

**MEDICAL ASSOCIATES HEALTH PLANS**

**OPERATIONS POLICY AND PROCEDURES MANUAL**

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**POLICY NUMBER:** 10C

**POLICY TITLE:** Medicare Standard Appeals/Reconsideration for Pre-Service and Post-Service

**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 organization determinations, which includes an adverse pre-service determination, concurrent review determination or denial of payments for services already received.

**Note:** All notifications to enrollees will be in a cultural and linguistic appropriate manner

**PROCEDURE:**

1. Definitions

<b>Term or Acronym</b>	<b>Definition</b>
MAHP	Medical Associates Health Plans, Inc.
CMS	The Centers for Medicare and Medicaid Services
IRE (MAXIMUS Federal)	Independent Review Entity. An independent review entity contracted by CMS to review adverse reconsiderations of adverse determinations.
ALJ	Administrative Law Judge
MAC	Medicare Appeals Council
QIO (MCM)  (Iowa – Kepro) (Illinois – Kepro) (Wisconsin – Kepro)	Quality Improvement Organization. Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and CORFs.
Organization Determination (MCM)	Any determination made by a Medicare health plan with respect to the following:  (a) Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;  (b) Payment for any health services furnished by a provider other than the Medicare health 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 Medicare health plan;

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	<p>(c) Medicare health plan’s refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan;</p> <p>(d) Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;</p> <p>(e) Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee; or</p> <p>(f) Medicare Savings Accounts (MSA) only: Decisions regarding whether expenses, paid for with money from the MSA Bank Account or paid for out of pocket, constitute Medicare expenses that count towards the deductible; and, prior to satisfying the deductible, decisions as to the amount the enrollee had to pay for a service.</p>
<p>Adverse Organization Determination (MCM)</p>	<p>When MAHP decides not to provide or pay for a requested service, in whole or in part, or if MAHP discontinues or reduces a service, this decision constitutes an adverse organization determination.</p>
<p>Complaint (MCM)</p>	<p>Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.</p>
<p>Appeal (MCM)</p>	<p>Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.</p>
<p>Reconsideration (MCM)</p>	<p>An enrollee’s first step in the appeal process after an adverse organization determination; a Medicare health plan or independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.</p>

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Expedited Reconsideration (MCM)	A request to expedite a reconsideration of a determination, in situations where applying the standard appeal procedure could seriously jeopardize a enrollee’s life or health or the enrollee’s ability to regain maximum function, including cases in which MAHP makes a less than favorable decision to the enrollee. <b>A request for payment of a service already provided to an enrollee is not eligible to be reviewed as an expedited reconsideration.</b>
Inquiry (MCM)	Any oral or written request to a Medicare health plan, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by an enrollee. Inquiries are routine questions about benefits (i.e., inquiries are not complaints) and do not automatically invoke the grievance or organization determination process.
Representative (MCM)	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 an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of an enrollee or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described at 42 CFR Part 405
Physician Reviewer	A physician with expertise in the field of medicine that is appropriate for the service at issue, who reviews reconsiderations when the original denial was based on a lack of medical necessity. The physician must be an individual was not involved in making the initial organization determination. The physician need not, in all cases, be of the same specialty or subspecialty as the treating physician, but must possess the appropriate level of training and expertise to evaluate the necessity of the service. The physician is not required to always possess identical specialty training.
Practitioner (NCQA)	An individual person who is licensed to deliver health care services without supervision.
Provider (NCQA)	A licensed health care facility, program, agency, or health professional that delivers health care services.
Ordering Provider (NCQA)	The physician or other provider who specifically prescribes the health care service being reviewed.
DENC (MCM)	Detailed Explanation of Non-coverage

- Medical Associates Health Plans, Inc. (MAHP) provides written information to Medicare enrollees or their representatives about appeal procedures including the right to an expedited review, at initial enrollment, upon notification of an adverse organization determination, upon notification of a service or coverage termination (e.g. hospital, CORF, HHA, or SNF settings), and annually

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thereafter.

