HEALTH PLAN POLICY	
Title: Non Contract Provider Appeal	**Number:** OPCGA23 **Revision:** H
Department: Operations	**Sub-Department:** Complaints, Grievances and Appeals
Applicable Lines of Business: ☐ Children's Health Insurance Plan ☒ Medicare ☐ Commercial Insured ☐ Non-Insured Business ☐ Health Insurance Exchange ☐ USFHP ☐ Medicaid	
Effective Date: 07/16/2015	
Revision Date(s): 12/01/2016, 09/28/2017, 02/27/2019, 03/25/2020, 03/11/2021, 02/21/2022, 03/20/2023, 03/21/2024	

PURPOSE:

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.
- **Organization Determination** – A health plan's response to a request for coverage (payment or provision) of an item or service – including auto-adjudicated claims, service authorizations which include prior-authorization (authorization that is issued prior to the services being rendered), concurrent authorization (authorization that is issued at the time the service is being rendered), and requests to continue previously authorized ongoing courses of treatment. It includes organizational determination and reconsideration requests submitted by contract providers on behalf of the enrollee and requests from non-contract providers. It does not include claims for payment or appeals from contract providers that are governed by the contractual arrangement between the MAO and its contract providers.
- **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. They 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 managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers. The QIOs also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in skilled nursing facilities (SNFs), home health agencies (HHAs) and comprehensive outpatient rehabilitations facilities (CORFs).
- **Reconsideration** – A member's first step in the appeal process after an adverse organization determination; a 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 either appointed by an enrollee or authorized under State or other applicable law to act on behalf of the enrollee in filing a grievance, requesting a coverage determination or in dealing with any of the levels of the appeals process. Unless otherwise stated in

part 423, subpart M of the Medicare Part D regulations, the representative has all of the rights and responsibilities of an enrollee in obtaining a coverage determination or in dealing with any of the levels of the appeals process, subject to the rules described in part 422, subpart M of the Medicare Part C regulations.

- **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;
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

REVISION HISTORY:

Revision	Date	Description of Change	Approval 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
H	03/21/2024	Annual review. Updated definitions and removed any that were not mentioned in the policy section. Minor grammatical and formatting changes.	Executive Leadership