MCCMH MCO Policy 2-006

Category: **CLINICAL PRACTICE**
Title: **SERVICE PROVIDER APPEALS**

Prior Approval Date: 9/12/02
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Approved by: Donald J. Hall Jr. 2/4/10
Executive Director Date

I. Abstract

This policy establishes the standards and procedures for MCCMH service providers (directly-operated and contract) to appeal Macomb County Community Mental Health (MCCMH) denials/reductions of service authorization made by the MCCMH Access Center.

II. Application

This policy shall apply to all directly-operated and contract network providers of the MCCMH Board. The appeals process established in this policy shall also be available to any hospital or facility denied authorization for payment by MCCMH for services to consumers of the MCCMH Board.

II. Policy

It is the policy of the MCCMH Board that a service provider or a hospital who believes its request for a service authorization for a consumer has been inappropriately denied/reduced may appeal the denial or reduction and that the appeal shall be addressed and resolved in a timely and objective manner.

IV. Definitions

A. Service Provider
An agency or organization directly-operated or under contract with the MCCMH Board to deliver services to consumers.

V. Standards

A. A MCCMH service provider or a hospital may file a formal appeal of utilization management decisions (authorizations) for payments related to service to consumers including decisions regarding:

1. Denial of authorization assignment to a service program to provide services to the consumer(s).

2. Denial of authorization to a service program to provide service of a particular type, amount, frequency or duration to a consumer.

3. Denial of authorization for payment to a hospital for inpatient admittance.

4. Denial of authorization for payment to a hospital for continued stay.

B. The use of such formal appeal mechanism is only to be initiated following informal attempts to clarify the decision and is not intended to replace normal day-to-day professional communication regarding planning for services to consumers.

C. Final decisions as to services to be provided and the provider to be utilized must be documented in the consumer's clinical record. Documentation of dialogue, conversation and opinions as to the appropriateness of utilization management decisions or the process by which decisions are made shall not be placed in the consumer's clinical record.

D. A process of three sequential steps shall be available for the resolution of such appeals, including:

1. Reconsideration of the decision by the MCCMH Access Center by an individual who was not involved in any previous level of review or decision-making.

2. Review and reconsideration of the decision by the MCCMH Access Center Physician.

3. Review and resolution by the MCCMH Clinical Services Director or Designee (for denials/reductions) or MCCMH Medical Director (for denials of authorization for payment for inpatient hospitalization/continued stay), either of whom may consult with appropriate MCCMH designees.

E. If at any point new information becomes available that could impact the decision to authorize or render payment for inpatient hospitalization/continued stay, the most recent reviewer will re-review the case and issue a decision regarding payment authorization. All new information submitted for consideration must be in writing.

F. The resolution process shall be handled in a manner to assure that the consumer is not placed at increased risk and that his/her health and safety needs are addressed during the period of the appeal.

VI. Procedures

A. Denials / Reductions of Non-Hospital Services

1. When a MCCMH service provider is notified and disagrees with a denial/reduction of service authorization made by the MCCMH Access Center, the provider's designee will immediately contact the MCCMH Access Center Supervisor or designee to request reconsideration.

2. The MCCMH Access Center shall re-review the pertinent information related to the provider's request and respond in writing within one (1) business day of receipt of the request for reconsideration.

3. If the provider disagrees with the MCCMH Access Center's decision, the provider may request an MCCMH Access Center Physician Review. The provider shall submit a letter to the MCCMH Access Center requesting a Physician Review, including the clinical rationale for the request, along with a copy of the complete clinical record.

4. The MCCMH Access Center Physician shall review the matter and convey a written response to the provider as soon as possible, not to exceed seven (7) business days of receipt of the request for reconsideration.

5. If the provider disagrees with the decision of the Physician's Review, the provider may request a review by the MCCMH Clinical Services Director. The provider will submit a letter to the MCCMH Clinical Services Director requesting a review along with a copy of the complete clinical record.

