

Upper Peninsula Health Plan
Policy & Procedure

Index #: 700-201


Effective: 1/1/26

Title: MI Coordinated Health Provider Claim Appeals

Scope: Clinical Services - Appeals, Finance - Claims

Revised: 12/10/25, 12/30/25

Reviewed:

Authorized By:  Date: 12/31/2025 Title: CEO

Product Type(s): All Products Medicaid Healthy Michigan Plan
 Medicare CSHCS MI Health Link
 MI Coordinated Health

Purpose

The purpose of this appeal policy is to establish an efficient, consistent, systematic, and fair method of managing and resolving MI Coordinated Health provider claim appeals. The following policy and procedure shall be maintained in compliance with the Upper Peninsula Health Plan (UPHP) MI Coordinated Health contract with the Centers for Medicare & Medicaid Services (CMS) and the Michigan Department of Health and Human Services (MDHHS).

Definitions

Administrative Law Judge (ALJ) Hearing: Third level of the appeals process. Reviews a decision made by the independent review entity (IRE) when the amount in controversy meets the appropriate threshold.

Adverse Benefit Determination: As defined in 42 CFR §438.400(b), any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service; a denial, in whole or in part, of a payment for a service solely because the claim does not meet the

definition of a “clean claim” at 42 CFR §447.45(b) is not an Adverse Benefit Determination;

- The failure to provide services in a timely manner, as defined by the State;
- The failure of UPHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals;
- For a resident of a rural area with only one contracted health plan, the denial of an Enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network;
- The denial of an Enrollee's request to dispute a financial liability, including without limitation, cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

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.

Appeal: As defined in 42 CFR 438.400(b), a request for review by UPHP of an adverse Organization Determination, and as defined in 42 CFR §422.561, any of the procedures that deal with the review of adverse Organization Determinations on the health care services the Enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Enrollee), or on any amounts Enrollee must pay for a service, as defined under 42 CFR §422.566(b) and the MI Coordinated Health Contract. These procedures include Reconsiderations by Contractor, and if necessary, an independent review entity, hearings, ALJs, review by the Medicare Appeals Council (Council), and judicial review. The term Appeal(s) when used in this Contract includes Integrated Appeals.

Appeals Coordinator: UPHP staff responsible for administering the provider claim appeal process.

Contracted Provider: A provider or supplier that has an executed contract with UPHP to provide services and supplies to members of UPHP. May also be referred to as an In-Network Provider.

Dismissal: A decision to not review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements.

External Appeal – An Appeal, subsequent to UPHP’s Appeal decision, to the State Fair Hearing process for a Medicaid-based Adverse Benefit Determination, or the Medicare process for a Medicare-based Adverse Benefit Determination.

Filing Time Frame: The length of time the provider has, from the date of the remittance notification notice, to submit an appeal request to UPHP.

Independent Review Entity (IRE): An independent entity contracted by CMS to review adverse Level 1 appeal decisions made by the plan. Under Part C, an IRE can review plan dismissals.

Inquiry: Any verbal or written request for information to a plan or its delegated entity that does not express dissatisfaction or invoke a plan's grievance, coverage, or appeal process, such as a routine question about a benefit.

Integrated Appeal: The procedures that deal with, or result from, adverse Integrated Organization Determinations by Contractor on the benefits both under Part C and under state Medicaid rules the Enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Enrollee), or on any amounts the Enrollee must pay for a service. Integrated Appeals do not include appeals related to Part D benefits.

Integrated Appeals cover procedures that would otherwise be defined and covered, for non-applicable integrated plans, as an Appeal defined in 42 CFR §422.561 or the procedures required for appeals in accordance with 42 CFR §§438.400 through 438.424. Such procedures include, without limitation, Integrated Reconsiderations.

Integrated Organization Determination: An Organization Determination that would otherwise be defined and covered, for a non-applicable integrated plan, as an organization determination under §422.566, an Adverse Benefit Determination under §438.400(b), or an action under 42 CFR §431.201. An Integrated Organization Determination is made by UPHP and is subject to the Integrated Organization Determination procedures in §§422.629, 422.631, and 422.634.

Integrated Reconsideration: A reconsideration that would otherwise be defined and covered, for a non-applicable integrated plan, as a Reconsideration under §422.580 and Appeal under §438.400(b). An Integrated Reconsideration is made by UPHP and is subject to the Integrated Reconsideration procedures in 42 CFR §§422.629 and 422.632 through 422.634. Integrated Reconsiderations do not include Redeterminations related to Part D benefits.

