ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

Date Issued 09/24

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Fiscal Management	07	002	0025

SECTION	**SUBJECT**
Accounting	Claims Payment Appeals

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I. APPLICATION:

- ☐ SCCCMH Board
- ☐ SCCCMH Providers & Subcontractors
- ☒ Direct Operated Programs
- ☒ Community Agency Contractors
- ☒ Residential Programs
- ☒ Specialized Foster Care

II. PURPOSE STATEMENT:

St. Clair County Community Mental Health (SCCCMH) must implement a claims payment/repayment grievance and appeal mechanism that ensures compliance with applicable standards and timely dispute resolution.

III. DEFINITIONS:

A. Appeal: With respect to this administrative procedure, a request for a review of the action taken with respect to the adjudication of a submitted clean claim.

B. Clean Claim: A claim submitted by a provider for behavioral health services rendered to an eligible member with supporting documentation (including documentation in the electronic health record that accurately mirrors the claim submitted) for SCCCMH to process the claim, which contains:

1. The required data elements (complete HCFA 1500 or UB-04 standard billing forms as described in MSA (Medical Services Administration) Bulletin, Chapter IV, Uniform Billing and Reimbursement, as revised).
2. Any additional data elements that are applicable due to coverage by more than one benefits plan.
3. Any additional data elements that are applicable due to an ability to pay assessed to a consumer in accordance with the Michigan Department of Health and Human Services (MDHHS) Financial Liability/Ability to Pay Rules contained in Chapter 8 of the Michigan Mental Health Code.
4. Any amount(s) paid by another insurance plan(s) or applicable third-party payer.
5. Any amount(s) paid by the individual as assessed by the sliding fee scale.
6. Verification of Deductible Invoices (Spend Down Reports) being submitted to applicable MDHHS office if claim is for a beneficiary who has a Medicaid spend down.

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7. Supporting documentation in the electronic health record must mirror the claim submitted to SCCCMH for payment. The document must contain: Date of Service, Start and Stop Time of Service, CPT Code billed, Place of Service, Individual Providing the Service with Credentials and Job Title, and the Location (Agency Name).

C. Deficient Claim: A submitted claim that does not contain the required clean claim elements as described in the above definition.

D. Denied Claim: A submitted claim that does not contain the required clean claims elements as described in the above definition necessary for payment of the claim.

E. Disputed Claim: A clean or replacement claim that is denied, rejected, or adjudicated resulting in a payment amount that provider does not agree with.

F. Grievance: With respect to this administrative procedure, an expression of dissatisfaction about any matter relative to the adjudication of a submitted clean claim.

G. Original Claim: The first submission of the claim to the payor.

H. Rejected Claim: Another term used to describe a denied claim.

I. Replacement Claim: A claim submitted when all or a portion of a previously adjudicated claim was paid incorrectly, or a first- or third-party payment was received after SCCCMH made payment, to correct information submitted on the original claim (except a provider ID # or a beneficiary ID #) or after a subsequent utilization review deemed a claim unsubstantiated.

J. Utilization Management Appeal Team: A team comprised of the Utilization Management Program Director, Chief Financial Officer, Quality Management/Data Management Director, and Claims Reviewer(s) whose purpose it is to complete second level appeal reviews with respect to disputed Utilization Review Claims Verification review findings.

K. Void/Cancel Claim: A claim submitted when a previously adjudicated claim was paid under an incorrect provider number or under an incorrect beneficiary ID number.

IV. STANDARDS:

A. Appeals with respect to the adjudication of original or replacement claims will be accepted by SCCCMH.

B. Notification of intent to appeal the adjudication of an original or replacement claim must be submitted in writing to the SCCCMH for all first level appeals, within 30 days of receipt of the remittance advice (Explanation of Benefits/Remittance Advice) of the original or replacement claim. SCCCMH must respond within 14 days.

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C. Notification of intent to appeal the decision of SCCCMH staff handling first level appeals of original or replacement claims must be submitted in writing to SCCCMH designee(s) for the second and all subsequent level appeals, within seven (7) days of the notification of the previous decision level. SCCCMH must respond within seven (7) days.

D. Notification of intent to appeal any decisions covered by this administrative procedure received by SCCCMH in excess of stated timelines will be denied.

E. Notification of a decision regarding any appeal covered by this administrative procedure not processed within the stated timelines of receipt of appeal will result in a decision in favor of the appellant SCCCMH.

F. Submittal of a replacement claim needed as a result of the final determination of an appeal process must be filed within 30 days of the notice of final determination.

V. PROCEDURES:

A. **Appeal Process For Adjudicated Claims Disputes**

Provider

1. Encouraged to first communicate all concerns and disagreements to the appropriate SCCCMH staff person responsible for the adjudication and denial of their claims.

2. Files a written appeal within thirty 30 days of the receipt of the denial of payment notice, if not satisfied with the outcome. Written appeals should be submitted to the Chief Financial Officer.

Chief Financial Officer

3. Reviews written appeal submitted by provider along with all documentation regarding the denial of payment. Chief Financial Officer reserves the right to request additional information or direct meetings with the provider to further gather all facts regarding denial/non-approval.

4. Makes final determination with respect to the disputed original or replacement claim and notifies the provider and applicable SCCCMH staff person of decision and related rationale within 14 days of receipt of written appeal.

B. **Appeal Process For Utilization Review Claims Verification Disputes**

SCCCMH Claims Verification Technician

1. Notifies the contract agency of findings related to the Claims Verification Review by sharing the Final Claims Verification Review and reconsideration amount.

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2. Submits a request for a claim reconsideration to the Chief Financial Officer, Chief Clinical Officer, and Supports Services Director for approval.

3. Once approval has been received, the Claims Verification Review Technician submits the approval to the SCCCMH staff person responsible for adjudication of the provider's claims and requests a takeback from the provider's payment.

SCCCMH Claims Adjudicator

4. Withholds takeback amount of denied claims from provider's next scheduled payment. Forwards all necessary documentation regarding denied claims along with provider's payment.

Provider

5. Communicates all concerns and disagreements to the appropriate SCCCMH staff person responsible for the adjudication and denial of their claims.

6. Files a written appeal within 30 days of the receipt of the denial of the payment notice if the provider is not satisfied with the outcome. Written appeals should be submitted to the Utilization Management Team.

Utilization Review Team

7. Reviews written appeal submitted by provider along with all documentation regarding the denial of payment. Utilization Review Team reserves the right to request additional information or direct meetings with the provider to further gather all facts regarding denial/non-approval.

8. Makes determination with respect to the disputed original or replacement claim and notifies the provider and applicable SCCCMH staff person of decision and related rationale within 14 days of receipt of written appeal.

Provider

9. Files a written appeal within seven (7) days of the receipt of the denial of payment notice if the provider is not satisfied with the outcome of the Utilization Management Review Team's decision. Written appeals should be submitted to the Chief Financial Officer.

Chief Financial Officer

10. Reviews written appeal submitted by provider along with all documentation regarding the denial of payment. The Chief Financial Officer reserves the right to request additional information or direct meetings with the provider to further gather all facts regarding denial/non-approval.

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11. Makes final determination with respect to the disputed original or replacement claim and notifies the provider and applicable SCCCMH staff person of decision and related rationale within seven (7) days of receipt of written appeal.

V. REFERENCES:

A. PIHP Contract

VI. EXHIBITS:

N/A

VIII. REVISION HISTORY

Dates issued 11/04, 09/07, 11/09, 01/12, 06/14, 11/15, 07/16, 07/17, 07/18, 07/19, 09/20, 08/21, 09/20, 09/22, 09/23.