<table>
<tr><td>Subject: Provider Appeals and Grievances</td><td>Accountability: Operations</td><td>Effective Date: 01/01/2014</td><td>Pages: 2</td></tr>
<tr><td colspan="2">REQUIRED BY:
BBA Section ____________________
PIHP Contract Section Section 6.6.3
NCQA/URAC Standard ________________
Other MCL 400.111i(4) and (5)</td><td>Last Reviewed Date:
11/16/17</td><td>Past Reviewed Dates:
6/18/15
9/7/16</td></tr>
<tr><td>LINE OF BUSINESS:
☒ Specialty Waiver (B/C)
☒ 1115 Waiver
☒ Healthy Michigan
☒ SUD Medicaid
☒ SUD Block Grant
☒ MI Health Link
☐ OTHER: ______</td><td>APPLICATION:
☒ SWMBH Staff and Ops
☒ Participant CMHSPs
☒ SUD Providers
☒ MH / DD providers
☐ Other:_______</td><td>Last Revised Date:
06/18/15</td><td>Past Revised Dates:</td></tr>
<tr><td colspan="2">Approved : [signature]
Date: 11/29/17</td><td colspan="2">Required Reviewer:
Director of Operations</td></tr>
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I. Purpose

To articulate the standards and procedures of Southwest Michigan Behavioral Health (SWMBH) regarding grievances and appeals made by providers that are not related to medical necessity criteria regarding claims.

II. Policy

Providers have the right to appeal adverse actions taken by SWMBH or Participant Community Mental Health Service Providers (CMHSP) in regards to claims denials.

Customer rights regarding appeals and grievances will be afforded via the Customer Service policies and procedures (SWMBH Policy Manual Section 6).

III. Standards

A. <u>Appeals</u>

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:
    a. Services denied due to contract/benefit plan limitation
    b. Reduction, suspension, or denial to provider payment
    c. Denied for delayed filing
    d. Denied for member ineligibility
2. Notification of the Right to Appeal will be included in each provider contract.
3. All provider appeals of claim payment should 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.
4. Within 10 days after a provider appeal request, a preliminary review of the claim and appeal details to determine if additional information from provider is required will be done by the claims processing department. If additional information is required the provider will be notified in writing of the request.

5. The provider must submit all documents, written statements, and other documentation that supports the appea within 10 days from receipt of the request. The provider should also include a copy of any denial notice/remittance advice and the dollar amount of the claim for each disputed claim.
6. Claims processors will review all information submitted and determine if the original denial should be overturned in their opinion. If the original denial is upheld by the claims processor they will submit all appeals and documentation to the Director of Operations for review and determination.
7. 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. The decision of the Director of Operations is considered final.
8. Claims submitted beyond 365 days post service date will not be considered for payment or appeal.

B. <u>Role of Participant CMHSP</u>

1. The Participant CMHSP is required to have a local Provider grievance and appeal policy and procedure that comports with the Participant Sub-Contract and Medicaid regulations. The CMHSP will convey its procedure for provider appeals to each of its contracted providers. The procedure must include timeframes to appeal and at least two levels to submit appeals and identify the individuals/staff responsible to respond to appeals and the timeframes by which responses to appeals must be made.
2. Upon resolution of a provider claims appeal documentation must be present with the claims in the Comments box of Care Management or upon request during site reviews.
3. Providers within the SWMBH region may, as a final step, appeal any Medicaid claims dispute decisions to the SWMBH Director of Operations.

C. <u>Role of SWMBH</u>

1. SWMBH will respond to calls or written inquiries from providers who feel their issue has not been resolved at the CMHSP level. This review process will afford an opportunity to ensure that consistency and fairness has been applied in considering like situations across the region.
2. Formal appeals for payment made to SWMBH will receive response within 30 days.

IV. Definitions

A. Adverse Actions: see glossary.

V. References

A. PIHP contract 6.3.3; ICO contract

VI. Attachments

None