6. The MCCMH Clinical Services Director shall convey a written decision to the provider within five (5) business days. Decisions by the MCCMH Clinical Services Director are final.

7. Copies of written documents created through the review process will be maintained in administrative files. The consumer's clinical record will reflect any service to be provided as a consequence of the final utilization management decision.

8. Procedures related to the provider appeal process for denials / reductions, including time frames, are outlined in Exhibit A.

B. Denial of Inpatient Admission / Continued Stay

1. When a hospital is notified by the MCCMH Access Center that additional information is needed to decide a pending request for authorization for payment for inpatient hospitalization admission, the hospital shall send the requested information immediately, or the MCCMH Access Center may deny the authorization for payment request based on the available information. The MCCMH Access Center shall re-review the additional information and convey a written response as soon as possible. The response shall be conveyed within three (3) hours of the consumer's arrival in the hospital's emergency room.

2. When a hospital is notified by the MCCMH Access Center that additional information is needed to decide a pending request for authorization for payment for continued stay, the hospital shall send the requested information immediately, or the MCCMH Access Center may deny the authorization for payment request based on the available information. The MCCMH Access Center shall re-review the additional information and convey a written response as soon as possible. The response shall be conveyed within one (1) business day of the original request for review.

3. If the hospital is notified and disagrees with the MCCMH Access Center's denial for authorization for payment for inpatient admission or continued stay (based on available or additional information received), the hospital's designee may submit a letter to the MCCMH Access Center Supervisor or designee requesting a reconsideration of the decision.

4. The MCCMH Access Center shall re-review the pertinent information related to the hospital's request and convey a written response as soon as possible, not to exceed five (5) business days of receipt of the request for the reconsideration.

5. If the hospital disagrees with the MCCMH Access Center Supervisor or designee's decision, the hospital may request a MCCMH Access Center Physician Review. The hospital shall submit a letter within 30 days of discharge to the MCCMH Access Center requesting a Physician Review, including the clinical rationale for the request, along with a copy of the complete clinical record.

6. The MCCMH Access Center Physician shall review the matter and convey a written response to the hospital as soon as possible, not to exceed seven (7) business days of receipt of the request for reconsideration.

7. If the hospital disagrees with the decision of the Access Center Physician, the hospital may request a review by the MCCMH Medical Director. The hospital shall submit a letter to the MCCMH Medical Director requesting a review along with a copy of the complete clinical record.

8. The MCCMH Medical Director shall review the matter and convey a written decision to the provider as soon as possible, not to exceed five (5) business days. Decisions by the MCCMH Medical Director are final.

9. Copies of written documents created through the review process will be maintained in administrative files. The consumer's clinical record will reflect any service to be provided as a consequence of the final utilization management decision.

10. Procedures related to the hospital appeal process or denials of payment for inpatient hospitalization and continued stay, including time frames, are outlined in Exhibits B and C.

