

MEDICAL ASSOCIATES HEALTH PLANS OPERATIONS POLICY AND PROCEDURES MANUAL

POLICY NUMBER: 10C3

POLICY TITLE: Medicare Expedited Appeal for Pre-Service Requests

POLICY STATEMENT: To establish and provide a consistent and timely process by which Medical Associates Health Plans (MAHP) responds to Medicare enrollee requests for an expedited appeal of adverse organization determinations, which include pre-service items or benefits, Part B drugs and concurrent review

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 (January 2020).

MAHP provides written information to enrollees or their representatives about appeal procedures including the right to an expedited 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 PP 62: 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

An expedited appeal determination may be requested in situations where application of the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, including cases in which MAHP makes a less than fully favorable decision to the enrollee.

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

MAHP can accept expedited appeals 24 hours a day, 7 days a week (including holidays) by telephone (including voicemail), mail/delivery service, fax, or MAHP secure member portal. Expedited requests will be documented with date and time received.

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

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PROCEDURE:

An oral or written expedited appeal must be filed within 60 calendar days from the date of the notice of the initial determination. The appeal request is made directly to MAHP and can be requested by:

- the enrollee;
- the enrollee's representative;
- any physician or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider) acting on behalf of the enrollee. MAHP considers a provider to be doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services.

All verbal expedited appeal requests will be summarized back to the person making the appeal and documented to ensure accurate understanding of the appeal.

Written expedited appeal requests should include enrollee name, information identifying which denial is being appealed and contact information for the appellant. The processing timeframe begins when the appropriate MAHP Dept. receives the expedited appeal 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).

Upon review of an expedited appeal request, MAHP must promptly decide whether to approve the request or to deny the request and follow the standard appeals time frame.

If MAHP **denies** an expedited appeal request, prompt oral notification is given to enrollee and written notification is mailed within 3 calendar days from oral notification which will:

- a. provide an explanation that MAHP is automatically transferring and processing the expedited appeal request using standard time frame for standard appeal requests;
- b. inform the enrollee of the right to file an expedited grievance, to include instructions and timeframes, if he/she disagrees with MAHP's decision not to expedite the appeal. (Refer to MAHP Operations PP 9A: Medicare Standard and Expedited Grievances (Complaints));
- c. inform the enrollee of the right to resubmit an expedited appeal request with a physician, prescribing physician, or other prescriber's support, including that if the enrollee gets the physician/prescriber support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, the request will be expedited automatically.

When an enrollee's request is not supported by a physician, MAHP determines whether the life or health of the enrollee, or the enrollee's ability to regain maximum function, could be seriously jeopardized by applying the standard time frame in the processing of the appeal request. A practitioner will review and determine whether or not the request meets the criteria for an expedited appeal.

If MAHP **approves** an expedited appeal request, MAHP provides the parties to the expedited appeal request reasonable opportunity to present evidence and allegations of fact or law related to the issues in dispute. The parties to an expedited appeal may present evidence in

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person or in writing. The enrollee is not required to submit additional evidence. MAHP takes the evidence into account when making an expedited appeal decision.

Expedited appeal requests are forwarded to a Physician/Practitioner for review and determination who was not part of the initial adverse determination. When initial adverse determination was denied based on a lack of medical necessity, the appeal must be performed by a physician with expertise in the field of medicine that is appropriate for the services at issue but need not be of the same specialty or subspecialty as the treating physician, but must have the appropriate level of training to evaluate the necessity of the service. The physician performing the appeal review will apply the prudent layperson standard in cases involving emergency and urgently needed services.

Expedited appeal requests for items and services and Part B drugs will be reviewed and responded to no later than 72 hours from when the appropriate MAHP Department receives the appeal. For timeframe tracking purposes, day one is the day after MAHP receives the request.

MAHP may extend the time frame by up to 14 additional calendar days on an expedited pre-service and benefit appeal if:

- the enrollee requests the extension;
- the extension is justified and in the enrollee's interest due to the need for additional medical evidence from a non-contract provider that may change MAHP's decision to uphold the denial of an item or service; or
- the extension is in the enrollee's best interest due to extraordinary, exigent, or other non-routine circumstances, such as a natural disaster.

MAHP cannot take an extension on Part B drug appeals.

When MAHP extends the time frame, the enrollee is notified in writing for the reasons for the delay, and informs the enrollee of the right to file an expedited grievance if he/she disagrees with MAHP's decision to grant itself an extension. When extensions are used, MAHP issues and effectuates its determinations as expeditiously as the enrollee's health condition requires, but no later than upon the expiration date of the extension.

When MAHP does not have complete documentation to review an expedited pre-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 MAHP needs information from a non-contract provider, MAHP will request the necessary information from the non-contract provider within 24 hours of the initial request for an expedited appeal. If all of the relevant documentation cannot be obtained, MAHP makes the decision based on the material available within the required timeframes.

Upon review of an expedited pre-service appeal, MAHP makes its reconsidered decision and provides written notification to the enrollee and the attending physician, and any health care provider or facility rendering the service as expeditiously as the enrollee's health condition requires within the required timeframes.

