Product Lines Affected

F&C	X	PHC (HMO SNP)[4]	X
MSC+[1]	X	MnCare	X
PWSHC (HMO SNP)[2]	X	Part D	
SNBC[3]	X	Other	

Gray text indicates quoted regulatory, statutory, or other language not subject to change

Policy Name	**Provider Appeal**
Policy Number	**PS01**
Origination Date	October 1, 2009
Revision Effective Date	June 5, 2025
Responsible Position	Provider Services Manager
Regulatory Requirement(s)	Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (effective July 19, 2024), referred to in this policy as "CMS Appeals Guidance" Title 42 Code of Federal Regulations (CFR) Part 422.214 42 CFR 422 and 423, subp. M 42 CFR 438, subp. F MAXIMUS Federal Medicare Health Plan Reconsideration Process Manual 2025 National Committee for Quality Assurance (NCQA) standards
Cross-References	QMAG01: Grievance and Appeal System QMAG08: Part D Grievance and Appeal System QMAG09: Medicare and Medicaid Unified Appeals and Grievances for Integrated Plans Notice of Dismissal of Appeal Request Waiver of Liability Statement PrimeWest Health Provider Appeal Desktop Process Provider Appeals of Denied Services Authorization Workflow
Attachments	

Policy

Pursuant to the above regulatory authorities and accreditation requirements, providers may Appeal PrimeWest Health's pre-service and claims adjudication decisions. PrimeWest Health ensures that provider Appeals are properly reviewed and resolved within regulatory and contractually required time frames for both participating and non-participating providers.

Appeal requests by participating providers 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 calendar days from the date of PrimeWest Health's denial notice. PrimeWest Health dismisses any Appeals received after the allowed 60- or 90-day time frame unless good cause is shown.

PrimeWest Health allows participating providers to Appeal claims rejected for untimely filing. (Participating providers are required to file 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 their 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 they will not seek payment from the member regardless of the outcome of the Appeal.

Appeals submitted by providers on behalf of members are considered member Appeals (see QMAG policies for more information).

[1]PrimeWest Health's Minnesota Senior Care Plus (MSC+) program for members who have only Medicaid coverage through PrimeWest Health
[2]PrimeWest Health's Minnesota Senior Health Options (MSHO) program for members who have both Medicaid and Medicare coverage through PrimeWest Health
[3]PrimeWest Health's Special Needs BasicCare (SNBC) program for members who have only Medicaid coverage through PrimeWest Health
[4]PrimeWest Health's Special Needs BasicCare (SNBC) program for members who have both Medicaid and Medicare coverage through PrimeWest Health

Definition(s)

Appeal: A provider request for 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 applicable requirements

Good cause: A circumstance that prevented the provider from submitting the provider Appeal request within the required time frame. Examples of circumstances where good cause may exist include, but are not limited to, the following situations: provider did not receive PrimeWest Health's adverse initial determination or they received it late; the provider was seriously ill, which prevented a timely Appeal; there was a death or serious illness in the provider's immediate family; a natural or man-made accident caused important records to be destroyed; documentation was difficult to locate within the time limits; the provider had incorrect or incomplete information concerning the Level 1 Appeal process; the provider sent the request to an incorrect address, in good faith, within the time limit and the request did not reach the plan until after the time period had expired.

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

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

Provider: Refers to both participating providers and non-participating providers for the purposes of this policy and procedure

