POLICY AND PROCEDURE MANUAL	BCCMHA	PAGE 1 OF 4
CATEGORY - REIMBURSEMENT	CHAPTER 13	SUBJECT B
PROVIDER CLAIM APPEALS	REVISED 05/13/08 02/21/14 03/01/11 02/19/15 10/10/16 05/26/17 12/21/18 09/09/2020	EFFECTIVE 03/28/06

I. PURPOSE

To establish guidelines for the administration of claims and the appeal process established by Barry County Community Mental Health Authority (BCCMHA), incorporating all applicable state and federal regulations relative to the processing of behavioral health services claims.

II. GOAL

Resolve provider claim disputes at the lowest level possible.

III. APPLICATION

The provisions of this subject apply to administrative staff, billing and accounting at BCCMHA.

IV. POLICY

Providers have the right to appeal adverse actions taken by BCCMHA for claim related denials. General reconsideration process can either be an appeal or claim dispute. Provider policies and appeal forms can also be found in the provider section of BCCMHA website, www.barrycountyrecovery.com.

V. STANDARDS

1. Providers may appeal adverse decisions where they are being held financially responsible for charges on the basis of the following issues:
   a. Denied due to contract/benefit plan limitation.
   b. Denied for exceeding filing limit.
   c. Reduction, suspension or denial of provider payment.
   d. Denied for member ineligibility.
2. Notification of the Right to Appeal will be included with each provider contract.
3. All provider appeal of claim payment should be made within 30 days of the original denial

and will not be accepted after 180 days from the original denial date. Any claim appeal beyond this timeframe will be considered to have reached a final resolution. The provider must submit all requested documents, written statements and other documentation that supports the appeal. The provider should also include a copy of any denial notice/remittance advice and the dollar amount for each disputed claim.

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

VI. APPEAL PROCESS

Level I Appeal

A review will be conducted by BCCMHA Claims Department, within 10 days from receipt of provider initial appeal request. The reviewer of the claim and appeal detail will determine if additional information from provider is required. If additional information is required, the provider will be notified in writing within 10 days.

Any additional requested documentation should be received by BCCMHA within 10 days of the receipt of the request for additional information.

Once all information is received by BCCMHA, the Reimbursement Supervisor will perform the Level I Appeal to determine if the original denial should be overturned and will either approve, partially approve or deny the claim and will submit to provider in writing of their decision within 10 days.

Level II Appeal

If Level I Appeal is denied, provider may submit a new Provider Claims Appeal form to the BCCMHA Corporate Compliance Officer requesting a Level II Appeal.

The Corporate Compliance Officer will determine if the Level I denial should be overturned and will either approve, partially approve or deny the claim and will submit to provider in writing of their decision within 10 days of the receipt of the Level II appeal.

Upon resolution of a provider claims appeal, documentation will be uploaded to the client EHR in BEHRI and available upon request during site reviews.

Provider will be advised of their right to appeal the BCCMHA decision through SWMBH's Director of Operations as the next step for appeal denied claims.

Level III Appeal

If Level II appeal is denied, provider may, as a final step, appeal any Medicaid

claims dispute decisions to SWMBH's Director of Operations.

Role of Southwest Michigan Behavioral Health (SWMBH):
SWMBH will respond to calls or written inquiries from providers who feel their issue has not been resolved at the lower level regarding Medicaid claims. This review process will afford an opportunity to ensure that consistency and fairness have been applied in considering like situations.

Formal appeals for payment made to SWMBH will receive a response within 30 days.

REFERENCES

DHHS Master Contract
PA519 Section 424(c)
MDHHS
CMS
BBA
False Claim Act

ATTACHMENTS

See Attachment Packet

QUALITY IMPROVEMENT

The Quality Improvement Committee on an annual basis to enhance and improve the quality will evaluate this policy/procedure.

At any time, employees can request in writing, on the form provided, that the Quality Improvement Committee review this policy or items in this policy. Employee's written requests can be given to any Quality Improvement Committee member.

When an area for improvement is indicated, the process for improvement as identified in the Quality Improvement Plan will be followed.

PROVIDER CLAIM

APPROVED BY:

Richard Thiemkey — Date
Executive Director

Kelly Jenkins — Date
Chief Operating Officer

Brenna Ellison, LLMSW, CAADC, QIDP, CMHP, QMHP — Date
Corporate Compliance Officer/Contract Manager

Julie Webster — Date
Reimbursement Officer

PROVIDER CLAIM

REVIEW DATE

02/22/06
03/14/07
05/07/08
04/22/09 – SA Merger
03/10/10
02/23/11
02/15/12
02/20/13
02/19/14
02/18/15
02/17/16
10/05/16
02/15/17
05/17/17
03/07/18
12/12/18
09/09/2020
11/04/2020