NORTHCARE NETWORK

POLICY TITLE: MI Health Link Provider Claims Reconsiderations – Medicare	**CATEGORY:** Provider Network Management	
EFFECTIVE DATE: 1/10/18	**BOARD APPROVAL DATE:** 1/10/18	
REVIEW DATE: 5/24/24	**REVISION(S) TO POLICY STATEMENT:** ☐ **Yes** ☒ **No**	**OTHER REVISION(S):** ☒ **Yes** ☐ **No**
RESPONSIBLE PARTY: Chief Financial Officer	**CEO APPROVAL DATE:** 6/11/24 Megan Rooney, CEO	

APPLIES TO

NorthCare Network Personnel
NorthCare Paneled Providers
NorthCare Non-Paneled Providers

POLICY

It is the policy of NorthCare Network to maintain an efficient, consistent, systematic, and fair method of managing and resolving provider claims reconsiderations. This policy and procedure shall be maintained in compliance with the NorthCare Network MI Health Link contract with the Upper Peninsula Health Plan (UPHP).

PURPOSE

To establish an efficient, consistent, systematic, and fair method of managing and resolving provider claims reconsiderations. The following procedure shall be maintained in compliance with the NorthCare Network MI Health Link contract with the Integrated Care Organization (ICO) and their three-way contract with the Centers for Medicare & Medicaid Services (CMS) and the Michigan Department of Health and Human Services (MDHHS).

DEFINITIONS

1. **Administrative Law Judge hearing (ALJ):** Third level of the appeals process. Reviews a decision made by the IRE when the amount in controversy meets the appropriate threshold.

2. **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.

3. **Claims Reconsideration:** As defined in 42 C.F.R. 438.400(b). A request for review of the ICO or PIHP's decision that results in the denial, in whole or in part of payment for a properly authorized and covered service; Effective no later than January 1, 2018, a Medicaid-based Claims Reconsideration is defined as a review by the ICO of an Adverse Benefit Determination.

4. **Contract Provider:** A provider or supplier that has an executed contract to provide services and supplies to members of NorthCare Network.

5. **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.

6. **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.

7. **Integrated Care Organization (ICO):** The Upper Peninsula Health Plan is the only ICO for the Upper Peninsula.

8. **Independent Review Entity (IRE):** An independent entity contracted by Centers for Medicare Services (CMS) to review adverse level 1 appeal decisions made by the plan. Under Part C, an IRE can review plan dismissals.

9. **Independent Review Organization (IRO):** An independent organization contracted by NorthCare Network to review clinical appeal determinations.

10. **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.

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

12. **Non-Contracted Provider**: A provider or supplier that does not contract with NorthCare to provide services covered by NorthCare.

13. **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.
    - 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.

14. **Paneled Provider**: A provider who has been approved and enrolled with NorthCare Network.

15. **Party**: The person who is appealing such as Paneled Provider, Non-paneled provider, member, member representative/guardian. This may also be a billing

company on behalf of the Provider, herein included as “Provider.”

16. **Provider Claims Reconsideration:** A dispute of payment from NorthCare Network in which the member is not at financial risk.

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

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

19. **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 evidence of record.

20. **Representative**: Under Part C, as defined in §422.561, an individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in a claim’s reconsideration. Unless otherwise provided in the applicable law, the representative will have all the rights and responsibilities of an enrollee or other party, as applicable.

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

22. **Withdrawal:** A voluntary verbal or written request to rescind or cancel a pending claims reconsideration request submitted by the same party.

REFERENCES

- Medicareappeals.com: Part C Reconsideration Manual—Appendix v.50-October 2015 Final – Case File Data Form
- Medicare Managed Care Manual Chapter 13
- Medicare-Wavier of Liability (WOL) Form – N:\Forms & Templates
- UPHP MI Health Link Provider Claim Appeals Policy

HISTORY

NEW POLICY: 1/10/18
REVISION DATE: 11/26/18, 2/4/20, 12/1/20, 1/11/22, 8/2/22,5/24/24
REVIEW DATE: 11/26/18, 2/4/20, 12/1/20, 1/11/22, 8/2/22, 5/24/24
CEO APPROVAL DATE: 12/11/17, 12/4/18, 2/26/20, 1/5/21, 8/2/22, 6/11/24
BOARD APPROVAL DATE: 01/10/18

PROCEDURES

1. When a provider disagrees with an Organization Determination made by NorthCare Network regarding payment for a Medicare covered services, they may file a reconsideration request in writing to NorthCare Network within sixty calendar days of the remittance notification date. NorthCare may allow more time to file the reconsideration 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 human-caused 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 reconsideration 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 had expired.