Procedure

A. Reviewing the Appeal Request

1. **Appeal Request**
   a. A provider may initiate an Appeal request by contacting PrimeWest Health.
   b. All Appeals are documented and tracked in the Provider Appeal Tool found in the PrimeWest Health Provider Web Portal.
   c. All Appeal files are considered confidential and are saved in a secure electronic file.
   d. All Appeal documentation is reviewed to determine whether the Appeal is on behalf of a member or provider.
   e. If a provider is Appealing the denial of a Service Authorization prior to the service being rendered, the Appeal is referred to Quality & Utilization Management Appeals & Grievances staff following Policy and Procedure QMAG01: Grievance and Appeal System. As the service has not yet been provided, the provider is Appealing on behalf of the member.
   f. If there is no prior decision by PrimeWest Health (e.g., no initial Service Authorization has been filed and/or no claim has been denied by PrimeWest Health), the Appeal is dismissed. Refer to the *Dismissals* section of this policy and procedure for more information.
   g. Providers Appealing a claim denied for untimely filing must include documentation showing a reasonable attempt to submit the claim(s) within the required time limit was made. Documentation may include, but is not limited to, the following:
      i. Proof of eligibility verification through the Eligibility Verification System (EVS), Minnesota Information Transfer System (MN–ITS), or PrimeWest Health Provider Web Portal
      ii. A printout from the provider's practice management software that confirms the claim was submitted within 180 days of the date of service
      iii. Copies from the provider's electronic data interchange (EDI) submission report indicating the claim was transmitted and accepted by PrimeWest Health
      iv. Documentation that fully explains extenuating circumstances for the delay in claims submission

B. Participating Provider Appeals

1. Appeal requests by participating providers 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. Participating providers must submit Appeal requests through electronic means to PrimeWest Health.
   a. Appeals must be submitted using the PrimeWest Health Provider Appeal Tool found on the PrimeWest Health Provider Web Portal.
3. All responses to Appeals are made via electronic written response or phone call to the provider within 30 days.

C. Non-Participating Provider Appeals

1. Appeal requests by non-participating providers must be made within 60 calendar days from the denial notice date on the claim or Service Authorization notification letter by PrimeWest Health.
   a. If an Appeal by a non-participating provider is made later than this time frame without good cause, PrimeWest Health dismisses the Appeal. Refer to the *Dismissals* section of this policy and procedure for more information.
   b. PrimeWest Health documents good cause for accepting untimely filed Appeals.
2. If oral Appeals are received by the PrimeWest Health Provider Contact Center, providers are directed to the PrimeWest Health Provider Web Portal to complete the Provider Appeal Tool.
   a. Expedited Appeals may be accepted verbally.
3. Examples of non-participating provider Appeals include, but are not limited to, the following:
   a. Diagnosis code/Diagnosis Related Group (DRG) payment denials
   b. Downcoding
   c. Bundling issues and disputed rates of payment
   d. Level of care or rate of payment denials
4. A non-participating provider does not need to receive zero payment to request an Appeal. See section 50.1.1 of the CMS Appeals Guidance.

D. Waiver of Liability Statement

a. A ***Waiver of Liability Statement*** is required when a non-participating provider Appeals a denied claim on its own behalf.
b. Non-participating providers may use electronic signatures on the ***Waiver of Liability Statement*** when it is submitted through the PrimeWest Health Provider Web Portal.
a. When a non-participating provider files an Appeal request for reconsideration of a denied claim but does not submit the ***Waiver of Liability Statement***, PrimeWest Health must make three attempts to contact the non-participating provider 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.

5. If the non-participating provider fails to submit the ***Waiver of Liability Statement*** within 60 calendar days from the date the Appeal request was received by PrimeWest, the invalid Appeal is dismissed. Refer to the *Dismissals* section of this policy and procedure for more information.

E. Dismissals

1. **When to dismiss a provider Appeal:** Provider Appeals are dismissed under any of the following circumstances:
   a. The non-participating provider fails to provide a ***Waiver of Liability Statement*** after being informed by PrimeWest Health that a ***Waiver of Liability Statement*** is required.
   b. The provider did not have good cause to explain why its Appeal was submitted after the allowed 60- or 90-day time frame.
   c. The provider requests to withdraw its Appeal.

2. **Dismissal Notice**: PrimeWest Health transmits a written notice of dismissals to providers via the PrimeWest Health Provider Web Portal. The dismissal notice states the reason for the dismissal, the right to request that PrimeWest Health vacate the dismissal action, and the right to request review by an independent review entity (IRE) of the dismissal. PrimeWest Health uses the CMS Appeals Guidance found at **https://www.cms.gov/medicare/appeals-grievances/managed-care/notices-forms**.