If MAHP completely reverses the initial adverse organization determination, MAHP will authorize or provide the service in dispute as expeditiously as the enrollee's health condition

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requires, but no later than 72 hours for items and benefits (or no later than upon expiration of an extension) and no later than 72 hours for Part B drugs.

MAHP will provide verbal notification to the enrollee and follow up with written notification within 3 days of the verbal notification to the enrollee, the enrollee's representative or requesting physician 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 forward the complete case to the IRE. Included in the case file:

1. The principal reasons to uphold the determination;
2. A statement of clinical rationale used in the decision-making will be provided upon request
3. All records reviewed in the case 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 an expedited 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.

An expedited pre-service appeal request may be withdrawn or dismissed accordingly. Refer to MAHP Operations PP 61: Dismissals and Withdrawals.

Submission of Expedited 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 24 hours of the expedited appeal decision. The IRE will notify the enrollee of forwarded expedited 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\2019\Appeals Grievances\Maximus Part C Reconsideration Manual_April 2018.pdf and may include a cover letter and MAHP case narrative form.

IRE expedited appeals are conducted as expeditiously as the enrollee's health condition requires and within 72 hours for pre-service items and benefits. 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 authorizes or provides the service in dispute as expeditiously as the enrollee's health condition requires, but no later than 72 hours from after the date it 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 pre-service items and benefits, then enrollee may have additional rights through an ALJ hearing, a MAC review and Judicial Review.

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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 an expedited 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 affective 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.

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:

Expedited Appeal Pre-Service Upheld Letter
Expedited Appeal Pre-Service Reversed Letter
Expedited Appeal Pre-Service Request Denied Letter

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Missed Appeal Filing Deadline Letter
Pre-Service Appeal Extension Letter
MAHP Case Narrative Forms
MAHP Medicare Maximus Letter
CMS Organization Determination/Appeals Process Flowchart
Preservice Expedited Appeals Flowchart

Barb Koerperich, MSN
Director of Quality and Health Care Services

Date

Karen Hoffmann
Director of Operations

Date

Elizabeth Heying
Compliance Manager

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, 7/19, 05/20, 5/21

REQUIRED DISTRIBUTION LIST

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**MEDICAL ASSOCIATES HEALTH PLANS
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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).

**MEDICAL ASSOCIATES HEALTH PLANS
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<DATE>

EXPEDITED PRE-SERVICE APPEAL REVERSED

<MEMBER NAME>

<MEMBER ADDRESS>

<MEMBER ADDRESS>

Dear < MEMBER NAME>:

<Member Number>

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

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

Any additional care from this provider for this service will need prior approval of the Medical Director. 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.

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 1176 NM

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<DATE>

<MEMBER NAME>
<MEMBER ADDRESS>
<MEMBER ADDRESS>

MISSED APPEAL FILING DEADLINE

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 contact the Member Services Dept. at 1-866-821-1365, 8:00 am to 8:00 pm, 7 days a week, CST. TTY users should 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

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<DATE>

<MEMBER NAME>

PRE-SERVICE APPEAL EXTENSION REQUEST

<MEMBER ADDRESS>

<MEMBER ADDRESS>

<Member Number>

Dear < MEMBER NAME>:

On <DATE>, Medical Associates Health Plans (MAHP) received a written appeal to reconsider coverage for <service> under the direction of <physician name> on <date>.

This letter is to notify you that MAHP is requesting up to 14 additional days to review your <appeal >, due to <brief explanation>.

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.

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Sincerely,

<MAHP Employee Name, Title>

Y0045_MAHP 1179 NM

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**MAHP CASE NARRATIVE NOTES
MEDICARE
ISSUES – DENIALS - APPEALS**

Enrollee Name: _____ Authorization #: _____

Member #: _____ MBI #: _____

Case Manager: _____ Contract: _____

Date Request Received: _____ Time: _____ Verbal / Written (circle)

Summary of question/issue:

Nurse Case Manager

Date

CMO/Physician Reviewer Decision:

Signature _____ Date _____ Time: _____

Member/Practitioner Informed of Decision/Denial/Redirect:

Verbal _____ Date: _____ Time: _____ Written Date: _____ Time: _____

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Appeal / Appeal Request Received:

Date: _____ Time: _____ Verbal: _____ Written: _____

Verbal Acknowledgement letter sent: Date _____

Expedited _____ (IA/WI 72 hours) _____ (IL 24 hours) Standard _____ (14 days)

Original decision maker: _____

Entered into appeals log: _____

Person appointed to review 1st level: _____

Copy of notes, emails pertaining to denial/redirect, supporting documents, letters with member's rationale, copy of denial letter.

