

HEALTH PLAN POLICY	
Policy Title: Non Contract Provider Appeal	Policy Number: OPCGA23 Revision: G
Department: Operations	Sub-Department: Complaints, Grievances and Appeals
Applies to Product Lines: <input type="checkbox"/> Medicaid <input type="checkbox"/> Children’s Health Insurance Plan <input type="checkbox"/> Health Insurance Exchange <input checked="" type="checkbox"/> Medicare <input type="checkbox"/> USFHP <input type="checkbox"/> Commercial Insured <input type="checkbox"/> Non Insured Business	
Origination/Effective Date: 07/16/2015	
Reviewed Date(s):	Revision Date(s): 12/01/2016, 09/28/2017, 02/27/2019, 03/25/2020, 03/11/2021, 02/21/2022, 03/20/2023

SCOPE:

This policy applies to all Medicare Advantage complaints about denials of service or payment.

DEFINITIONS AND ACRONYMS:

- **Appeal** - 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.
- **Effectuation** - Compliance with a reversal of the Medicare health plan’s original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.
- **Independent Review Entity** - An independent entity contracted by CMS to review Medicare health plans’ adverse reconsiderations of organization determinations.
- **Organization Determination** - Any determination made by a Medicare health plan with respect to any of the following:
 - Payment for temporarily out of the area renal dialysis services, emergency services post stabilization care, or urgently needed services
 - Payment for any other health services furnished by a provider other than the 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;
 - The 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;
 - Reduction, or premature discontinuation of a previously authorized ongoing course of treatment; or
 - 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

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determination, such that a delay would adversely affect the health of the enrollee.

- **Quality Improvement Organization (QIO)** - 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.
- **Reconsideration** - 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.
- **Representative** - 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.
- **Waiver of Liability (WOL)**

POLICY:

- A. Non-contracted providers are permitted to file a standard appeal for a denied claim only if the non-contracted provider completes a waiver of liability (WOL) statement.
- B. This provides that the non-contracted provider will not bill the member regardless of the outcome of the appeal.
 1. Physicians and suppliers who execute a waiver of beneficiary liability are not required to complete the CMS Form 1696, Appointment of Representative;
 2. The physician is not acting as a representative for the beneficiary, but as a party to the organization determination;
 3. The member no longer has an appealable right on the issue and all correspondence about the appeal should be sent to the non-contracted provider.
- C. Receipt of a request for reconsideration from a non-contracted provider is considered incomplete without a signed waiver of liability.
 1. The health plan will take necessary and reasonable steps to request a complete waiver of liability statement and any other documentation necessary to complete the processing of the request;
 2. The health plan will not undertake the review of the issue until the signed request for reconsideration and the waiver of liability are submitted;
 3. If the health plan does not receive the necessary form/documentation by the conclusion of the appeal time frame plus extension, the health plan will dismiss the request;
 4. Appeals must be submitted by the provider within 60 calendar days from the initial determination/denial date;

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5. An acknowledgement letter will be sent to the provider within five (5) calendar days;
6. The appeal resolution must be done within 60 calendar days from receipt of the appeal request.

D. Training

1. All appeals and grievance processors are required to complete the health plan Basic Appeals and Grievance Training program.
2. Upon completion, processors will possess a thorough understanding of the CMS requirements for processing appeals and grievances, as demonstrated by a passing score of at least 85% on tests required by the program.
3. As needed, the health plan will take timely and appropriate action to train appeals and grievance processors of any changes to regulations or CMS guidance and applicable memorandums that would impact the processing of member complaints/grievances.

E. Appeal and Grievance Oversight

1. Reports will be provided to the appeals and grievance manager generated from the case tracking systems.
2. Timeliness is tracked and monitored for compliance.
3. The appeals and grievance manager will conduct a periodic review of appeal cases processed to identify opportunities for improvement and training
4. Audits will be conducted by the compliance department annually to assess compliance with all of the CMS requirements.

REFERENCES:

- [Parts C&D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance \(cms.gov\)](#) 50.1.1 Requirements for Provider Claim AppealsCMS Form 1696, Appointment of Representative
- Waiver of Liability

RELATED DOCUMENTS:

None

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REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	07/16/2015	Initial release.	Board of Directors
A	12/01/2016	Yearly review, updated template and signature	Board of Directors
B	09/28/2017	Yearly review. No content change. Changed signatory to reflect CEO.	Board of Directors
C	02/27/2019	Yearly review. No content change. Corrected minor typos.	Executive Leadership
D	03/25/2020	Annual review. No change to policy content.	Executive Leadership
E	03/11/2021	Annual review. No change to policy content.	Executive Leadership
F	02/21/2022	Annual review. No change to policy content.	Executive Leadership
G	03/30/2023	Annual review – update to reference.	Executive Leadership