POLICY AND PROCEDURE

CHAPTER: 03 NUMBER 031.008

RE: PROVIDER APPEALS AND GRIEVANCES

BASE: SWMBH CLAIMS POLICY, 9.5 PROVIDER APPEALS AND GRIEVANCES, MDHHS CONTRACT SECTION 6.6.3, MCL400.111(4) AND (5)

APPLICATION: PINES CLAIMS DEPARTMENT, CUSTOMER SERVICES, AND PROVIDERS

POLICY: PROVIDERS HAVE THE RIGHT TO APPEAL ADVERSE ACTIONS TAKEN BY PINES BEHAVIORAL HEALTH SERVICES IN REGARDS TO CLAIMS DENIALS. GENERALLY THE RECONSIDERATION PROCESS CAN BE EITHER AN "APPEAL" OR A "CLAIM DISPUTE".

PROCEDURES:

APPEALS

1. Providers may Appeal adverse decisions where they are being held financially responsible for charges on the basis of the following non-clinical related issues. Some frequent examples include:

- Services denied due to contract/benefit plan limitation
- Reduction, suspension, or denial to provider payment
- Denied for delayed filing
- Denied for member ineligibility

2. The procedure and time frames to file an Appeal are outlined within the provider contract.

PROVIDER CLAIMS DISPUTES

1. Providers may request that claims denied for administrative reasons be reconsidered. Some examples of these claims denials are:

a) Claim denied for no authorization
b) Claims denied for missing information
c) Claim underpaid due to billing/processing error
d) Disagreement regarding payment methodology

2. Notification of the Right to Appeal will be included in each Provider Contract.

CLAIMS DISPUTE PROCEDURE:

ROLE OF PINES

Pines Behavioral Health Services will respond to all calls or written inquiries from providers questioning claim denials or methodology for payment calculation. All provider appeals or disputes of claim payment must be made within 30 days of denial and will not be accepted after 180 days post denial date. Any claims denied beyond this time frame are considered to have reached a FINAL resolution. Resolution of these inquiries should include:

- Documentation of the issue in Care Management comments box.
- Research to determine if re-processing is warranted due to error or additional information.
- Identification and correction of eligibility and system issues.
- Submission of requests to have claims corrected (where appropriate).
- Involving provider relations, as needed, to resolve contractual issues and provide education.
- Ensuring provider is advised of the outcome of the dispute.

Within 10 days of receipt of appeal request Claims processor will review all information submitted and determine if denial should be overturned in their opinion. If original denial is upheld by the Claims processor they will submit all appeals and documentation to the Finance Officer for review and determination.

Final determination of claims status will be made within 30 days of receipt of all requested information. The final determination will be made in writing and explain the facts upon which the determination is made.

Claims submitted beyond 365 days post service date will not be considered for payment or appeal.

ROLE OF SOUTHWEST MICHIGAN BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Director of Operations will respond to calls or written inquiries from Providers who feel their Medicaid claim dispute has not been resolved at the Affiliate level. This review process will afford an opportunity to ensure that consistency and fairness has been applied in considering like situations. Formal appeals for payment made to SWMBH will receive response within 30 days.

Original: 6/29/2011 RNR: 5/23/12 Revised: 2/6/15 Revised 3/30/16 Revised 3/8/17 Revised: 3/13/18

Approved By: _____ Date:_____

Susan M. Germann, CEO