

## MEDICAL ASSOCIATES HEALTH PLANS OPERATIONS POLICY AND PROCEDURES MANUAL

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**POLICY NUMBER:** 10C4

**POLICY TITLE:** Medicare Standard Appeal for Post Service Requests (Claims Appeals)

**POLICY STATEMENT:** To establish and provide a consistent and timely process by which Medical Associates Health Plans (MAHP) responds to Medicare enrollee requests for reconsideration of adverse post service organization determinations of denial of payments for services

MAHP provides its enrollees with reasonable assistance in completing forms when an appeal request is received. This includes, but is not limited to, a toll-free number with TTY capability and interpreter capability. All notifications to enrollees will be in a cultural and linguistic appropriate manner.

MAHP adheres to the guidance set forth in the CMS's Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance (August 2022).

MAHP provides written information to enrollees or their representatives about appeal procedures including the right to a standard review, at initial enrollment, upon notification of an adverse pre-service request, upon notification of a service or coverage termination (e.g. hospital, CORF, HHA, or SNF settings), and annually thereafter.

MAHP identifies the following as parties with an appealable interest:

- Enrollee, including appointed representatives (Appointment of a Representative Form will be obtained if necessary. Refer to MAHP Operations Policy and Procedure: Medicare Appointment of Representative);
- an assignee of the enrollee (i.e. a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);
- the legal representative of a deceased enrollee's estate; or
- any other provider or entity (other than MAHP) determined to have an appealable interest in the proceeding

For the purposes of this Policy and Procedure, an appeal is considered the same as a reconsideration, a post service request is considered an organization determination (claims payment), an enrollee is considered a member and a physician may include practitioner/provider.

MAHP can accept standard appeals 24 hours a day, 7 days a week (including holidays) by mail/delivery service, fax, or MAHP secure member portal.

MAHP documents all claims appeal requests in the Appeal excel spreadsheet found at H:\Appeals\ (Year) Appeals.

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

---

MAHP conducts ad hoc training to the Member Services Dept., Health Care Services Dept. and applicable Managers/staff with regard to identifying inquiries versus grievances and annually review the CMS Web-Based Training Course entitled Part C Organization Determinations, Appeals & Grievances available via the Medicare Learning Network.

### **PROCEDURE:**

Standard post service appeal requests must be filed within 60 calendar days from the date of the notice of the initial determination (denial) and must be submitted in writing.

The appeal request is made directly to MAHP and can be requested by:

- the enrollee;
- the enrollee's representative;
- non-contract provider;
- the legal representative of a deceased enrollee's estate: or
- any other provider or entity (other than the MAHP) determined to have an appealable interest in the proceeding.

Written appeal requests should include enrollee name, information identifying which denial is being appealed and contact information for the appellant. The processing timeframe begins when MAHP receives the request. If the appeal is received after 60 days, MAHP will process according to good cause exception for late filing (Refer to MAHP Operations PP 60: Medicare Good Cause Exceptions for Late Filing).

When a non-contract provider files a post service appeal request, he/she must also submit a completed Waiver of Liability (WOL) statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal.

If the WOL is not filed with the appeal, MAHP will make and document reasonable efforts to obtain the WOL. (Refer to MAHP Operations PP 63: Outreach Process).

MAHP will not issue a decision without the required WOL, however, MAHP may begin the review while continuing efforts to obtain a WOL. The 60-day timeframe begins when MAHP receives the completed WOL. If MAHP does not receive the WOL by the end of the 60-day review timeframe, MAHP will issue a dismissal notice.

MAHP does accept electronic signatures on WOL documentation when submitted through MAHP's secure portal.

MAHP requires all standard post service appeal requests to be made in writing. Standard post service appeals will be reviewed and responded to no later than 60 calendar days from the date MAHP receives the appeal. For timeframe tracking purposes, day one is the day after MAHP receives the request.

When MAHP does not have complete documentation for a standard post service appeal request, reasonable and diligent efforts are made to obtain the necessary documentation. Additional information may be submitted in person or in writing. If all of the relevant documentation cannot be obtained, MAHP makes the decision based on the material available.

