This program was formerly called the Prepaid Medical Assistance Program (PMAP)

PrimeWest Health's Minnesota Senior Care Plus (MSC+) program for members who have only Medicaid coverage through PrimeWest Health

PrimeWest Health's Minnesota Senior Health Options (MSHO) program for members who have both Medicaid and Medicare coverage through PrimeWest Health

PrimeWest Health's Special Needs BasicCare (SNBC) program for members who have only Medicaid coverage through PrimeWest Health

PrimeWest Health's Special Needs BasicCare (SNBC) program for members who have both Medicaid and Medicare coverage through PrimeWest Health

Policy

Pursuant to the above regulatory authorities and accreditation requirements, PrimeWest Health provides a fair and reasonable process whereby providers may Appeal PrimeWest Health’s claims adjudication decisions and ensures that provider Appeals are properly investigated and resolved within 30 days of receipt of all necessary and pertinent documentation from participating providers and within 60 days for non-participating providers. Appeal requests by a participating provider must be made within 90 days from the date the claim or Service Authorization request for such covered services was denied by PrimeWest Health. Non-participating providers are required to Appeal within 60 days. PrimeWest Health makes no corrective adjustments based on a provider Appeal after the allowed 60- or 90-day time frame.

PrimeWest Health requires providers to ensure that claims for covered services rendered to PrimeWest Health members are correctly submitted to and received by PrimeWest Health no later than 180 days from the date of service or 180 days from the third party liability crossover claim.

Pursuant to the above regulatory authorities, a non-participating provider, on his/her own behalf, is permitted to file a standard Appeal for a denied claim only if the provider completes the Waiver of Liability Statement, stipulating that he/she will not seek payment from the member regardless of the outcome of the Appeal.
**Definition(s)**

**Appeal:** The provider is requesting a reconsideration of a previously adjudicated claim or Service Authorization decision.

**Dismissal:** A decision not to review a request for a Grievance, initial determination, or Appeal because it is considered invalid or does not otherwise meet PrimeWest Health requirements.

**Participating provider:** An individual provider or a facility contracted with PrimeWest Health for purposes of this policy and procedure.

**Non-participating provider:** An individual provider or a facility not contracted with PrimeWest Health for purposes of this policy and procedure.
Procedure

A. Appeals Process – A provider may initiate an Appeal request by contacting PrimeWest Health. The provider must include appropriate documentation of the denial.

1. The Provider Relations Coordinator verifies whether the Appeal is being requested by a participating provider or by a non-participating provider.
   a. If the Appeal request is from a non-participating provider, refer to the Non-Participating Provider Appeals section of this policy, which sets forth the Waiver of Liability Statement requirement, prior to proceeding.

2. All Appeals are documented and tracked in the Provider Appeal Web Portal application.

3. All Appeal files are considered confidential and are saved in a secure electronic file.

4. All Appeal documentation is reviewed to determine whether the Appeal is on behalf of the member or provider.

5. If the provider is Appealing the denial of a Service Authorization prior to the service being rendered, the Appeal is referred to Quality Appeals & Grievances staff following Policy and Procedure QMAG01: Grievance System.

6. If the provider is Appealing the denial of a Service Authorization after the service has been rendered, the Provider Relations Coordinator advises Utilization Management (UM) of the provider Appeal and requests a review by an appropriate medical reviewer.
   a. If no Service Authorization has been filed, the Appeal is dismissed and the Provider Relations Coordinator notifies the provider via phone or letter of the dismissal.

