



2009 Post Service Appeals

To: In and Out-of-Network Providers
From: Health Plan of Michigan
Bulletin #: 09-0519
Date: May 19, 2009
Re: GRIEVANCE & APPEALS PROCESS FOR DENIED CLAIMS

GRIEVANCE & APPEALS PROCESS FOR DENIED CLAIMS

Health Plan of Michigan offers a post-service claim appeal process for disputes related to denial of payment for services rendered to HPM members. This process is available to all providers, regardless of whether they are in or out of network.

What Types of Issues Can Providers Appeal?

The appeals process is in place for two main types of issues:

1. The provider disagrees with a determination made by HPM, such as combining two stays as a 15-day readmission. In this case, the provider should send additional information (such as medical records) that support the provider's position.
2. The provider is requesting an exception to an HPM policy, such as prior authorization requirements. In this case, the provider must give an explanation of the circumstances and why the provider feels an exception is warranted in that specific case.

Health Plan of Michigan's physician reviewer is available for a discussion with the treating physician or your physician reviewer prior to a post-service appeal decision. The physician may call for a peer-to-peer discussion by calling 888-322-8843, ext 1311. If a specific time frame for the call is desired, a facility representative acting on behalf of the physician may call to schedule a peer-to-peer discussion.

A provider's lack of knowledge of a member's eligibility or insurance coverage is not a valid basis for an appeal. Providers cannot appeal denials due to member ineligible on the date of service or non-covered benefits.

How to File a Post-Service Claim Appeal

1. Please send a letter explaining the nature of your appeal and any special circumstances that you would like HPM to consider.
2. Attach a copy of the claim and documentation to support your position, such as medical records.
3. Send the appeal to the following address:

Health Plan of Michigan
Attention: Claims Appeals Department
777 Woodward Ave.
Suite 600
Detroit, MI 48226

Time Frame for Filing a Post Service Appeal

Appeals must be filed within one year from the date of service. HPM will allow an additional 120-day grace period from the date of the last claim denial, provided that the claim was submitted within one year of the date of service. Appeals submitted after the time frame has expired will not be reviewed.

Response to Post Service Claims Appeals

Health Plan of Michigan typically responds to a post-service claim appeal within 30 days from the date of receipt. If additional information is needed, such as medical records, then HPM will respond within 30 days of receiving the necessary information. Providers will receive a letter with HPM's decision and rationale.

There is only one level of appeal available within Health Plan of Michigan. All appeal determinations are final. If a provider disagrees with HPM's determination regarding an appeal, the in or out-of-network provider may pursue one of the following options:

- Binding Arbitration
 - A provider may initiate arbitration by making a written demand for arbitration to HPM. The Provider and HPM agree to mutually select an arbitrator and the process for resolution.
- DCH Rapid Dispute Resolution (Only applies to Out of Network Hospitals that have signed an Access Agreement through the State of Michigan)

If you have any questions about the post-service claim appeal process, please call HPM Provider Services at 1-888-773-2647 for more information.

RAPID DISPUTE RESOLUTION PROCESS

1. Hospitals and Health Plans agree to exhaust their efforts to achieve reconciliation solutions for outstanding accounts via internal means on a regular basis before pursuing the *RAPID DISPUTE RESOLUTION PROCESS (RDRP)* including the use of an Accounts Receivable Reconciliation Group (ARRG).
2. Where a disputed claim remains either the Hospital or the Health Plan may submit a request to DCH for RDRP. Upon receipt of a request, DCH will contact the other party to obtain that party's agreement to pursue resolution of the disputed claim in this manner.
3. The DCH will contact a mediator, selecting one at random from the list of available mediators that it has prepared. The Mediator will schedule the mediation session within fifteen (15) calendar days of contact by DCH. The Mediator will issue his/her decision within fifteen (15) calendar days of the mediation session.
4. Hospitals and Health Plan agree that, should this process be elected/agreed to by both parties, the outcome, including any monetary award will be binding. Both parties agree to assume the burden of costs for presentation of their positions before the mediator. The cost of the mediation will be borne proportionally.

If the Hospital's position is granted, the Health Plan agrees to make payment for the disputed claim within thirty (30) days. If the Health Plan fails to make payment within the required timeframe, the DCH will enforce the decision through a withhold of the disputed amount from the Health Plan's Capitation payment and direct payment to Hospital.