Upper Peninsula Health Plan
Policy & Procedure

Index #: 300-031 **Effective:** 06/01/16

Subject: Medicaid Provider Appeals **Revised:** 01/03/18

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) contract with the Michigan Department of Health and Human Services (MDHHS).

Definitions

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.

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.

Rapid Dispute Resolution Process: The process implemented by MDHHS to administer and resolve claim disputes according to the terms set forth in the Rapid Dispute Resolution Process.

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

Policy

When a provider disagrees with a determination made by UPHP regarding payment for Medicaid 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 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
- 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
853 W. Washington Street
Marquette, MI 49855
Fax: 906-225-7720

If UPHP does not receive the 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 from UPHP.

If a hospital disagrees with the UPHP reconsideration, they may submit a request to MDHHS for Rapid Dispute Resolution. 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 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. MDHHS 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. 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

None

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

END OF POLICY & PROCEDURE