MAHP provides its enrollees (including his/her appointed representative), an assignee of the enrollee (i.e. a non-contracted provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service), a physician, 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 internal process for filing appeal requests.

When an enrollee appoints an individual to act as his/her representative, a consent form must be signed, dated, and completed by both the enrollee and the authorized representative. The consent form includes the necessary elements of the CMS-1696 Appointment of Representative form and it conforms to the Privacy Act requirements (not required if POA documentation on file). A physician who provides treatment to an enrollee, upon providing notice to the enrollee, may request a standard plan reconsideration on the enrollee's behalf without having to be appointed as the enrollee's representative. Regarding a representative appointed by an enrollee, unless revoked, an appointment is considered valid for one year from the date that the appointment is signed by both the enrollee and the representative.

Either the signed representative form for a representative appointed by an enrollee, or other appropriate legal papers supporting an authorized representative's status, must be included with each request for reconsideration.

**For reconsiderations submitted either without a representative form or with a defective representative form-**MAHP will inform the enrollee and purported representative, in writing, that the reconsideration request will not be considered until the appropriate documentation is provided. If the reconsideration request is filed by a person claiming to be a representative, but the representative does not provide appropriate and necessary documentation upon MAHP's request, MAHP will document the efforts to secure the necessary documentation. MAHP will not conduct a review until or unless such documentation is obtained. The time frame for acting on an appeal request will begin when the documentation is received.

For a reconsideration request, if MAHP does not receive the appropriate appointment documentation within a reasonable time, generally 14 days, MAHP will dismiss the request on the grounds that a valid request was not received.

Unless otherwise stated in the rules described in subpart M of part 422, the representative has all the rights and responsibilities of an enrollee in filing a reconsideration. The representative may, on behalf of an enrollee:

- Obtain information about the enrollee's claim to the extent consistent with current Federal and state law;
- Submit evidence;
- Make statements of fact and law; and
- Make any request or give or receive any notice about the proceedings.

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MAHP will send any notices or other correspondence intended for the enrollee to the enrollee's representative instead of to the enrollee.

A party to the appeal may request a standard reconsideration by filing a signed, written request with MAHP. Except in the case of an extension of the filing time frame, a party **must file the request for reconsideration within 60 calendar days from the date of the organization determination**. The appeal time frame starts when MAHP receives the appeal request. When an oral reconsideration request is made, the time frame for processing the reconsideration begins with the acceptance of the oral request.

When MAHP receives an appeal after the 60 calendar day filing timeframe, MAHP sends a letter to the individual who submitted the appeal informing them that the enrollee must file an appeal within 60 calendar days of the date MAHP notified them of non-coverage or denial. The letter also includes language that the individual may request an extension of this time frame for filing an appeal. The request for an extension must be in writing and should include the reason(s) why the appeal was not submitted within the required timeframe.

MAHP may extend the time frame for filing a request for reconsideration if a party shows good cause. Examples of circumstances where good cause may exist include, but are not limited to, the following situations:

- The enrollee did not personally receive the adverse organization determination notice, or he/she received it late;
- The enrollee was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the enrollee's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits;
- The enrollee had incorrect or incomplete information concerning the reconsideration process; or
- The enrollee lacked the capacity to understand the time frame for filing a request for reconsideration.

An enrollee may file a grievance with MAHP if it denies the enrollee's request for a good cause extension.

Upon reconsideration of an adverse pre-service organization determination, MAHP makes its reconsidered determination 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, but no later than **30 calendar** days from the date it receives the request for a standard reconsideration of the denial of a request for service.

MAHP **may extend the time frame by up to 14 calendar days** if the enrollee requests the extension or if MAHP justifies a need for additional information and documents how the delay is in the interest of the enrollee. 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

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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 for a reconsideration request, reasonable and diligent efforts are made to obtain the necessary documentation. If all of the relevant documentation cannot be obtained, MAHP makes the decision based on the material available.