## MEDICAL ASSOCIATES HEALTH PLANS OPERATIONS POLICY AND PROCEDURES MANUAL

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MAHP ensures that the person reviewing the standard post service appeal was not involved in making the initial organization determination. If the original post service denial was based on a lack of medical necessity or involved medical judgment, the appeal is performed by a physician with expertise in the field of medicine that is appropriate for the item, service, or drug in question. The physician performing the appeal review will apply the prudent layperson standard in cases involving emergency and urgently needed services.

Upon review of a post service appeal, MAHP makes its reconsidered decision and provides written notification to the enrollee/the enrollee's representative, non-contract provider, legal representative or any provider or entity determined to have an appealable interest within the required timeframes.

If MAHP completely reverses the initial adverse organization determination, MAHP will authorize or provide the service in dispute no later than 60 calendar days from the date appeal request was received by MAHP.

MAHP will send written notification within 3 days of standard appeal approval to the enrollee/the enrollee's representative, non-contract provider, legal representative or any provider or entity determined to have an appealable interest in the proceeding indicating the conditions of the approval which will include the duration of the approval and any limitations associated with the approval.

If MAHP affirms in whole or in part the initial adverse organization determination, MAHP will provide a written notification to the enrollee/the enrollee's representative, non-contract provider, legal representative or any provider or entity determined to have an appealable interest to include:

- a. the principal reasons to uphold the determination;
- b. a statement of clinical rationale used in the decision-making will be provided upon request;
- c. a statement that the case has been forwarded to the IRE;
- d. information advising the enrollee of his/her right to submit additional evidence that may be pertinent to the enrollee's case, if the enrollee chooses;
- e. directions for the enrollee to submit such evidence to the IRE; and
- f. information on how to contact the IRE.

MAHP sends the complete case file to the IRE no later than 60 calendar days from the date MAHP receives the appeal and includes a written explanation of its reconsidered determination.

If MAHP fails to provide the enrollee with an appeal decision within the specified time frames, the failure constitutes an adverse decision and MAHP must submit the complete file to the IRE.

If MAHP makes a fully favorable decision on a standard appeal less than 24 hours after the end of the adjudication timeframe, MAHP will effectuate the decision and notify the enrollee of the favorable appeal decision in lieu of forwarding the appeal to the IRE.

A standard post service appeal request may be withdrawn or dismissed accordingly. Refer to MAHP Operations PP 61: Medicare Dismissals and Withdrawals.

## MEDICAL ASSOCIATES HEALTH PLANS OPERATIONS POLICY AND PROCEDURES MANUAL

---

### Submission of Standard Appeal to Independent Review Entity (IRE)

MAHP will submit a complete case file with a written explanation of MAHP's decision to the IRE within 60 calendar days of receipt of the appeal request. The IRE will notify the enrollee of forwarded standard post service appeal.

MAHP will prepare and submit electronically via the secure portal the appeal case file to the IRE according to the Maximus Federal Process Manual. [H:\Admin\MEDICARE\2022\Appeals and Grievances\New-Manual-November-2022\\_FINAL002.pdf](H:\Admin\MEDICARE\2022\Appeals and Grievances\New-Manual-November-2022_FINAL002.pdf) and may include a cover letter and MAHP case narrative form.

IRE standard post appeals are conducted within 60 calendar days of receipt. The IRE is responsible for notifying all the parties of the reconsidered determination and for sending a copy of the reconsidered determination to the CMS Regional Office.

If the IRE reverses in whole or in part of MAHP's appeal decision, MAHP will reprocess the claim no later than 60 calendar days from after the date MAHP receives notice that the IRE reversed the determination. The Maximus Statement of Compliance form is completed and submitted to document effectuation of the IRE decision.

If the IRE affirms the appeal of the denial of post service items and benefits, then enrollee may have additional rights through an ALJ hearing, a MAC review and Judicial Review.