Judicial Review: Fifth level of the appeals process when the Medicare Appeals Council adopted, modified, or reversed the ALJ decision and the amount in controversy meets the appropriate threshold.

Medicare Appeal Council (MAC): Fourth level of the appeals process that reviews a decision made by an ALJ.

Non-Contracted Provider: A provider or supplier that does not contract with UPHP to provide services covered by UPHP. May also be referred to as an Out-of-Network Provider.

Organization Determination: As defined in 42 CFR §422.566 Medicare Advantage Program, Grievances Organization Determinations and Appeals, Organization

Determinations, any determination made by UPHP with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
- Payment for any other health services furnished by a provider other than UPHP that the Enrollee believes—
 - Are covered under Medicare; or
 - If not covered under Medicare, should have been furnished, arranged for, or reimbursed by UPHP.
- UPHP's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Enrollee believes should be furnished or arranged for by UPHP.
- Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment.
- Failure of UPHP to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the Enrollee.

Provider Claim Appeal: A dispute of payment from UPHP in which the member is not at financial risk. Appeals filed by members and/or their authorized representatives (including providers when applicable) regarding adverse benefit determinations or non-coverage decisions made by UPHP are handled through the member appeal process, in accordance with UPHP Policy 700-202, MI Coordinated Health Member Appeals.

Rapid Dispute Resolution Process: The process implemented by MDHHS to administer and resolve claim disputes.

Reconsideration: The health plan's review of an adverse or partially favorable organization determination, also referred to as an Appeal.

Reopening: A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.

Waiver of Liability Form (WOL): A required form that a Non-Contracted Provider must complete to initiate an appeal with UPHP requesting payment, which also provides that the Non-Contract Provider will not bill the enrollee regardless of the outcome of the appeal.

Withdrawal: A verbal or written request to rescind or cancel a pending grievance, initial determination, or appeal request submitted by the same party.

Policy

If a provider disagrees with an organization determination made by UPHP regarding payment for Medicare and/or Medicaid covered services, they may request a reconsideration (appeal) by writing to UPHP within 65 calendar days from the remittance notice date, referred to as the appeal filing time frame. The *Remittance Notification Dates* section on page 12 explains how providers can identify the remittance notification date for a claim. UPHP may allow more time to file the appeal if the provider shows good cause for missing the filing time frame. Examples of circumstances where good cause may exist include, but are not limited to:

- The party did not receive the notice for the adverse organization determination, or they received it late.
- An accident (e.g. a natural or man-made disaster) caused important records to be destroyed.
- Documentation was difficult to locate within the time limits.
- The party had incorrect or incomplete information concerning the UPHP appeal process.
- The party sent the request to an incorrect address, in good faith, within the time limit and the request did not reach the plan until after the time period had expired.

UPHP will review each provider claim appeal and issue a decision in writing within 60 calendar days of receiving the valid appeal request, referred to as the appeal resolution time frame. If the original adverse organization determination is overturned, payment will also be issued within the 60 calendar day appeal resolution time frame.

UPHP designates persons who were not involved in the initial organization determination to review reconsiderations (appeals). If the denial or reduction in payment is based on lack of medical necessity, the appeal is reviewed by a physician with expertise in the field of medicine that is appropriate for the services at issue. An inquiry submitted by a provider is not subject to the appeals process.

Procedure

To request a reconsideration (appeal), the provider must have submitted a claim for the services or supplies in question and received a denial or payment reduction from UPHP. The provider must submit a written request to UPHP explaining the basis for the appeal that includes the following:

- Member name
- Member identification number
- Remittance notification showing the denial or reduction in payment
- Waiver of Liability Form (Only Required for Non-Contracted Providers)

- Supporting documentation that should be considered with the appeal, 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, mailing address, and telephone number for the person filing the appeal

Providers may submit MI Coordinated Health claim appeals to UPHP via mail, fax or online form using the following contact information:

Mail: Upper Peninsula Health Plan
Attn: Clinical Services - Appeals
853 W. Washington Street
Marquette, MI 49855

Online:
www.uphp.com/clinicalsubmissionform/

Fax: 1-906-225-7720

Upon receipt of a valid reconsideration (appeal) request, UPHP will send an acknowledgement letter to the filer. If no mailing address is provided, written correspondence pertaining to the appeal will be sent to the billing address on file. Acknowledgement of receipt letters will be mailed or faxed within 10 business days of receiving the valid appeal request. If an appeal is valid but filed after the 65 calendar day filing time frame without good cause, UPHP will acknowledge receipt of the appeal in writing via the *Appeal Dismissal Notice*.

