Upper Peninsula Health Plan
Policy & Procedure

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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) 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.

Appeal: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council, and judicial review.

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: 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 if 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-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.

Reconsideration: Under Part C, the first level in the appeals process which involves a review of an adverse organization determination by an MA plan, the evidence and findings upon which it

was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS. Under Part D, the second level in the appeals process which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the enrollee submits or the IRE obtains. As used in this guidance, the term may refer to the first level in the Part C appeals process in which the MA plan reviews an adverse Part C organization determination or the second level of appeal in both the Part C and Part D appeals process in which an independent review entity reviews an adverse plan decision.
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 (WOL): 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.

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 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. 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 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 WOL 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

Upon receiving a valid appeal request, UPHP will mail an acknowledgement letter, within 5 calendar days, to the appealing party indicating the appeal has been received. *See dismissals section regarding non-valid appeals.*

UPHP will process the reconsideration request and provide a written response and payment (if applicable) within 60 calendar days of the request. 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 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 an 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 1decision, 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.

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 the ALJ's decision, the provider may request a review by the 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.

Dismissals

Non-Contract Providers:

UPHP will dismiss a non-contract provider appeal under any of the following circumstances:

- UPHP does not receive the signed provider WOL from a non-contract provider within 60 calendar days of UPHP receipt of appeal request. UPHP will make at least 3 outreach via phone and/or in writing to the appealing party to obtain the needed information prior to dismissal
- Party fails to file the reconsideration within the established timeframes and good cause for late filing has not been established.
- The party filing the appeal request submits a timely request for withdrawal of the appeal with UPHP.
    - The appealing party who files an appeal with UPHP may withdraw the request in writing or verbally at any time before an appeal decision is mailed by UPHP. For verbal requests, UPHP will document the date, the name of the individual making the request, their relationship to member if applicable and the reason for withdrawal in the UPHP appeals system.

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

- Reason for the dismissal and
- Right to request that UPHP vacate the dismissal action
- Rights to appeal to the IRE.

If good cause is established, UPHP may vacate its dismissal of an appeal within 6 months from the date of the notice of dismissal.

UPHP's dismissal is binding unless the member or other party requests review by the CMS IRE, or if the decision is vacated by UPHP. If the IRE determines that UPHP's dismissal was in error, vacates the dismissal and remands the case to UPHP for reconsideration; the IRE's decision regarding the dismissal is binding and not subject to further review.

Contract Providers:

UPHP may dismiss an appeal from a contract provider if the provider does not file the appeal within the established timeframes and good cause for late filing has not been established or if there is no claim on file. UPHP will send a notice informing provider of the dismissal.

UPHP's dismissal determination is final for contracted providers.

Contract providers 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.

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_____