Upper Peninsula Health Plan
Policy & Procedure

Index #: 800-318 **Effective:** 06/01/16

Subject: MI Health Link Provider Claim Appeals **Revised:** 06/28/18; 10/02/19

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 claim appeals. The following policy and procedure shall be maintained in compliance with the Upper Peninsula Health Plan (UPHP) MI Health Link 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.

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 C.F.R. § 438.400(b). A request for review of a ICO or PIHP's decision that results in any of the following actions: (1)The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part of payment for a properly authorized and covered service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of an Entity to act within the established timeframes for grievance and appeal disposition; (6) For a resident of a rural area with only one Integrated Care Organization, the denial of an enrollee's request to exercise his or her right, under 42 C.F.R. § 438.52(b)(2)(ii), to obtain services outside the network. Effective no later than January 1, 2018, a Medicaid-based Appeal is defined as a review by the ICO of an Adverse Benefit Determination.

Contract Provider: A provider or supplier that has an executed contract with UPHP to provide services and supplies to members of UPHP.

Dismissal: A decision not to 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.

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.

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.

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: Fourth level of the appeals process that reviews a decision made by an ALJ.

Non-Contract Provider: A provider or supplier that does not contract with UPHP to provide services covered by UPHP.

Organization Determination: Any determination made by a Medicare Advantage plan, or its delegated entity with respect to 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 the MA plan), that the enrollee believes are covered under Medicare, or if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the MA plan.
- Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services, which the enrollee believes should be furnished or arranged by the MA plan;
- Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment; or
- Failure of the MA plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide 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.

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

Reconsideration: Plan review of an adverse or partially favorable organization determination

Reopening: 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: Required form a non-contract provider must sign 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 grievance, initial determination, or appeal.

Policy

When a provider disagrees with an Organization Determination made by UPHP regarding payment for Medicare and/or Medicaid covered services, they may file an appeal in writing to UPHP within 60 calendar 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. . Examples of where good cause may exist include (but are not limited to):

- The party did not receive the notice for adverse initial determination, or they received it late;
- An accident (e.g. a natural or man-made disaster) cause important records to be destroyed;
- Documentation was difficult to locate within the time limits;
- The party had incorrect or incomplete information concerning the level 1 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 issue its reconsidered determination in writing and send payment (if adverse determination is overturned) by mail no later than 60 calendar days from the date UPHP received the request for payment reconsideration. UPHP uses designated 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 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 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 claim appeal requests are to be mailed or faxed to:

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

If UPHP does not receive the signed Waiver of Liability Form from a non-contract provider and/or other required documentation within 60 calendar days of UPHP receipt of the appeal request, the request for appeal will be dismissed. UPHP will send written notification of the dismissal. For non-contracted providers, UPHP will utilize the model Notice of Dismissal of Appeal Request to notify the provider of the dismissal. UPHP will make at least 3 outreach attempts via phone and/or in writing to the appealing party to obtain the needed information prior to dismissal.

Upon receiving a valid appeal request, UPHP will mail an acknowledgement letter, within 5 calendar days, to the appealing party indicating that the appeal has been received.

The appealing party may withdraw their appeal request at any time before an appeal decision is mailed by UPHP. UPHP accepts withdrawal requests in writing or verbally. Verbal withdrawal requests will be documented in the UPHP appeals system. UPHP will send a written confirmation to the appealing party within 3 calendar days of the request. If the withdrawal request is received after UPHP has forwarded the case file to the IRE, UPHP will forward the withdrawal request to the IRE for processing.

UPHP will process the reconsideration request and provide a written response and payment (if applicable) within 60 calendar days. For Medicare and Medicaid covered services, this is the final reconsideration process for UPHP contracted providers.

For non-contracted providers, if UPHP continues to deny payment in whole or in part for Medicare covered services, UPHP will send the complete case file to the IRE contracted by CMS by mail, overnight delivery service at its designated address, or through 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 receives the request for reconsideration.

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

- An Appeal Transmittal Cover Sheet on top of the case file;
- Reconsideration Background 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 supporting documentation such as medical records, or evidence submitted by the provider;
- Representation documentation for representative appeals;
- Evidence of Coverage on a CD (if the file is not submitted via IRE web portal);
- Dismissal Case File Data Form (if applicable)

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

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 is dissatisfied with an ALJ 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 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. That timeframe 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 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.

For Medicaid covered services, if a non-contracted hospital disagrees with the UPHP reconsideration, 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 Rapid Dispute Resolution process. When UPHP is notified by MDHHS of a request for RDR, the request will be sent to 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 to continue with RDR. The Clinical Services Manager-Utilization Management (UM) will be present to go over the case and appeal determination made by the UPHP Appeal Panel. Upon determination by the ARRG, UPHP General Counsel will communicate with MDHHS, be responsible for providing necessary documentation, be present during the RDR hearing and 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, these providers must send a written request to:

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

UPHP will contact MDHHS who will provide a list of neutral arbitrators that can be made available to resolve billing disputes. These 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 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.

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

Waiver of Liability Statement

Enrollee's Name_____ Enrollee ID Number _____

Provider_____ Date 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_____