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MAHP complies with enrollees' rights regarding reconsiderations by an Independent Review Entity (IRE), hearings before an Administrative Law Judge (ALJ), reviews by the Medicare Appeals Council (MAC), and judicial review through its appeal procedures.

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 provides an estimate of the cost for duplicating the case file. 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 MAHP that is over and above the cost of mailing the material to the enrollee.

An enrollee or any physician (regardless of whether the physician is affiliated with MAHP) may request that MAHP expedite a reconsideration pre-service request.

If the reconsideration also includes a grievable issue, then MAHP will address and handle the grievance issue according to MAHP Operations PP 9A-Medicare Complaints/Grievance.

MAHP does not discriminate or take punitive action against any enrollee or authorized representative acting on behalf of the enrollee who files a standard appeal.

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 reconsideration.

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 logs and files for ten years following the resolution of the appeal, unless litigation, claim negotiation, audit, or other activities involving the records starts before the expiration of the ten years. In that case, the records are retained until completion of the action and resolution of all issues that arise from it or until the end of the initial ten year period, whichever is later. 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

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rendering the service;

5. Minutes or transcripts of appeal proceedings; and
6. The name and credentials of the Physician Reviewer.

MAHP's policies and procedures pertaining to adverse organization determination and appeals are available, upon request, to any enrollee, provider, or facility rendering service.

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/TDD and interpreter capability.

1. MAHP documents oral and written appeal requests in its appeal data database upon receipt of the appeal request and maintains documentation in the case file.
2. Verbal Requests
  - a. Upon receipt of a verbal request, the request is documented in the enrollee's own words.
  - b. An acknowledgment letter is mailed to the enrollee to confirm the facts and basis of the appeal, and requests the enrollee to sign and return the acknowledgment letter. The letter explains that until the acknowledgment letter is returned, no final decision can be issued.
  - c. MAHP does not issue a final decision on the appeal until it receives the signed acknowledgment letter, or other document relevant to the appeal request.
  - d. If MAHP does not receive a returned, signed acknowledgment by the conclusion of the appeal timeframe, plus extension, MAHP will dismiss the appeal.
3. Appointment of a Representative (Consent Form)
  - a. The signed, dated, and completed consent form or other appropriate legal papers supporting the authorized representative's status, is included with each appeal. CMS Form 1696, Appointment of Representative Form, is preferred consent form.
  - b. An appointment of a representative is considered valid for one year from the date that the consent is signed by both the enrollee and the representative unless revoked by the enrollee.
  - c. The representation is valid for the duration of the appeal.
  - d. A photocopy of the signed consent form must be submitted with future appeals on behalf of the enrollee in order to continue representation.
  - e. Any appeal received with a photocopied consent form that is more than one year old is invalid to appoint that person as a representative and a new consent must be executed.
4. MAHP provides the parties to the reconsideration request reasonable opportunity to present evidence and allegations of fact or law related to the issues in dispute.
5. The parties to an appeal may present evidence in person or in writing. The enrollee is not required to submit additional evidence. MAHP takes all the evidence into account when making a decision without regard to whether such information was submitted or considered in the initial consideration of the case.
6. MAHP ensures that someone other than the person involved in making the initial organization

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determination is designated for review of a reconsideration request.