VII. References / Legal Authority

A. MCL 330.1228

B. MDCH-MCCMH Managed Specialty Supports and Services Contract

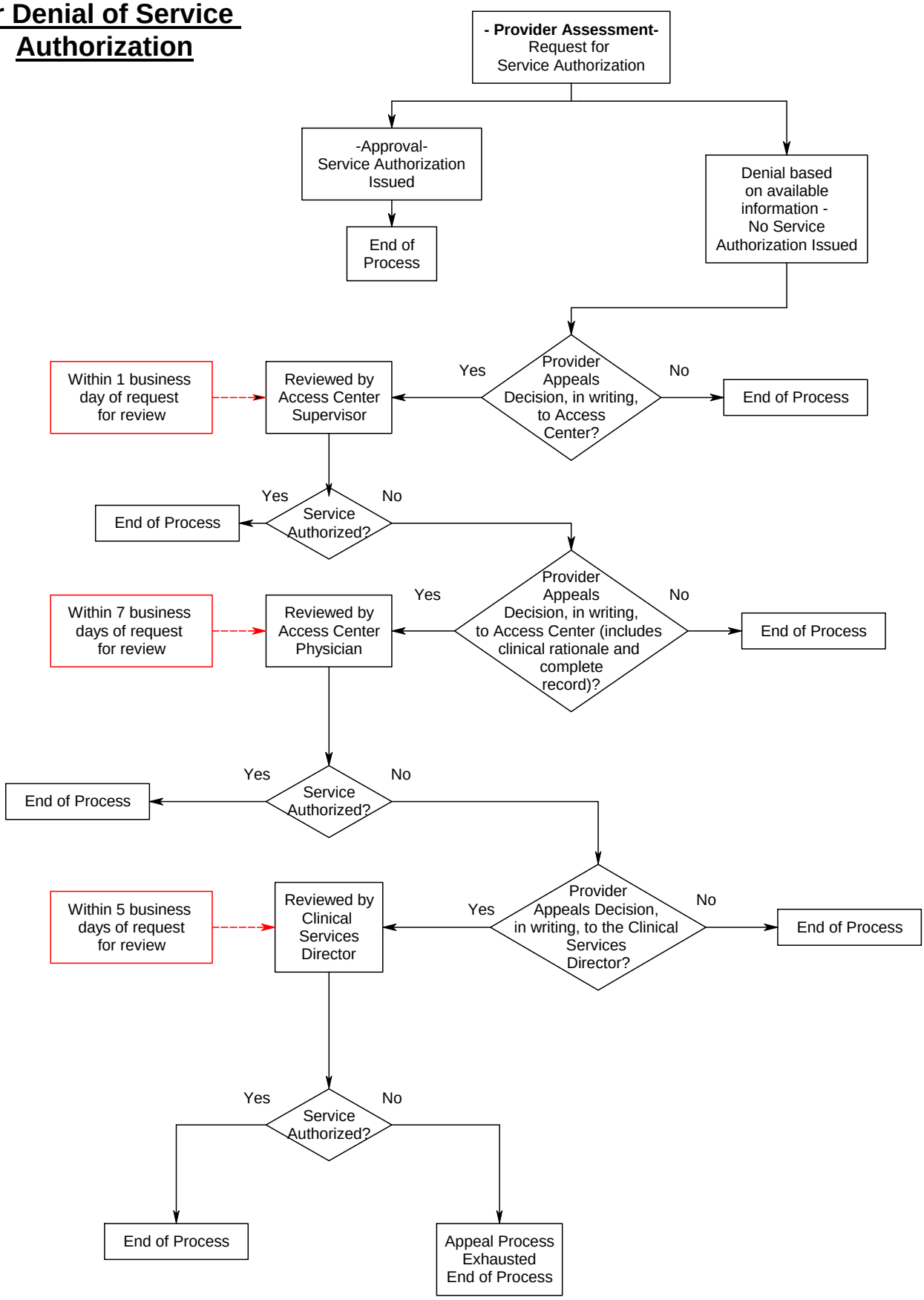