F. Appeal Review Process

1. Once PrimeWest Health has determined that a provider's request is a valid Appeal, PrimeWest Health conducts a thorough review of the Appeal.
   a. The claim is researched to verify the history of the claim, including claim number, date of service, date claim was received, and claim status.
   b. The Provider Services Coordinator reviews the report summary, which includes the claim history information. The provider's documentation history may also be reviewed by the Provider Services Manager if necessary.
   c. The Provider Services Coordinator provides a recommendation to the Provider Services Manager as to whether the denial should be overturned or upheld. The Provider Services 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 Services Coordinator notifies Business IT & Claims Administration staff to overturn the denial and reprocess the claim(s).
   d. The Chief Executive Officer (CEO) and/or the Joint Powers Board (JPB) must make decisions regarding Appeals where the allowed amount is $5,000 or greater. If the CEO and/or JPB make a decision to overturn such an Appeal, PrimeWest Health reimburses the provider the lesser of either the provider's billed charges or the facility per diem rate.
   e. The Appeal review process governs Appeals of denied claims. If a provider is Appealing a denied Service Authorization and the service has not yet been provided, follow Policy and Procedure QMAG01: Grievance and Appeal System and its associated polices.

G. Appeal Processing Time Frames

1. Participating provider Appeals: 30 calendar days
2. Non-participating provider claim payment Appeals (time frame begins upon receipt of ***Waiver of Liability Statement***): 60 calendar days

H. Written Notification for Non-Participating Provider Medicare Appeals

1. **Favorable Appeals Decision**
   a. If PrimeWest Health fully grants a non-participating provider's Appeal request, PrimeWest Health must do the following:
      i. Notify the non-participating provider of its favorable determination in writing within 60 calendar days. This written notification may be made through the PrimeWest Health Provider Web Portal.
      ii. Effectuate the favorable decision within 60 calendar days.
2. **Partially Favorable, Adverse, or Untimely Appeals Decision**
   a. If PrimeWest Health's decision is partially favorable, adverse, or untimely, PrimeWest Health must do the following:
      i. Send the complete case file with a written explanation of PrimeWest Health's decision to the IRE within 60 calendar days.
      ii. Notify the non-participating provider of its partially favorable, adverse, or untimely Appeal decision via the PrimeWest Health Provider Web Portal.
3. **No Member Notice Required**
   a. No member notice is required when non-participating providers execute a ***Waiver of Liability Statement*** as the member does not have an Appealable interest. See section 50.1.1 of the CMS Appeals Guidance.

I. IRE Process for Non-Participating Provider Medicare Appeals

1. IRE Process

a. If the benefit or service under Appeal by the non-participating provider is a Medicare-covered service or benefit for a Medicare member and the Appeal is *upheld*, PrimeWest Health forwards the case to the CMS IRE, MAXIMUS Federal Services (MAXIMUS), for review. MAXIMUS has made available different methods to submit Appeal cases for its review, including uploading through the MAXIMUS portal.
b. PrimeWest Health must also forward any non-participating provider Appeals to the IRE if PrimeWest Health fails to provide an Appeal decision within 60 calendar days. Failure to meet the Appeals time frame constitutes an adverse decision.
c. PrimeWest Health reviews the checklist for preparing the case file for the IRE per section 50.12.3 of the CMS Appeals Guidance and/or the MAXIMUS ***Reconsideration Manual***, as applicable.
d. MAXIMUS issues a ruling on the non-participating provider's Appeal within IRE review time frames and issues a notice of its decision to the non-participating provider and PrimeWest Health.
e. For any full or partial overturn determinations, MAXIMUS also issues a ***Notice to Comply with IRE Part C Reconsideration Determination*** to PrimeWest Health. This document references the overturn determination notice and advises PrimeWest Health of its obligation to effectuate the overturn decision. PrimeWest Health must submit the ***Notice to Comply with IRE Part C Reconsideration Determination*** to MAXIMUS within the applicable effectuation time frame.

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

Board Approval:  **Date:** 06/05/2025

Gary Hendrickx, Chair
PrimeWest Health Joint Powers Board of Directors