7. If the original denial was based on a lack of medical necessity or involved medical judgment, the reconsideration is performed by a Physician Reviewer.
8. The Physician Reviewer reviews the appeal, renders an appeal determination, and notifies the appropriate MAHP Case Manager of his/her decision.
9. MAHP documents the appeal determination in its appeal data database.
10. Standard Reconsideration of the Denial of a Pre-Service Request (Health Care Services)
  - a. When MAHP completely reverses the initial adverse organization determination, it authorizes or provides the service in dispute as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days (or no later than upon expiration of an extension) from the date the request for reconsideration is received by MAHP.
  - b. When MAHP makes a reconsideration determination that affirms in whole or in part, its adverse organization determination, it provides a written notification to the enrollee or the enrollee's designee and the attending physician or other provider or facility rendering the service.
    - 1) MAHP's written notification includes:
      - 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.
    - 2) MAHP sends the complete case file to the IRE as expeditiously as the enrollee's health condition requires. This is completed no later than 30 calendar days from the date MAHP receives the request for a standard reconsideration (or no later than the end of any extension), and includes a written explanation of its reconsidered determination.
    - 3) If MAHP fails to provide the enrollee with a reconsidered determination within the specified time frames, the failure constitutes an affirmation of the adverse organization determination and MAHP must submit the complete file to the IRE.
11. Standard Reconsideration of the Denial of a Request for Payment (Member Services)
  - a. When MAHP reverses its adverse organization determination denying the enrollee's request for payment, the reconsidered determination is issued and/or payment for the service is mailed to the enrollee/provider no later than 60 calendar days from the date MAHP received the request for standard reconsideration.
  - b. When MAHP makes a reconsideration determination that affirms in whole or in part, its adverse organization determination, MAHP provides a written notification to the enrollee or the enrollee's designee and the attending physician or other provider or facility rendering the service. The complete case file is sent to the IRE no later than 60 calendar days from the

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- date MAHP received the request for a standard reconsideration, or no later than the end of any extension.
- c. MAHP's notification includes the information listed in section 3.10.b.
  - d. If MAHP fails to provide the enrollee with a reconsidered determination within the specified time frames, the failure constitutes an affirmation of the adverse organization determination and MAHP submits the complete file to the IRE.
12. MAHP will dismiss a reconsideration request if any of the following circumstances occur:
- a. Reconsideration request received but no proper authorization or documentation of legal authority provided. MAHP required to attempt to obtain documentation.
  - b. Non-contracted provider requests a reconsideration of a denied claim but fails to provide a waiver of liability statement.
  - c. Enrollee or authorized representative fails to file reconsideration within timeframe and there is no good cause for late filing established.
  - d. Standard pre-service reconsideration is requested but MAHP is informed that the enrollee already received the service before MAHP completed the authorization process.
  - e. Other circumstance where MAHP lacks jurisdiction to review the case.
13. If MAHP denies a request for an expedited reconsideration (a request for payment of a service already provided to a enrollee is not eligible to be reviewed as an expedited reconsideration), it transfers the request to the standard reconsideration process and makes a determination no later than 30 calendar days from the date of receipt of the request for an expedited reconsideration. MAHP provides prompt oral notice of the denial of the request for an expedited reconsideration and the enrollee's rights as well as following-up in writing within three calendar days of the oral notification. This written letter includes:
- a. An explanation that MAHP will automatically transfer and process the request using the 30-day time frame for standard reconsiderations;
  - b. Information regarding the enrollee's right to file an expedited grievance if he/she disagrees with MAHP's decision not to expedite the reconsideration;
  - c. Information regarding the enrollee's right to resubmit a request for an expedited reconsideration and that if the enrollee provides any physician's support indicating that applying the standard time frame for making a determination could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, the request will be expedited automatically; and
  - d. Instructions about the grievance process and required time frames.
14. MAHP forwards the member's case file to the IRE as expeditiously as the member's health condition requires, but no later than within 30 calendar days from the date MAHP receives the member's request for reconsideration or no later than upon the expiration of an extension.