### General Information

MAHP, upon the enrollee's request, provides the enrollee with timely access to his/her case file and a copy of the contents of the case file, including but not limited to, a copy of supporting medical records and other pertinent information used to support the decision subject to federal and state law regarding confidentiality of patient information.

MAHP has the right to charge the enrollee a reasonable amount for duplicating the case file material. MAHP informs the enrollee of the per-page duplicating cost and provide an estimate of the cost for duplicating the case file material. Enrollees may also be charged for the cost of mailing the material to a specified address. Enrollees are not charged for additional costs for courier delivery of the material to a plan location that is over and above the cost of mailing the material to the enrollee.

MAHP does not take punitive action against a provider who requests an alternative resolution or supports an enrollee's appeal, including a request for a standard appeal.

MAHP does not take punitive action against an enrollee or enrollee's representative, who requests an alternative resolution, including a request for a standard appeal. Filing a standard appeal regardless of the outcome, does not affect an enrollee's membership or continued coverage with MAHP.

MAHP receives, responds to, reviews, investigates, resolves, documents, tracks, and reports appeals requested from enrollees or their authorized representative through MAHP's governance structure and to CMS in accordance with regulatory requirements.

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

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MAHP evaluates appeal trends and completes analyses to identify opportunities for improvement.

MAHP maintains appeal log and files for ten years following the resolution of the appeal files. MAHP's policies and procedures pertaining to appeals are available, upon request, to any enrollee, provider, or facility rendering service.

Appeal files include:

1. The name of the enrollee, provider, and/or facility rendering the service;
2. The original appeal determination documentation;
3. Dates of appeal reviews, documentation of actions taken, and final resolution;
4. Copies of MAHP correspondence as well as that from the enrollee, provider, or facility rendering the service;
5. Minutes or transcripts of appeal proceedings; and
6. The name and credentials of the Physician Reviewer.

**Attachments:**

Standard Claim Appeal Upheld Letter  
Standard Claim Appeal Reversed Letter  
Missed Appeal Filing Deadline Letter  
MAHP Medicare Maximus Letter  
CMS Organization Determination/Appeals Process Flowchart

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Barb Koerperich, MSN  
Director of Quality and Health Care Services

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Date

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Karen Hoffmann  
Director of Operations

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Date

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Elizabeth Heying  
Compliance Manager

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Date

Original Effective Date: 03/10

Revised Date(s): 04/10, Moved to Operations Manual – 07/11, 11/11, 03/14, 09/14, 04/15, 05/16, 5/18, 4/19, 07/19, 05/20, 2/21, 2/22, 2/23.

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

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**REQUIRED DISTRIBUTION LIST**

- |  |  |   |
|--|--|---|
| <input checked="" type="checkbox"/> Administration | <input type="checkbox"/> EDI                             | <input checked="" type="checkbox"/> Member Services |
| <input checked="" type="checkbox"/> Claims         | <input type="checkbox"/> Facilities                      | <input type="checkbox"/> Provider Relations         |
| <input type="checkbox"/> Commercial Sales          | <input type="checkbox"/> Finance                         | <input type="checkbox"/> Physicians/Practitioner    |
| <input checked="" type="checkbox"/> Compliance     | <input checked="" type="checkbox"/> Health Care Services | <input type="checkbox"/> Pharmacy                   |
| <input type="checkbox"/> Configuration             | <input type="checkbox"/> Marketing                       | <input type="checkbox"/> Quality Improvement        |
| <input type="checkbox"/> Credentialing             | <input checked="" type="checkbox"/> Medicare Compliance  |   |

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

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<DATE>

<MEMBER NAME>

**STANDARD CLAIM APPEAL REVERSED**

<MEMBER ADDRESS>

<MEMBER ADDRESS>

Dear < MEMBER NAME>:

<Member Number>

On <DATE>, Medical Associates Health Plans (MAHP) received a written appeal to reconsider payment for a claim(s) with the date of service of <MM/DD/YYYY>. Your request for reconsideration has been reviewed.