7. Providers filing a timely filing Appeal must include documentation showing a reasonable attempt to submit the claim(s) within the required time limit. Documentation may include, but is not limited to, the following:
   a. Proof of eligibility verification through the Eligibility Verification System (EVS), Minnesota Information Transfer System (MN–ITS), or PrimeWest Health’s web portal
   b. A printout from the provider’s Practice Management Software that confirms the claim was submitted within 180 days of the date of service
   c. Copies from the provider’s electronic data interchange (EDI) submission report indicating the claim was transmitted and accepted by PrimeWest Health
   d. Documentation that fully explains extenuating circumstances for the delay in claims submission

8. Review process
   a. The claim is researched (verifying the history of the claim, including claim number, date of service, date claim was received, and claim status).
   b. The Provider Relations Coordinator reviews the report summary, which includes the claim history information. The provider’s documentation history may also be reviewed by the Provider Relations Coordinator if necessary.
   c. The Provider Relations Coordinator advises the Provider Relations & Contracting Manager whether the denial should be overturned or upheld. The Provider Relations & Contracting Manager provides final approval. The PrimeWest Health Provider Appeal Desktop Process is followed when determining whether to uphold or overturn a denial. When a decision is made to overturn a denial, the Provider Relations Coordinator notifies Claims Administration staff to overturn the denial and reprocess the claim(s).
      If the Chief Executive Officer (CEO) or the Joint Powers Board (JPB) make a decision to overturn a high-dollar Appeal ($5,000 or greater), PrimeWest Health reimburses the provider to reflect the lesser of either provider’s billed charges or the facility per diem rate.

B. Participating Provider Appeals

1. Appeal requests by a participating provider must be made within 90 days from the date the claim or Service Authorization request for such covered services was denied by PrimeWest Health.

2. A participating provider must submit Appeal requests through electronic means to PrimeWest Health.
   a. Appeals must be submitted using the PrimeWest Health Provider Appeal Form found on the PrimeWest Health website.

3. All responses to Appeals are made by letter or phone call to the provider within 30 days.
C. **Non-Participating Provider Appeals.** The Provider Relations Coordinator uses the following procedure for non-participating provider Appeals:

1. Appeal requests by a non-participating provider must be made within 60 calendar days from the date the claim or Service Authorization request for such covered services was denied by PrimeWest Health (except in the case of an extension of the filing time frame).

2. If oral Appeals are received by the Provider Contact Center, providers are directed to the website to complete the **Provider Appeal Form** and submit it electronically to PrimeWest Health for review.

3. If PrimeWest Health **denies a claim/claim line for payment** (not related to a reimbursement or rate dispute) submitted by a non-participating provider Appealing on his/her own behalf, PrimeWest Health notifies the non-participating provider of the specific reason for the denial and provides a description of the Appeals process.

4. PrimeWest Health also explains that, in the event that the non-participating provider wishes to **Appeal for purposes of obtaining payment only**, the non-participating provider must sign the **Waiver of Liability Statement**. Signing the **Waiver of Liability Statement** means that the non-participating provider formally agrees to waive any right to collect payment from a member. With inclusion of the **Waiver of Liability Statement**, the non-participating provider may do the following:
   a. Submit an Appeal on any denial received using the appropriate **Provider Appeal Form**
   b. Request a retroactive Service Authorization
   c. Submit a timely filing Appeal

5. In the case of Medicare benefits, claim reconsiderations must be completed by PrimeWest Health within 60 days of receipt of request. The time frame commences upon receipt of the signed **Waiver of Liability Statement** in accordance with the **Medicare Managed Care Manual**, chapter 13. The **MAXIMUS Reconsideration Process Manual** states a **STANDARD CLAIM RECONSIDERATION** is defined by: “Reconsiderations related solely to a denial of claim payment or reimbursement. Claim reconsiderations must be completed within 60 days of request receipt. Claim reconsiderations may not be expedited. May also be referred to as a retrospective appeal.”