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15. Preparing the Case File for the IRE according to the Maximus Federal Process Manual and appendix (located H:\MCare\Man Care Adm Sec\Letter Templates\Health Care Services\All Templates for Nurses\MAXIMUS CHDR
  - a. All files have individual folders, labeled with the enrollee's name.
  - b. Case files contain:
    - 1) Cover Letter;
    - 2) Maximus Appeal Transmittal Cover Sheet on top of the case file;
    - 3) Maximus Reconsideration Background Data Form;
    - 4) MAHP case narrative form
    - 5) Maximus Statement of Compliance; and
    - 6) Maximus Waiver of Liability Statement.
  - c. A CD with a complete version of the relevant Evidence of Coverage is sent as well.
16. Reconsiderations by the IRE
  - a. The IRE conducts the reconsideration as expeditiously as the enrollee's health condition requires and in the same time frames as MAHP.
  - b. 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.
  - c. When MAHP's reconsideration of a denial of service is reversed in whole or in part by the IRE, MAHP authorizes and/or provides the services under dispute as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days from the date it receives notice that the IRE reversed the determination.
  - d. MAHP informs the IRE that it has effectuated the decision via the Maximus Statement of Compliance form.
  - e. When MAHP's reconsideration of a denial of payment is reversed by the IRE, MAHP pays for the service no later than 30 calendar days from the date it receives notice of the IRE's reversal.
  - f. MAHP informs the IRE that it has effectuated the decision via the Maximus Statement of Compliance form.
    - 1) The IRE's reconsideration determination is final and binding on all parties unless an appropriate party requests an ALJ hearing or the case is revised.
17. A party who files a reconsideration may withdraw the request at any time before a decision is mailed by writing to MAHP. If the withdrawal request is received after MAHP has forwarded a reconsideration case to the IRE, MAHP forwards the withdrawal request to the IRE for processing.
18. Enrollee has additional rights through an ALJ hearing, a MAC review, and judicial review.

### 3. References

- Medicare Managed Care Manual Chapter 13 – Last Updated – Rev. 105, 4-20-12
- 42 C.F.R., Part 422, Subpart M - Grievances, Organization Determinations and Appeals (2002)

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- MAHP Operations PP 9A - Medicare Complaints/Grievances
- MAXIMUS Federal Services, Inc. Medicare Advantage Organization Reconsideration Process Manual 1-2014

**4. Attachments**

- 5.1 Standard Appeal Upheld Letter Template
- 5.2 Standard Appeal Reversed Letter Template
- 5.3 Appointment of Representative Letter Template
- 5.4 Appointment of Representative Form
- 5.5 Missed Appeal Filing Deadline Template
- 5.6 Denial/Appeals Flow Sheet
- 5.7 Appeal Extension Timeframe Letter Template
- 5.8 Verbal Appeal Acknowledgement Letter
  
- 5.9 MAHP Case Narrative Form
  
- 5.10 Notice of Dismissal of Appeal Request
  
- 5.11 MAHP Medicare Maximus Letter
  
- 5.12 Notice of Dismissal of Appeal Request

**5. History of Significant Changes**

04/2010 Changed seven years to ten years for maintaining records/files.

11/1/11 Changed numbering and layout, updated forms and letters.

04/2014 Updated definitions, updated Appointment of Representative Form 1696, revised letters

09/2014 Update QIO to Kepro

04/2017 Updates letters with Section 1557 language; updated Appt. of Rep. form 1696

**6. Required Approval and Signatures**

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Barb Koerperich, MSN  
Director of Health Care Services

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Date

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Karen Hoffmann  
Director of Operations

Date

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Jill Mitchell  
Director of Finance

Date

Original Effective Date: 03/10

Revised Date(s): 04/10, Moved to Operations Manual – 11/11, 06/13, 04/14, 09/14, 04/15, 05/16, 05/17, 5/18

**REQUIRED DISTRIBUTION LIST**

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<DATE>

<MEMBER NAME>

**STANDARD PRE-SERVICE APPEAL UPHELD**

<MEMBER ADDRESS>

<MEMBER ADDRESS>

Dear < MEMBER NAME>:

<Member Number>

On <DATE>, Medical Associates Health Plans (MAHP) received a written appeal to reconsider coverage for <service> under the direction of <physician name> on <date>. Your 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> was correct. The denial decision has been upheld based on <decision rationale>.