Date above documents forwarded to decision maker: _____

1st Level Decision:

Signature _____ Date _____ Time: _____

Date Member Notified: Verbal _____ Written _____ Time: _____

Decision 100% Favorable to Member Yes _____ No _____

IF NO

MAXIMUS Federal Services Form Completed: _____

Date Sent to MAXIMUS: _____ Time: _____

(Send letters Certified/Keep copies)

MAXIMUS Federal Services Decision

Received on Date: _____ Time: _____ Upheld _____ Reversed _____

If Reversed: _____ Entered into Amisys

_____ Claims Notified

_____ Member Notified

MAXIMUS Statement of Compliance Form Completed

Date: _____

**MEDICAL ASSOCIATES HEALTH PLANS
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Enrollee Name:
Member #:
MBI #:

I CASE SUMMARY

II CHRONOLOGY OF CARE

III ENROLLEE'S ARGUMENTS FOR COVERAGE

IV MCO RATIONAL FOR SERVICE OR CLAIM DENIAL

IV.A Summary Statement of Reason for Denial

IV.B Justification

UPDATE

**MEDICAL ASSOCIATES HEALTH PLANS
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Maximus Checklist

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
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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
Case Narrative Section
Initial Denial letter to Enrollee
Appeal Notification letter to Enrollee
MAHP Health Care Services documentation of case review Medical Records
Evidence of Coverage

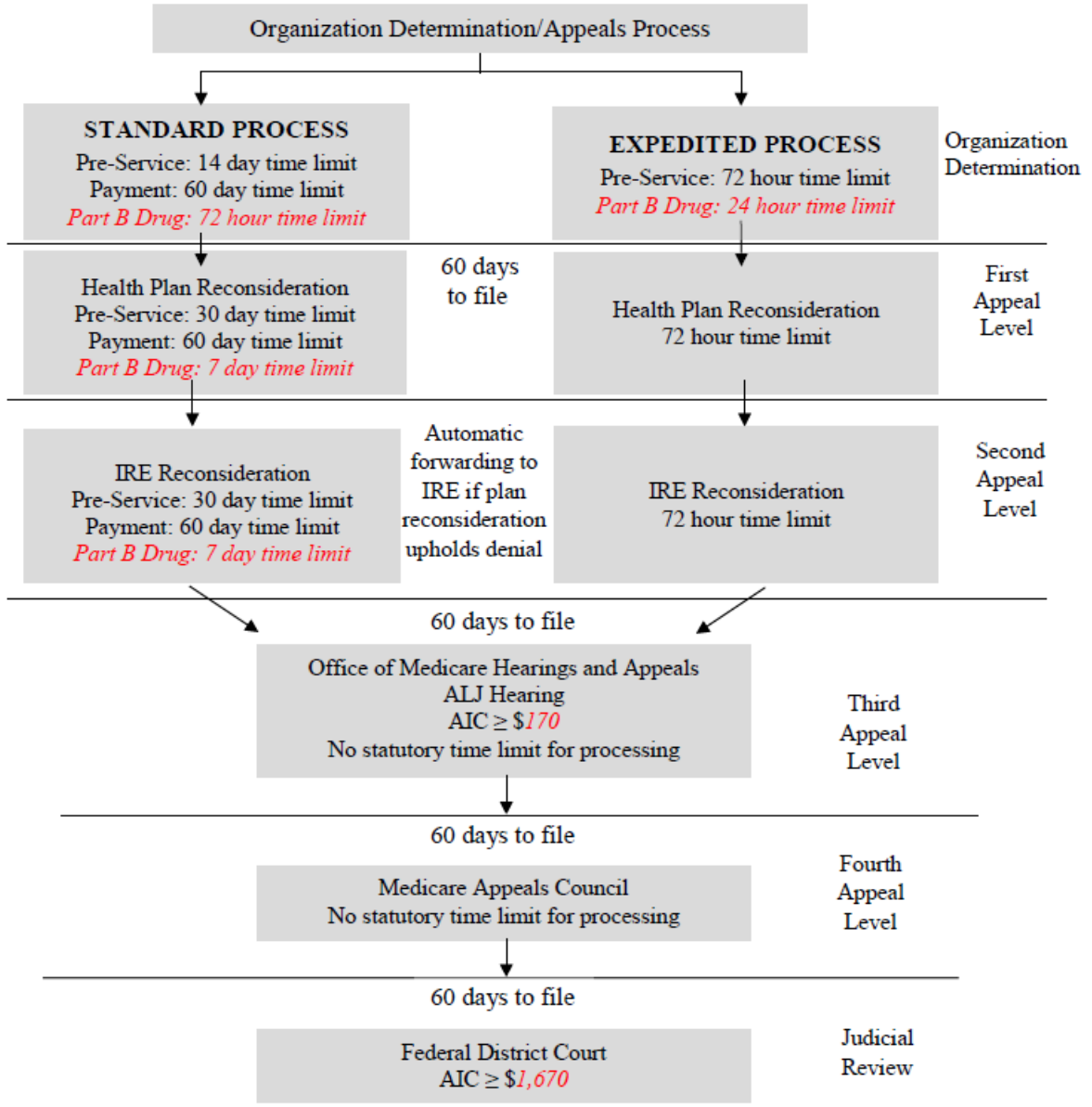
If any further information is needed, please contact me at (563)-<XXX-XXXX> or <1-8XX-XXX-XXXX.>

Sincerely,

<Case Manager Name>

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Medicare Managed Care (Part C - Medicare Advantage)



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PreService Expedited Appeals