Examples of invalid appeal requests include:

- The appeal was filed by an unauthorized representative (e.g. a third-party biller that doesn't provide evidence showing they can file on behalf of the provider);
- It isn't possible to identify the claim subject to appeal in the submitted information; or,
- For Non-Contracted Providers, a valid Waiver of Liability (WOL) form was not included with the appeal request.

If UPHP does not receive required information within 60 calendar days of receiving the request, the appeal will be dismissed. UPHP will notify the provider of the dismissal in writing. Before dismissal, UPHP will make reasonable efforts to contact the appealing party by phone and/or in writing to obtain the needed information. *See the Dismissals sections starting on page 9 for more information.*

If UPHP receives an appeal request that includes medical records for a claim that was denied because UPHP did not receive a response to a request for medical records, an Appeals Coordinator/designee will review the request and process as follows:

- If the appeal request and medical records are received within one (1) year (365 days) of the mail date for the remittance notice, the request will be forwarded to the UPHP Claims department for review and will not be set up as an appeal. The provider will receive an updated remittance notice and/or payment, if the original organization determination is overturned, once the claim has been

reviewed. The provider may then submit another request for an appeal once they receive an updated remittance notice for the claim.

- If the appeal request and medical records are received later than one (1) year of the mail date for the remittance notice, the Appeals Coordinator will proceed with processing the request as an appeal. If the appeal request does not include good cause for late filing or is otherwise missing necessary information for processing, it will be dismissed.

If UPHP receives an appeal for a claim that has not been finalized (no decision or remittance notice has been issued), an Appeals Coordinator/designee will notify the filer in writing that the request cannot be processed. Providers may submit a new appeal after receiving a remittance notice showing a denial or reduced payment.

UPHP will process the appeal and issue a written determination, including payment if the adverse decision is overturned, within 60 calendar days of receiving a valid appeal request. For Contracted Providers, this is the final appeal level for Medicare and/or Medicaid covered services.

For Non-Contracted Providers, if UPHP continues to uphold the adverse decision in whole or in part during the internal appeal process for a Medicare covered service, UPHP will send the complete appeal case file to the Independent Review Entity (IRE) contracted by CMS via mail, overnight delivery service at its designated address, or via the online portal. For requests for payment, UPHP must forward the case file to the IRE no later than 60 calendar days from the date UPHP received the valid reconsideration (appeal) request. This process does not apply to services that are only covered by Medicaid. This is the second level of appeal for a Medicare covered service furnished by a Non-Contracted Provider.

UPHP maintains its appeal case files in a web application named Beacon Appeals Manager (BAM). The case file that is sent to the IRE will include the following:

- An Appeal Transmittal Cover Sheet on top of the case file;
- Reconsideration Background Data Form or Dismissal Case File Data Form (not required if submitted via IRE web portal);
- Case narrative;
- Copy of the initial organizational determination request and notice;
- Copy of the Level 1 appeal request and notice;
- Copy of information used to make the health plan internal level 1 decision, including all supporting documentation such as medical records, or evidence submitted by the provider;
- Representation documentation for representative appeals; and
- Evidence of Coverage on a CD (if the file is not submitted via IRE web portal).

When the IRE makes its determination, it is responsible for notifying the involved parties of the determination and for informing parties, other than the health plan, of their right to an Administrative Law Judge (ALJ) hearing if the Amount in Controversy

(AIC) meets the appropriate threshold requirement and the adverse organization determination is upheld in full or in part. The IRE will describe the procedures that the parties must follow to obtain an ALJ hearing.

If the AIC meets the monetary threshold, the provider may request an ALJ hearing within 60 days of receipt of the IRE decision. This is the third level of appeal for a Medicare covered service furnished by a Non-Contracted Provider. The IRE is responsible for compiling the reconsideration (appeal) 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 (appeal). 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 time frame may be extended for a variety of reasons including, but not limited to, the case being escalated from the reconsideration (appeal) 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 Medicare Appeals Council (MAC) level.