Please refer to your <Plan Name> Evidence of Coverage, <page # and language>.

Medicare requires MAHP to send all cases where we have not changed our decision to an independent review entity. MAXIMUS Federal Services, Inc. is the independent review entity that Medicare uses to review cases to make sure that we made the right decision.

Your appeal is being sent to MAXIMUS Federal Services, Inc. You have the right to submit additional information that may be important to the review of your appeal. MAXIMUS Federal Services, Inc. will be in contact with you soon to let you know where to send any additional information and about other rights that you may have.

You also have the right to get a copy of the case file that we are sending to MAXIMUS Federal Services, Inc., including but not limited to guidelines and protocol used in the determination. If you have any questions, please contact the Health Care Services Dept. at 1-800-325-7442, Monday through Friday, 8:00 am to 5:00 pm. TTY users should call 1-800-735-2942. There may be a fee to copy your file and send it to you.

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.

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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. 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).

Medical Associates <SmartPlan, Basic Plan, Community Plan or Freedom Plan> is a Cost Plan with a Medicare Contract. Enrollment in Medical Associates <SmartPlan, Basic Plan, Community Plan or Freedom Plan> depends on contract renewal.

Sincerely,

<MAHP Employee Name, Title>

CC: <Physician/Provider>

Y0045\_MAHP 857 NM

<DATE>

<MEMBER NAME>

**STANDARD PRE-SERVICE APPEAL REVERSED**

<MEMBER ADDRESS>

<MEMBER ADDRESS>



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Medical Associates <SmartPlan, Basic Plan, Community Plan or Freedom Plan> is a Cost Plan with a Medicare Contract. Enrollment in Medical Associates <SmartPlan, Basic Plan, Community Plan or Freedom Plan> depends on contract renewal.

Sincerely,

<MAHP Employee Name, Title>

CC: <Physician/Provider>

Y0045\_MAHP 858 NM

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**APPEAL or COMPLAINT/GRIEVANCE**

**APPT OF REPRESENTATIVE LETTER**

<Date>

<MEMBER Name>

<MEMBER Address>

<MEMBER Address>

Dear <MEMBER Name>:

<Member Number>

Medical Associates Health Plans (MAHP) has received an <appeal request or complaint/grievance> from <name> on your behalf. However, in reviewing your file, MAHP does not have documentation on file to allow us to release any information to <name>.

If you would like to appoint the above named person as your representative, please complete the highlighted sections of the enclosed Appointment of Representative Form and return in the enclosed envelope.

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> or <Health Care Services Dept. at 1-800-325-7442, Monday through Friday, 8:00 am to 5:00 pm>. TTY users should call 1-800-735-2942.

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. Language assistance services are available free of charge. Call 1-866-821-1365 (TTY: 1-800-735-2942).

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UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-821-1365 (TTY: 1-800-735-2942).

**MEDICAL ASSOCIATES HEALTH PLANS**

**OPERATIONS POLICY AND PROCEDURES MANUAL**

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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)

Medical Associates <SmartPlan, Basic Plan, Community Plan or Freedom Plan> is a Cost Plan with a Medicare Contract. Enrollment in Medical Associates <SmartPlan, Basic Plan, Community Plan or Freedom Plan> depends on contract renewal.

Sincerely,

<MAHP Employee Name, Title>

Y0045\_MAHP 853 NM

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved  
 OMB No. 0938-0950

**APPOINTMENT OF REPRESENTATIVE**

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier Number (provider as party)
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**Section 1: Appointment of Representative**

**To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):**

I appoint this individual, \_\_\_\_\_ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

**Section 2: Acceptance of Appointment**

**To be completed by the representative:**

I, \_\_\_\_\_, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (DHHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an \_\_\_\_\_  
 (Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

**Section 3: Waiver of Fee for Representation**

**Instructions:** This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)

I waive my right to charge and collect a fee for representing \_\_\_\_\_ before the Secretary of DHHS.