VIII. Exhibits

A. Provider Appeal Process (Denials / Reductions)

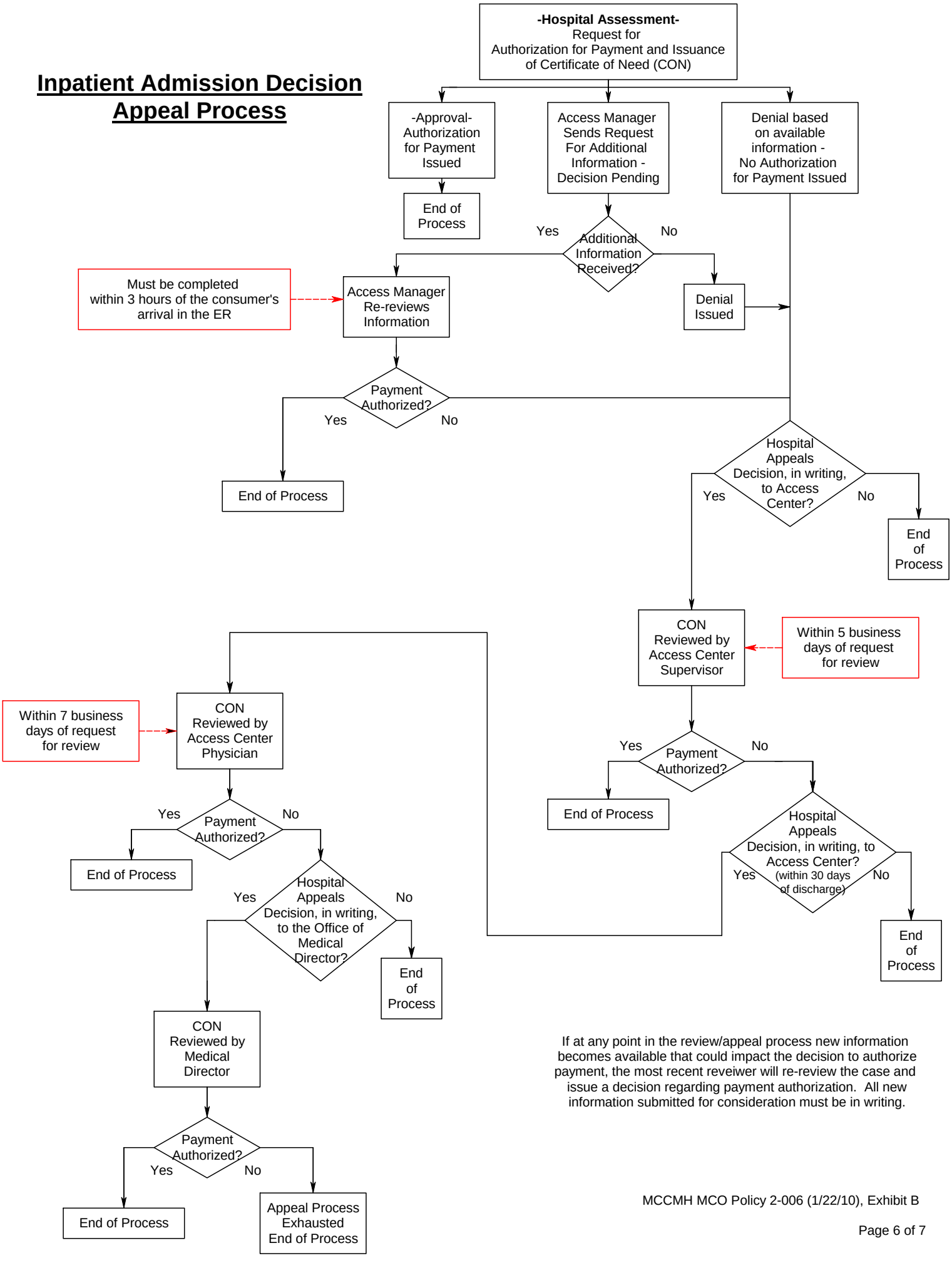
B. Inpatient Admission Decision Appeal Process

