

**MEDICAL ASSOCIATES HEALTH PLANS
OPERATIONS POLICY AND PROCEDURES MANUAL**

POLICY NUMBER: 10B-2

POLICY TITLE: Appeal (Verbal) Procedures for Commercial Members - Wisconsin

POLICY STATEMENT: To assure a timely, efficient and consistent process for administering appeals from MAHP Members covered by Wisconsin-based employer group health plans.

PROCEDURE:

The following Procedure shall apply to **verbal** appeals of pre-service and post-service denials of coverage from Commercial Members in Wisconsin. If a Member files a **written appeal**, this is a “grievance” pursuant to Wisconsin law, and should be processed as set forth in Policy 10B: Grievance Procedures for Commercial Members – Wisconsin.

General Notes:

- All notifications to members will be in a cultural and linguistic appropriate manner.
- For concurrent care appeals, enrollees are allowed continued coverage under their medical benefit pending the outcome of the appeal.
- At any time in the appeal process, MAHP will inform the Member of his/her right to be represented by someone of his/her choosing and to communicate by conference call or other technology

*Wisconsin law does not set a time limit on a member’s right to request an appeal.

A. Pre-Service Appeal Process (Health Care Services):

“Pre-Service” means that receipt of the benefit, in whole or in part, is conditioned on approval in advance.

To file a request verbally, the member may contact the Health Care Services (HCS) Department directly. HCS will document the verbal request, as well as the substance of the appeal and actions taken. HCS also will investigate all aspects of clinical care involved.

The following information should be obtained:

- member name
- member number
- state
- group number
- authorization number
- date received
- who is filing appeal

MAHP will appoint a person (or persons) who did not participate in the initial decision to review the appeal request. The reviewer will be a board-certified physician (same or similar specialty who typically treats the condition, health problem or performs the procedure).

1. Non-urgent care:

If additional information is required to review the pre-service appeal, MAHP will notify the Member or Member’s authorized representative within **three (3) business days** of additional information required

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to evaluate the appeal (Attachment D). All non-urgent care appeals need to be completed within 30 calendar days of receipt of the appeal.

2. Expedited/Urgent:

In the event a Member's health, life or ability to regain maximum function may be jeopardized as the result of a denial of care or care issues, the Member may request an expedited/urgent pre-service appeal.

MAHP will review this request and make a determination whether the request for appeal should be administered according to the pre-service or expedited/urgent pre-service appeal process. MAHP will resolve the expedited/urgent pre-service appeal within **72 hours**. Information pertaining to an expedited/urgent pre-service appeal may be requested in writing or via phone and can include part or all of the medical records or statement from the attending practitioner. If an expedited/urgent pre-service appeal request involves a concurrent review determination, the service must be continued without liability to the Member until the Member is notified of the decision, unless it is related to an initial unauthorized admission.

Letters documenting MAHP's response to a non-urgent pre-service or expedited/urgent pre-service appeal will be sent via certified mail to the Member or Member's authorized representative by Member Services/HCS Department (Attachment A). The letter will include clear, detailed reasons for the determination, the medical or clinical criteria for the determination, the name of the medical experts who reviewed the case and information regarding the Member's right to a grievance (expedited or non-expedited).

If the pre-service appeal decision is a fully favorable decision (reversed), letters documenting MAHP's response will be sent to the Member or Member's authorized representative by the HCS Department (Attachment B).

When the appeal is complete, the HCS Intake Specialist will document the information in the appeals Excel spreadsheet @ H:\Appeals\2019 Appeals.xlsx (see MAHP Administrative Policy, Appeal/Grievance Tracking Procedures).

B. Post-Service Appeal Process (Health Care Services and Member Services):

"Post-Service" is defined as all claims that are not pre-service claims. Care has already been received.

To file a request verbally, the Member may contact Member Services or HCS Department directly. The department taking the call will document the verbal request, the substance of the appeal, and the actions taken. This information is entered into the appeals Excel spreadsheet.