Signature	Date
-----------	------

**Section 4: Waiver of Payment for Items or Services at Issue**

**Instructions:** Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date
-----------	------

## MEDICAL ASSOCIATES HEALTH PLANS

# OPERATIONS POLICY AND PROCEDURES MANUAL

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### **Charging of Fees for Representing Beneficiaries before the Secretary of DHHS**

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of DHHS (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council review, or a proceeding before an ALJ or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

### **Approval of Fee**

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

### **Conflict of Interest**

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

### **Where to Send This Form**

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance if you are filing a grievance, initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227). TTY users please call 1-877-486-2048.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov).

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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Form CMS-1696 (11/15)

2

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

---

<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 contact the <Member Services Dept. at 1-866-821-1365, 8:00 am to 8:00 pm, 7 days a week> or <Health Care Services Dept. at 1-800-325-7442, Monday through Friday, 8:00 am to 5:00 pm>. TTY users should call 1-800-735-2942.

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

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Sincerely,

<MAHP Employee Name, Title>

CC: <Physician/Provider>

Y0045\_MAHP 859 NM

**MEDICARE**  
**ISSUES – DENIALS - APPEALS**

Enrollee Name: \_\_\_\_\_ Authorization #: \_\_\_\_\_

Member #: \_\_\_\_\_ HICN #: \_\_\_\_\_

Case Manager: \_\_\_\_\_ Contract: \_\_\_\_\_

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

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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: \_\_\_\_\_

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

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**Appeal / Reconsideration 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 1<sup>st</sup> 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: \_\_\_\_\_

1<sup>st</sup> Level Decision:

Signature \_\_\_\_\_ Date \_\_\_\_\_ Time: \_\_\_\_\_

Date Member Notified: Verbal \_\_\_\_\_ Written \_\_\_\_\_ Time: \_\_\_\_\_

Decision 100% Favorable to Member Yes \_\_\_\_\_ No \_\_\_\_\_

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

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**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: \_\_\_\_\_

<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>.

**MEDICAL ASSOCIATES HEALTH PLANS**

**OPERATIONS POLICY AND PROCEDURES MANUAL**

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If you need assistance or have any questions, please call us at (563) 584-3275 or 1-800-325-7442, Monday through Friday, 8:00 am to 5:00 pm. TTY users please call 1-800-735-2942.

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Sincerely,

<MAHP Employee Name, Title>

Y0045\_MAHP 860 NM

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

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<DATE>

<MEMBER NAME>

**VERBAL APPEAL ACKNOWLEDGEMENT**

< MEMBER ADDRESS>

< MEMBER ADDRESS>

Dear < MEMBER NAME>:

<Member Number>

On <DATE>, Medical Associates Health Plans (MAHP) received a verbal appeal request. This letter is in follow up to the conversation and acknowledges the basis of the appeal.

MAHP understands that you are requesting reconsideration of <<coverage for <service> under the direction of <physician name> on <date>> or <payment for claim with date of service of <date>.

If this understanding is correct, please sign and date this letter so that MAHP can finalize the appeal review process. MAHP cannot issue a final decision until this letter is signed and returned, along with any additional relevant documentation to the appeal.

If this understanding is not correct, please contact the <Member Services Dept. at 1-866-821-1365, 8:00 am to 8:00 pm, 7 days a week> or <Health Care Services Dept. at 1-800-325-7442, Monday through Friday, 8:00 am to 5:00 pm>. TTY users should call 1-800-735-2942.

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

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Sincerely,

<MAHP Employee Name, Title>

I, <MEMBER Name>, acknowledge the information above is correct in regard to appeal request/reconsideration.