2. NorthCare uses designated persons who were not involved in making 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.

3. To file a reconsideration, the Provider must have submitted a claim for the service and/or supply(ies) in question and have received a denial or reduction in payment from NorthCare Network. An inquiry is not subject to the reconsiderations process. The Provider wanting to file a formal administrative request for reconsideration may do so by sending to:

   NorthCare Network
   ATTN: Provider Network Management
   1230 Wilson Street
   Marquette, MI 49855
   or by faxing 906-232-1070

   All requests must be submitted within sixty calendar days of the remittance advice and include the following:
   - Member Name
   - Member identification number
   - Remittance notification showing the denial.
   - Signed Waiver of Liability Form (Non-paneled providers)
   - Supporting documentation such as proof of timely filing, medical records, reason for not obtaining authorization, or other information that supports the request for reconsideration or is pertinent to the reconsideration.
   - The name, address, and telephone number of the person responsible for filing the reconsideration.

4. Upon receiving a valid claim reconsideration, NorthCare will provide written acknowledgement of the request for reconsideration within five calendar days to the requesting party indicating that the request has been received. *See dismissals section regarding non-valid reconsiderations.*

5. The Provider will have the right to consideration by an authorized representative of the organization not involved in the initial decision that is the subject of the dispute.

6. NorthCare will issue its reconsidered determination in writing and send payment (if adverse determination is overturned) by mail no later than sixty calendar days from the date NorthCare received the request for payment reconsideration. For Medicare covered services, this is the final reconsideration process for NorthCare Network paneled providers.

Non-paneled Provider Reconsideration Process

1. If NorthCare Network upholds the denial of payment in whole or in part for Medicare covered services, NorthCare Network will notify the ICO within thirty calendar days of receiving the request for reconsideration and submit information as requested.

   The ICO will submit directly to the IRE (Independent Review Entity – Maximus Federal) within 60 days of the Provider's initial reconsideration request. 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 reconsideration 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 for the reconsideration. Hearing preparation procedures are set by the ALJ. NorthCare Network 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 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 hearing request to other parties, and the initiation of discovery if the Centers for Medicare and Medicaid (CMS) is a party. If the ALJ does not issue a decision within the applicable time limit, the provider may ask the ALJ to escalate the case to the Reconsiderations Appeals 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 Appeals Council 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 time limit may be extended for several 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 time limit, 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

Paneled Providers:

NorthCare may dismiss a reconsideration from a paneled provider if the Provider does not file the reconsideration within the established time limits and good cause for late filing has not been established or if there is no claim on file. NorthCare will send a notice informing Provider of the dismissal.

Paneled providers may withdraw their reconsideration request at any time before a reconsideration decision is mailed by NorthCare. NorthCare accepts withdrawal requests in writing or verbally. Verbal withdrawal requests will be documented in the NorthCare appeals module. Written withdrawal requests will be uploaded to the appeals module.

NorthCare's dismissal determination is final for contracted providers.

***Non-Paneled Providers*:**
NorthCare will dismiss a non-contract provider reconsideration under any of the following circumstances:

- NorthCare does not receive the signed Waiver of Liability form (WOL) from a non-paneled provider within 60 calendar days of NorthCare's receipt of reconsideration request. NorthCare will make at least three outreach attempts 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 time limits and good cause for late filing has not been established.
- The Provider filing the reconsideration request submits a timely request for withdrawal of the reconsideration with NorthCare.
    - The Party who files a reconsideration with NorthCare may withdraw the request in writing or verbally at any time before any reconsideration decision is mailed by NorthCare. For verbal requests, NorthCare 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 NorthCare system.

NorthCare will send the *Notice of Dismissal of Appeal Request* to the Party at the end of the applicable adjudication time limit. This notice will provide the:

- reason for the dismissal.
- right to request that NorthCare vacate the dismissal action.
- for appeals involving Medicare services the right to request review of the dismissal by the ICO/IRE.
- for appeals involving Medicaid services the right to request a state Fair Hearing to review the dismissal.

If good cause is established, NorthCare may vacate its dismissal of a reconsideration within 6 months from the date of the notice of dismissal.

NorthCare's dismissal is binding unless the member or Provider requests review by the ICO/IRE or state fair hearing, or if the decision is vacated by NorthCare. If the ICO/IRE/state fair hearing determines that NorthCare's dismissal was in error, vacates the dismissal and remands the case to NorthCare for reconsideration; the ICO/IRE/state fair hearing decision regarding the dismissal is binding and not subject to further review.