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

If the MAC adopted, modified, or reversed the ALJ decision and the AIC meets the appropriate threshold, the provider may request Judicial Review in federal district court. This is the fifth and final level of appeal for a Medicare covered service furnished by a Non-Contracted Provider. Information regarding this level of review is provided by the MAC.

Providers can contact UPHP at 1-877-349-9324 (TTY: 711) to ask questions about the appeals process or request assistance with filing an appeal.

Miscellaneous

Appeal Correspondence

Providers filing claim appeals are responsible for ensuring accurate contact information

is included with their appeal requests. UPHP may attempt to complete verbal outreach to get additional information prior to closing an appeal. UPHP will also always send appeal resolution notices in writing.

If an outreach call is unanswered, UPHP staff will leave a voicemail requesting a return call if the option is available. If the voicemail greeting does not identify or match the appealing party, the voicemail left by UPHP will be generic to avoid sharing protected health information with inappropriate persons.

UPHP will send written correspondence to the appealing party's fax number or mailing address. This is often the address included on the appeal request fax coversheet, in the appeal request letter, or in the letterhead that the appeal request letter is printed on. If UPHP cannot successfully send a fax without an error message, or if a mailing address is not included with the appeal request, all correspondence regarding the appeal will be sent to the billing address for the claim subject to appeal.

Contracted Provider Dismissals

UPHP will dismiss an appeal from a Contracted Provider if the provider does not request a reconsideration (appeal) within the established timeframes and good cause for late filing has not been shown. UPHP will also dismiss an appeal from a Contracted Provider if there is no claim on file. UPHP will send written notice informing the provider of the dismissal.

Contracted Providers may withdraw their appeal request at any time before an appeal decision is mailed or faxed by UPHP. UPHP accepts withdrawal requests verbally or in writing. Verbal withdrawal requests will be documented in the UPHP appeal system. UPHP will send written confirmation of receipt of the withdrawal to the appealing party within five (5) business days of receiving the request to withdraw.

UPHP's dismissal determination is final for Contracted Providers.

Non-Contracted Provider Dismissals

UPHP will dismiss a Non-Contracted Provider appeal under any of the following circumstances:

- The appealing party is a third-party biller that does not provide evidence that they are authorized to file the appeal on the provider's behalf. UPHP will make at least three (3) outreach attempts verbally and/or in writing to the appealing party to obtain the needed information prior to dismissing the appeal request;
- The appealing party does not submit a valid Waiver of Liability form (WOL) within 60 calendar days of UPHP receiving the appeal request. *See the Non-Contracted Provider Waiver of Liability Form (WOL) section, starting on page 10, for more information.* UPHP will make at least three (3) outreach attempts

verbally and/or in writing to the appealing party to obtain a valid WOL form prior to dismissing the appeal request;

- The appealing party fails to file the reconsideration (appeal) within the established timeframes and does not show good cause for late filing;
- The appealing party submits a timely request for withdrawal of the appeal with UPHP.
 - The appealing party may withdraw the appeal request in writing or verbally at any time before an appeal decision is mailed or faxed by UPHP. For verbal requests, UPHP will document the date the withdrawal request was received, the name of the individual making the request, their relationship to the member if applicable and the reason for withdrawal in the UPHP appeals system.

UPHP will send the *Notice of Dismissal of Appeal Request* letter to the appealing party at the end of the applicable adjudication timeframe. This notice will include:

- The reason for the dismissal;
- The right to request that UPHP vacate the dismissal action;
- For appeals involving Medicare covered services, and Medicare and Medicaid overlap services, the right to request review of the dismissal by the CMS IRE;
- For appeals involving Medicaid covered services, and Medicare and Medicaid overlap services, the right to request a State Fair Hearing to review the dismissal.

If good cause is shown by the appealing party, UPHP may vacate its dismissal of an appeal within six (6) months from the date of the dismissal notice.

UPHP's dismissal determination is binding unless the provider requests review by the IRE or State Fair Hearing, or if the dismissal decision is vacated by UPHP. If the IRE or State Fair Hearing determines that UPHP's dismissal was in error, they will vacate the dismissal and remand the case to UPHP for reconsideration. The CMS IRE or State Fair Hearing decision regarding the dismissal is binding and is not subject to further review.