After reviewing the facts of your case, the original decision to deny payment has been reversed. Your claim(s) will be reprocessed and paid according to the benefits and limitations of your Evidence of Coverage and subject to any applicable copayments.

If you have any questions, please contact the Member Services Dept. at 1-866-821-1365, 8:00 am to 8:00 pm, 7 days a week. TTY users should call 1-800-735-2942.

MAHP is a Cost Plan with a Medicare Contract. Enrollment in MAHP depends on contract renewal.

Sincerely,

<MAHP Employee Name, Title>

Y0045\_MAHP 1277 NM

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

---

MAHP complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Language assistance services are available free of charge. Call 1-866-821-1365 (TTY: 1-800-735-2942).

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

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-821-1365 (TTY: 1-800-735-2942)。

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 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).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-821-1365 (TTY: 1-800-735-2942).



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OPERATIONS POLICY AND PROCEDURES MANUAL**

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

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<DATE>

<MEMBER NAME>

**MISSED APPEAL FILING DEADLINE**

<MEMBER ADDRESS>

<MEMBER ADDRESS>

Dear < MEMBER NAME>:

On <DATE>, Medical Associates Health Plans (MAHP) received an appeal request. This letter is to inform you that you must file a request for reconsideration within 60 calendar days from the date MAHP notified you of non-coverage or denial. Your appeal request was received beyond the 60th day and therefore, will not be reviewed due to the missed filing deadline.

You may still request an extension of the timeframe for filing an appeal. The request must be in writing and should include the reason(s) why the appeal request was not submitted within the required timeframe. MAHP will review the extension request and may approve the request if there is good cause.

If you have any questions, please call us at 563-584-4885 or 1-866-821-1365, 7 days a week, 8:00 am to 8:00 pm, CST. TTY users please call 1-800-735-2942.

You may call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, including weekends, for help or more information about the appeals process. TTY users should call 1-877-486-2048.

MAHP is a Cost Plan with a Medicare Contract. Enrollment in MAHP depends on contract renewal.

Sincerely,

<MAHP Employee Name, Title>

<cc: Physician/Provider>

Y0045\_MAHP 1178 NM

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

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OPERATIONS POLICY AND PROCEDURES MANUAL**

---

**Maximus Checklist – would this form  
used for claims appeals?  
Referencing Case Manager and  
secretary – which Member Services  
wouldn't necessarily use?**

Please initial that each component of  
the Maximus request is present and  
ready to be submitted.

Enrollee Name Member Number Enrollee MBI	Case Manager	Secretary
	_____	_____
1. Medicare Maximus Letter	_____	_____
2. Reconsideration Background Data Form	_____	_____
3. Case narrative	_____	_____
4. Organization Determination and Reconsideration Process Notices	_____	_____
5. Records of Adverse Determination	_____	_____
6. MCO Decision Making Criteria		
7. Medical Records (if applicable)		

**CASE MANAGER**

**SECRETARY**

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

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

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<DATE>

**MEDICARE MAXIMUS LETTER**

<IRE Name>  
<IRE Address>  
<IRE Address>

**Enrollee Name:**  
**Member #:**  
**MBI #:**

To Whom It May Concern:

We would like to clarify that Medical Associates Health Plans (MAHP) has a Cost Contract with CMS.

This appeal has been reviewed and denied because <Reason, i.e. contract language, Medicare criteria, etc.>.

We have divided the information into sections to enable you to better follow the events of this case:

(EXAMPLE)

The Reconsideration Background Data Form  
Case Narrative Section  
Initial Denial<letter/EOB> to Enrollee  
Appeal Notification letter to Enrollee  
<MAHP Health Care Services documentation of case review Medical Records>  
Evidence of Coverage

If any further information is needed, please contact me at (563)-<XXX-XXXX> or <1-8XX-XXX-XXXX.>

Sincerely,

<MAHP Employee Name>

# MEDICAL ASSOCIATES HEALTH PLANS OPERATIONS POLICY AND PROCEDURES MANUAL

## Medicare Managed Care (Part C - Medicare Advantage)