- When an oral appeal is received by MAHP, the staff member receiving the appeal shall gather documentation regarding the appeal (see MAHP Administrative Policy, Appeal/Grievance Tracking). The following information should be obtained:
 - member name
 - member number
 - state
 - employer group
 - group number
 - authorization number
 - date received

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- who is filing appeal
- If Member Services receives a post-service appeal, Member Services staff will gather the information and follow the process unless it pertains to medical necessity in which HCS staff will guide and assist them through the appeal process.
- If additional information is required to review the post-service appeal, MAHP will notify the Member or Member’s authorized representative within **three (3) business days** of additional information required to evaluate the appeal (Attachment D).

Post-service appeals need to be completed no later than **60 calendar days** once all of the information is provided.

Letters documenting MAHP’s response to a post-service appeal will be sent via certified mail to the Member or Member’s authorized representative by Member Services/HCS Department (Attachment A). The letter will include clear detailed reasons for the determination, the medical or clinical criteria for the determination, the name of the medical experts who reviewed the case, and information regarding the Member’s right to a grievance (expedited or non-expedited).

If the post-service appeal decision is a fully favorable decision (reversed), letters documenting MAHP’s response will be sent to the Member or Member’s authorized representative by the HCS Department (Attachment B).

When the appeal is completed, the HCS Intake Specialist/Member Services Department staff will document the information in the appeals Excel spreadsheet @ H:\Appeals\2019 Appeals.xlsx.

Attachments

- A. 1st Letter Appeal Decision Upheld Wisconsin
- B. 1st Letter Appeal Decision Reversal Wisconsin
- C. Wisconsin Appeal Extension Letter
- D. Wisconsin Request for Additional Information

Barb Koerperich, MSN
Director of Quality and Health Care Services

Date

Karen Hoffmann
Director of Operations

Date

Original Effective Date: 06/95
Revised Date(s): 02/96, 02/97, 08/97, 08/98, 01/99, 04/99, 08/99, 10/99, 04/00, 04/01, 07/01, 01/02, 02/02, 05/02, 06/02, 12/02, 02/03, 01/03, 04/04, 01/05, 03/05, 05/06, 02/07, 01/08, 05/08, 02/09, 11/09, 04/10, 02/11, 07/12, 04/13, 04/14, 04/15, 05/16, 05/17, 5/18, 4/19, 3/20

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Date

Attachment A

**1st Level Appeal Decision Upheld Wisconsin
(Send Letter Certified Mail)**

Subscriber

Address

City, State, Zip

Dear Subscriber:

On (date), Medical Associates Health Plans (MAHP) received a verbal appeal from (member or member's representative) regarding the denial of coverage for (service) for (member) on (date). This letter is to notify you that your appeal has been reviewed by (Dr. Name), a Board-Certified Physician (list specialty or title of reviewer), who was not involved in the initial decision. After reviewing the request and all other pertinent information, the original denial has been upheld. It has been determined that (Service) is not a covered benefit. Any claims submitted to MAHP will not be paid.

According to your Subscriber Agreement ...

Upon request, you are entitled to receive copies and reasonable access to all documents relevant to your appeal. These are documents or records used when making the appeal decision. Upon request, you may also obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.

If you believe your appeal decision is not consistent with your benefits, as described in your Subscriber Agreement, you have the right to file a grievance. Your request for a grievance must be sent in writing to Medical Associates Health Plans. If you have any questions regarding the grievance process, please contact our Health Care Services Department at (563) 584-3275 or 1-800-325-7442, or by writing to:

Medical Associates Health Plans
Attn: Health Care Services
1605 Associates Drive, Suite 101
Dubuque, IA 52002

A committee of representatives who were not involved in the appeal decision will review your grievance. You have the right to appear before the grievance committee. You also have the right to communicate with the grievance committee by conference call or other appropriate technology. You may also have a practitioner or authorized representative(s) act on your behalf.