Non-Contracted Provider Waiver of Liability Forms (WOL)

A WOL is considered valid if the following requirements are met:

- The enrollee's name is accurate;
- The enrollee's ID number is their accurate Medicaid ID or MBI;
- It is reasonably clear that the provider name included on the form aligns with the claim information;
- The date(s) of service included match the appealed claim (must be an exact match);
- The health plan name clearly identifies UPHP;
- The signature is from an individual who has the authority to waive the provider's ability to bill the enrollee for services (facility names are not acceptable);

- The signature date is later than the remittance notice date for the claim.

UPHP will make at least three (3) outreach attempts verbally and/or in writing to the appealing party to obtain a valid WOL form prior to dismissing the appeal request. *See the Dismissals sections starting on page 9 for more information.*

Rapid Dispute Resolution and Arbitration

If a non-contracted hospital disagrees with UPHP's reconsideration (appeal) decision, they may submit a request to MDHHS for Rapid Dispute Resolution (RDR). UPHP must comply with the Hospital Access Agreement for any non-contracted hospital providers. This applies solely to disputes with non-contracted hospital providers that have signed the Hospital Access Agreement. Non-contracted hospital providers that have not signed the Hospital Access Agreement do not have access to the RDR process.

When UPHP is notified by MDHHS of a request for RDR, the request will be sent to the UPHP General Counsel who will coordinate a meeting with the UPHP Accounts Receivable Reconciliation Group (ARRG), which consists of the UPHP Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Quality Officer (CQO) and Director of Claims Administration, to review the case a second time to determine if payment should be made or if the RDR process should continue. The Clinical Services Manager – Appeals will attend the meeting to explain the case and determination made by the appeal reviewer. Once a determination has been made by the ARRG regarding if payment should be made, the UPHP General Counsel will communicate with MDHHS regarding the RDR request, will be responsible for providing necessary documentation, will be present during the RDR hearing and will communicate the RDR outcome to the ARRG.

When a non-hospital provider or hospital provider that has not signed the Hospital Access Agreement requests arbitration, UPHP will participate in a binding arbitration process. Providers must exhaust the UPHP internal provider appeal process before requesting arbitration.

To request arbitration, providers must send a written request to:

Upper Peninsula Health Plan (UPHP)
Attn: UPHP General Counsel - Arbitration Request
853 W. Washington Street
Marquette, MI 49855

Upon receipt of an arbitration request, UPHP will contact MDHHS to request a list of neutral arbitrators that can be made available to resolve billing disputes. The arbitrators will have the appropriate expertise to analyze medical claims and supporting documentation available from medical record reviews and determine whether a claim is complete, appropriately coded, and should or should not be paid. Coordination of the arbitration process will be handled by the UPHP General Counsel. The party found to be

liable will be assessed the cost of the arbitrator. If both parties are at fault, the cost of the arbitration will be apportioned.

Remittance Notification Dates

Providers have 65 calendar days to file an appeal from the remittance notification date for the claim. This date can be found at the top of mailed remittance notices or at the top of electronic remittance notices accessed in UPHP's secure provider portal.

Providers who elect to receive payment from UPHP via Electronic Funds Transfer (EFT) instead of check will not receive mailed remittance notices. Providers receiving EFT payments can access their remittance notices electronically via UPHP's secure provider portal. The secure provider portal can be used to access electronic remittance files (835 files), status claims and discuss claim issues by direct messaging with UPHP Claims Services Representatives. To access the portal, providers can visit the UPHP website at www.uphp.com and select "Login" on the homepage.

Contracted Provider Appeal Filing Timeframes

All contracted and non-contracted providers have 65 calendar days from the remittance notification date to submit an appeal to UPHP unless an alternative timeframe is outlined in their contract. In these instances, all other provisions of this policy remain in effect.

Attachments

Waiver of Liability Form

Exception(s) to this policy may be made with the approval of the Chief Executive Officer or an authorized designee.

END OF POLICY & PROCEDURE

Waiver of Liability Statement

Enrollee Name

Enrollee ID Number

Provider

Dates of Service

Health Plan

By signing below, I give up ("waive") any right to collect payment from the enrollee (above) for the item, service or Part B drug furnished to the enrollee that the enrollee's health plan has denied. I understand that signing this waiver doesn't negate my right to appeal under 42 CFR §422.600.

Signature

Date