6. When a non-participating provider files a request for reconsideration of a denied claim but does not submit the **Waiver of Liability Statement** documentation upon PrimeWest Health’s request, PrimeWest Health must make, and document, its reasonable efforts to secure the necessary **Waiver of Liability Statement**. PrimeWest Health does not undertake a review until or unless such statement is obtained. The time frame for acting on a non-participating provider’s reconsideration request commences when the properly executed **Waiver of Liability Statement** is received.
   a. The signed **Waiver of Liability Statement** is required for all Appeals initiated by a non-participating provider. If PrimeWest Health does not receive the **Waiver of Liability Statement** within 60 days from the time the non-participating provider files the Appeal, the following applies:
      i. If the service is a Medicare benefit, PrimeWest Health dismisses the reconsideration request and sends a written notice of the dismissal to the parties at their last known address within the applicable adjudication time frame pursuant to the requirements of Title 42 Code of Federal Regulations (CFR) Part 422, Subpart M. The dismissal notice states the reason for the dismissal and explains the right to request Independent Review Entity (IRE) review of the dismissal within 60 calendar days after receipt of the written notice of PrimeWest Health’s dismissal. Requests for IRE review of PrimeWest Health’s dismissal are filed with the IRE. The dismissal notice explains that a request for review of PrimeWest Health’s dismissal should be filed with the IRE at the following address:
         MAXIMUS Federal
         Medicare Managed Care Reconsideration Project
         3750 Monroe Ave, Ste 702
         Pittsford, NY 14534-1302
         Fax: 1-585-425-5292

         Upon receipt of such request, the IRE contacts PrimeWest Health to obtain the case file. PrimeWest Health assembles and forwards the case file to the IRE within 24 hours of receiving the IRE’s case file request.
ii. For all other services, an Appeal is dismissed without additional review if a Waiver of Liability Statement is not received within 60 days of PrimeWest Health’s receipt of the Appeal. The Provider Relations Coordinator makes three attempts to contact the provider and request the Waiver of Liability Statement during the 60-day period.

7. If MAXIMUS Federal Services agrees that the dismissal was appropriate, MAXIMUS Federal Services affirms PrimeWest Health’s dismissal. Per CMS’ guidance, MAXIMUS Federal Services’ decisions regarding dismissal reviews are binding. No parties to the dismissal have further Appeal rights of the dismissal decision.

8. If MAXIMUS Federal Services finds that PrimeWest Health’s dismissal was not appropriate (or new information has been discovered since the time of PrimeWest Health’s dismissal making the Appeal request valid), MAXIMUS Federal Services overturns PrimeWest Health’s dismissal and advises PrimeWest Health that it needs to perform a substantive reconsideration. If, at the end of this reconsideration, PrimeWest Health denies the item or service in dispute, in whole or in part, PrimeWest Health follows the appropriate steps for forwarding the case for independent review to MAXIMUS Federal Services as per the instructions in the MAXIMUS Reconsideration Process Manual.

9. If the benefit or service under Appeal is for a Medicare member as well as a Medicare-covered service or benefit and the Appeal is upheld, PrimeWest Health forwards the case to the Centers for Medicare & Medicaid Services (CMS) IRE, MAXIMUS Federal Services, for review as part of the reconsideration process described in CMS Medicare Managed Care Appeals & Grievances Guidance.

10. Upon completion of its reconsideration, MAXIMUS Federal Services issues a “reconsideration determination” notice to the Appealing party, and sends a copy to PrimeWest Health and the CMS regional office. All MAXIMUS Federal Services reconsideration determination notices that are not fully in the member’s favor contain an explanation of the member’s right to request additional Appeal options before an Administrative Law Judge.

11. A MAXIMUS Federal Services reconsideration determination notice that overturns a PrimeWest Health determination, in whole or in part, contains the explanation of how the member can obtain the disputed payment or covered service. A MAXIMUS Federal Services determination is a ruling on PrimeWest Health’s obligation for coverage (payment or arrangement for a specific benefit, service, or treatment).

12. For any full or partial overturn determinations, MAXIMUS Federal Services also issues to PrimeWest Health a Notice to Comply with IRE Part C Reconsideration Determination. This document references the overturn determination notice and advises PrimeWest Health of its obligation to effectuate the overturn decision.

Violation of this Policy or Procedure
No or only partial adherence to this policy or procedure may result in noncompliance with current regulatory requirements and subsequent penalties to PrimeWest Health. Remediation for violators includes, but is not limited to, disciplinary action up to and including termination depending on the circumstances of the situation at the time.

Signatures

Medical Director Approval: Date: 06/06/2019
Susan Paulson, MD
Chief Senior Medical Director

Board Approval: Date: 06/06/2019
Jeanne Ennen, Chair
PrimeWest Health Joint Powers Board of Directors