When we receive your grievance request, a meeting of the Grievance Committee of Medical Associates Health Plans will convene and render a decision within 30 calendar days. If you feel that your health, life, or ability to regain maximum function may be seriously harmed by waiting for the Grievance Committee to convene, you may request an expedited grievance. We will have a decision within 72 hours for expedited grievances.

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Name
Date
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You may also be entitled to an Independent External Review. Please contact Member Services at (563) 584-4885 or 1-866-821-1365 to request an external review, or if you have any questions regarding the external review process or other matters in this letter.

If your treating physician would like to discuss this case with a physician reviewer, please call Health Care Services at (563) 584-3275 or 1-800-325-7442.

Sincerely,

(Member Services Name or
HCS Case Manager Name and title)

CC:

Medical Associates Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-821-1365 (TTY: 1-800-735-2942).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-821-1365 (TTY: 1-800-735-2942)

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**Attachment B
1st Level Appeal Decision Reversal Wisconsin
(Send Letter Certified Mail)**

Name

Address

City, State, Zip

Dear Subscriber:

On <DATE>, Medical Associates Health Plans (MAHP) received a verbal appeal to reconsider coverage for <service> under the direction of <physician name> on <date>. The request for reconsideration has been reviewed by a Board Certified Physician in the department of <department name> who was not involved in the initial decision.

After reviewing the facts of your case, the original decision to deny <coverage and/or payment> has been reversed. Coverage for <service> will be processed and paid according to the benefits and limitations of your contract and subject to any applicable copayments.

Any additional care will need prior approval of the Medical Director. If you need any assistance, please call Health Care Services at (563) 584-3275 or 1-800-325-7442.

This letter is being sent as part of the appeal follow-up required of Medical Associates Health Plans. On (date) you were notified by phone of this decision. Please contact Health Care Services with any additional questions.

Sincerely,

(HCS Staff name and title)

CC:

Medical Associates Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-821-1365 (TTY: 1-800-735-2942)

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**Attachment C
Wisconsin Appeal Extension Letter**

Name
Address
City, State, ZIP

Dear Subscriber:

Medical Associates Health Plans is in the process of reviewing your appeal, but is in need of additional information. Therefore, we need to inform you that a 15-day extension is necessary for the resolution of your appeal. We apologize for the delay.

In order to proceed with your appeal, please provide the additional information necessary to resolve your appeal as soon as possible. If you have any questions, feel free to contact the Health Care Services Department at (563) 584-3275 or 1-800-325-7442.

Sincerely,

(Member Services Staff name or
HCS Case Manager Name and title)

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-821-1365 (TTY: 1-800-735-2942).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-821-1365 (TTY: 1-800-735-2942)

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Date

**Attachment D
Wisconsin Request for
Additional Information**

Subscriber Name

Address

City/State/Zip

Dear Subscriber:

On (*Date*), a verbal request for an appeal was received by Medical Associates Health Plans (MAHP) from (*member or member's representative*) regarding the denial of coverage for (*member*) for (*Service*) on (*Date*). This letter is to notify you that additional information is required to evaluate your appeal. We have requested additional information from (*provider/facility*) on (*date*). You may wish to contact (*provider/facility*) on the status of this request.

For Pre-Service Claims: You will have 45 days from the receipt of the request for additional information to provide MAHP with the information requested. MAHP will then make a decision on your appeal within 30 calendar days after all of the information has been provided. **OR**

For Post-Service Claims: You will have 45 days from the receipt of the request for additional information to provide MAHP with the information requested. MAHP will then make a decision on your appeal within 60 calendar days after all of the information has been provided.

If you have any questions, please call Member Services at (563) 584-4885 or 1-866-821-1365.

Sincerely,

(Member Services Staff name or
HCS Case Manager Name and title)

CC.

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LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-821-1365 (TTY: 1-800-735-2942)