C. Continued Stay Decision Appeal Process

Provider Appeal Process for Denial of Service Authorization

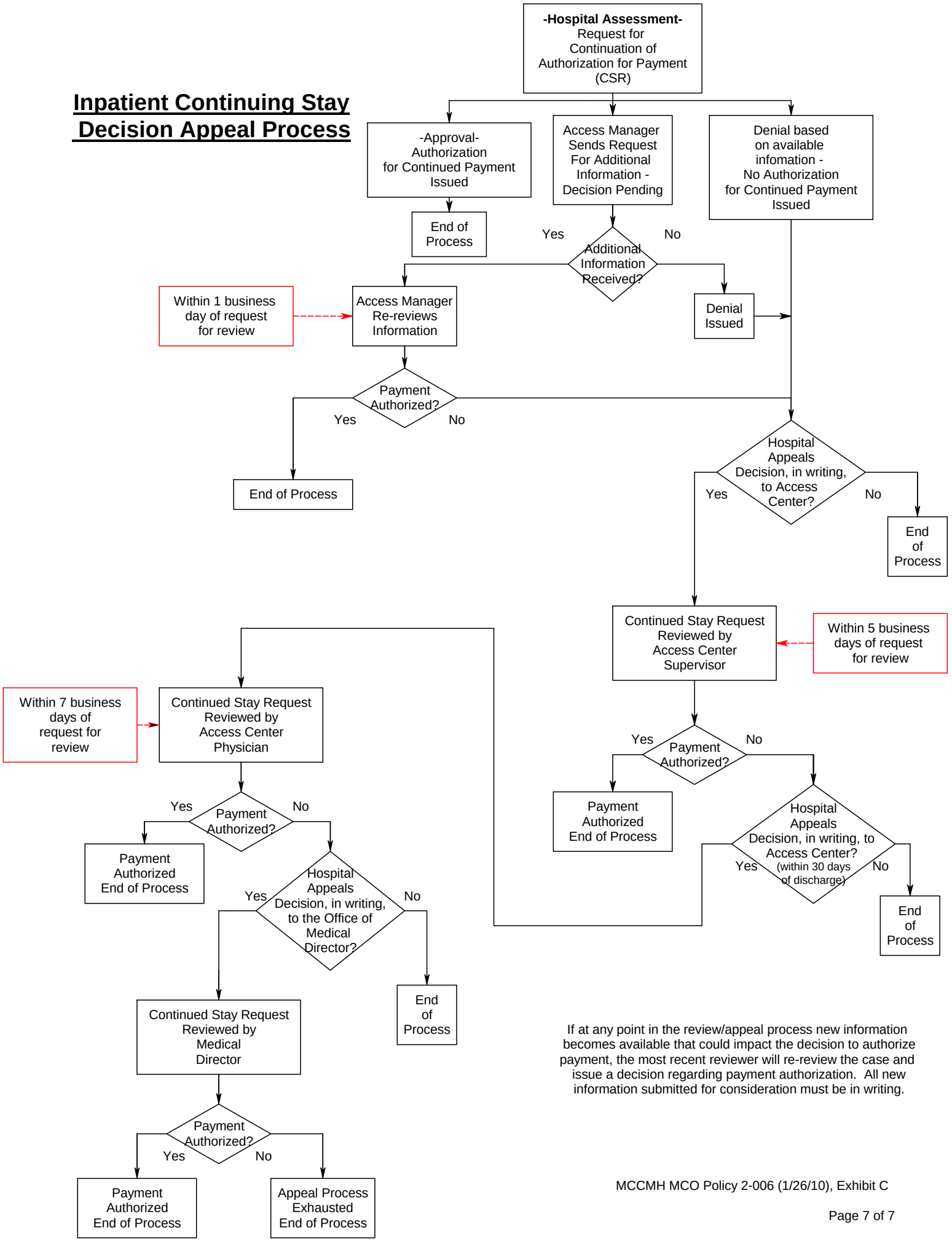


Inpatient Admission Decision Appeal Process



If at any point in the review/appeal process new information becomes available that could impact the decision to authorize payment, the most recent reveiwer will re-review the case and issue a decision regarding payment authorization. All new information submitted for consideration must be in writing.

Inpatient Continuing Stay Decision Appeal Process



If at any point in the review/appeal process new information becomes available that could impact the decision to authorize payment, the most recent reviewer will re-review the case and issue a decision regarding payment authorization. All new information submitted for consideration must be in writing.