than 60 calendar days from the date UPHP received the request for payment reconsideration. UPHP designates persons who were not involved in the making of the initial organization determination when reviewing reconsiderations. If the denial is based on lack of medical necessity, the reconsideration is reviewed by a physician with the expertise in the field of medicine that is appropriate for the services at issue. An inquiry is not subject to the appeals process.

Procedure

To file an appeal, the provider must have submitted a claim for the service and/or supplies in question, and/or received a denial or reduction in payment from UPHP. The provider must

submit a written request explaining the basis for the appeal to UPHP which includes the following:

- Member name
- Member identification number
- Remittance notification showing the denial
- Signed Waiver of Liability form (non-contract providers)
- Supporting documentation such as proof of timely filing, medical records, reason for not obtaining authorization, or other information that supports the appeal or is pertinent to the appeal.
- The name, address, and telephone number of the person responsible for filing the appeal

All provider appeal requests are to be mailed or faxed to:

Upper Peninsula Health Plan
Attn: Review and Appeals Coordinator
228 W. Washington Street
Marquette, MI 49855
Fax: 906-225-7720

If UPHP does not receive the signed provider Waiver of Liability (WOL) from a non-contract provider and/or other required documentation within 60 calendar days of UPHP receipt of appeal request, the request for appeal will be dismissed. UPHP will send written notification of the dismissal. UPHP will outreach via phone and in writing to the appealing party to obtain the needed information prior to dismissal.

UPHP will process the reconsideration request and provide a written response within 60 calendar days. This is the final reconsideration for UPHP contracted providers.

For non-contracted providers, if UPHP continues to deny payment in whole or in part, UPHP will send the complete case file to the Independent Review Entity (IRE) contracted by CMS by mail or overnight delivery service at its designated address. For requests for payment, UPHP must forward the case file to the IRE no later than 60 calendar days from the date UPHP receives the request for reconsideration.

UPHP maintains its appeal case files in an appeals software system. The case file sent to the IRE will include:

- An Appeal Transmittal Cover Sheet on top of the case file, so that the IRE can clearly differentiate new cases from other incoming materials;
- Reconsideration Background Data Form, which is a standard data collection document with supplementary narrative description and attachments;
- Case Narrative
- Copy of Organizational Determination Notices;
- Copy of the reconsideration request;

- Copy of information used to make the health plan internal reconsideration decision, including supporting documentation such as medical records; and
- Evidence of Coverage on a CD

When the IRE completes its reconsidered determination, it is responsible for notifying the involved parties of the reconsidered determination and informs parties, other than the health plan of their right to an administrative law judge (ALJ) hearing if the amount in controversy meets the appropriate threshold requirement and the decision is adverse. The IRE will describe the procedures that the parties must follow to obtain an ALJ.

If the amount in controversy meets the monetary threshold of the reconsideration, the provider may request an ALJ hearing within 60 days of receipt of the reconsideration decision. This is the third appeal level. The IRE is responsible for compiling the reconsideration file and forwarding it to the appropriate ALJ hearing office. The provider must send a copy of the ALJ hearing request to all other parties to the reconsideration. Hearing preparation procedures are set by the ALJ. UPHP may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and the parties to the hearing. The ALJ will generally issue a decision within 90 days of receipt of the hearing request. This timeframe may be extended for a variety of reasons including, but not limited to the case being escalated from the reconsideration level, the submission of additional evidence not included with the hearing request, the request for an in-person hearing, the provider's failure to send notice of the hearing request to other parties, and the initiation of discovery if CMS is a party. If the ALJ does not issue a decision within the applicable timeframe, the provider may ask the ALJ to escalate the case to the Appeals Council level.

If the provider to the ALJ hearing is dissatisfied with the ALJ's decision, the provider may request a review by the Medicare Appeals Council (MAC), which is the fourth level of appeal. A minimum monetary threshold is not required to request Appeals Council review. The request must be submitted in writing within 60 days of receipt of the ALJ's decision or dismissal, and must specify the issues and findings that are being contested. In general, the Appeals Council will issue a decision within 90 days of receipt of a request for review. That timeframe may be extended for various reasons, including but not limited to, the case being escalated from an ALJ hearing. If the Appeals Council does not issue a decision within the applicable timeframe, the provider may ask the Appeals Council to escalate the case to the Judicial Review level.

If the MAC adopted, modified, or reversed the ALJ decision and the amount in controversy meets the appropriate threshold the provider may request judicial review in federal district court. This is the fifth and final level of appeal.

Attachments

Waiver of Liability Form

Exception to this policy may be made with the approval of the

Chief Executive Officer or an authorized designee.

END OF POLICY & PROCEDURE

Upper Peninsula Health Plan

WAIVER OF LIABILITY STATEMENT

_____ _____

Enrollee's Name Medicare/HIC Number

_____ _____

Provider Dates of Service

_____

Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600

_____ _____

Signature Date