\_\_\_\_\_  
<MEMBER Name>

\_\_\_\_\_  
Date

Y0045\_MAHP 861 NM

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

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**Enrollee Name:**

**Member #:**

**HICN #:**

**I      CASE SUMMARY**

**II     CHRONOLOGY OF CARE**

**III    ENROLLEE'S ARGUMENTS FOR COVERAGE**

**IV    MCO RATIONAL FOR SERVICE OR CLAIM DENIAL**

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

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**IV.A Summary Statement of Reason for Denial**

**IV.B Justification**

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

---

**Maximus Checklist**

Date \_\_\_\_\_

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

Enrollee Name

Member Number

Enrollee HICN

**KEEP A COPY OF CERTIFIED MAIL RECEIPT**

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

**CASE MANAGER**

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECRETARY**

Signature \_\_\_\_\_

Date \_\_\_\_\_

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

---

<DATE>

MEDICARE Maximus LETTER

<IRE Name>

<IRE Address>

<IRE Address>

**Enrollee Name:**

**Member #:**

**HICN #:**

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 to Enrollee

Appeal Notification letter to Enrollee

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

---

MAHP Health Care Services documentation of case review Medical Records  
Evidence of Coverage

If any further information is needed, please contact me at (563)-584-3275 or 1-800-325-7442.

Sincerely,

<Case Manager Name>

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

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## Notice of Dismissal of Appeal Request

---

Date: \_\_\_\_\_

Enrollee's Name: \_\_\_\_\_ Enrollee ID Number: \_\_\_\_\_

(Insert Non-contract Provider Name, if applicable:) \_\_\_\_\_

Health Plan Name/Medicare Contract Number: \_\_\_\_\_

Health Plan Contact Fax Number: \_\_\_\_\_

- 
- We dismissed the appeal request you filed on \_\_\_\_\_  
(Insert date request received by the plan.)
  - We can't process your appeal request because:  
(Instructions: Use the space below to explain the specific reason for dismissal and what is missing from the request (e.g., lack of an appointment of representation (AOR) form, lack of waiver of liability (WOL) for a request filed by a non-contract provider). See Chapter 13 of the Medicare Managed Care Manual for guidance on when it may be appropriate to dismiss a reconsideration request.)
- 

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### Do You Have Questions?

**If you have questions** about this notice, please contact \_\_\_\_\_ at the following: \_\_\_\_\_  
(Insert Health Plan Name)

Toll Free Phone: \_\_\_\_\_ Days & hours of operation: \_\_\_\_\_

TTY Users Phone: \_\_\_\_\_ Days & hours of operation: \_\_\_\_\_

**If you disagree with our decision to dismiss your appeal request**, you have the right to ask an independent reviewer contracted with Medicare to review our decision. You must mail or fax your written request within 60 calendar days of receipt of this **Notice of Dismissal of Appeal Request** to:

MAXIMUS Federal Services, Inc. Medicare Managed Care & PACE Reconsideration Project 3750 Monroe Avenue, Suite 702 Pittsford, NY 14534-1302	Phone: 585-348-3300 Fax: 585-425-5292
---	--

Include a copy of this **Notice of Dismissal of Appeal Request** along with any supporting information with your request for review. The independent reviewer will send you a notice of its decision. If the independent reviewer agrees that your appeal should not have been dismissed, your appeal request will be returned to \_\_\_\_\_ for processing.

(Insert Health Plan Name)

---

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

---

<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.

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**MEDICAL ASSOCIATES HEALTH PLANS**  
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Sincerely,

<MAHP Employee Name, Title>

Y0045\_MAHP 869 NM

<DATE>

<MEMBER NAME>

**STANDARD CLAIM APPEAL DENIED**

<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 will remain denied. This decision has been determined according to the benefits and limitations of your Evidence of Coverage. Please provide any additional information that you have that may have an impact on the appeal reviewed.

Since the appeal will remain denied, MAHP will be forwarding all the appeal information to MAXIMUS, INC., an independent review entity for their review and decision on the appeal. You will be notified directly from MAXIMUS of their decision.

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

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Sincerely,

<MAHP Employee Name, Title>

Y0045\_MAHP 870 NM