Administrative Appeals

Frequently Asked Questions (FAQs) and Training
for the PerformCare Provider Network

PerformCare®

Delivering
High-Quality
Service and Support

General Information for the Administrative Appeals Process

PerformCARE®

Definition: Process by which claims denials, that are not approved because they do not meet contractual or administrative requirements, are reviewed. Administrative denials are NOT denied based on medical necessity guidelines.

- This process is based on the PerformCare Policy *FI-027 Appeals of Administrative Denials*.
- Before submitting an administrative appeal request to PerformCare, the provider must have billed a claim and received a claims denial notification. **An administrative appeal will not be processed without a specified claim number(s) included on the Request Form.**
- Please submit all administrative appeal requests by postal mail to: **PerformCare Admin Appeals, P.O. Box 7301, London, Kentucky 40742**
- Each appeal request should be specific to only **one** member and **one** service/CPT code, but please feel free to include as many dates of service as needed.
- An Administrative Appeal Request form should be submitted with all information completed or the appeal may be rejected for insufficient information.
- Appeal decisions are made within 30 days of receipt by PerformCare.
- The process allows only a **one-time submission.** *PerformCare does not offer second level appeals.* Please include completed information and all appropriate supporting documentation with the first submission. **All decisions are final.**
- Please feel welcome to call PerformCare's Claims Department for assistance at 1-888-700-7370, option 1.

Documentation Requirements for Administrative Appeal Requests

PerformCARE®

For requests related to **retroactive** eligibility issues:

- ✓ Always include Eligibility Verification System (EVS) documentation from the start date of service with your appeal request.
- ✓ If appeal is related to substance abuse services, please include documentation of the Member's American Society of Addiction Medicine (ASAM) criteria.
- ✓ If appeal is related to a service that requires precertification for authorization, please include the Member's medical record.
- ✓ If the appeal is related to Behavioral Health Rehabilitation Services (BHRS), please submit the Member's complete request packet.
- ✓ If the appeal is related to Family Based Mental Health Services (FBMHS), please include all progress notes for one month prior to the dates of service and specify the exact number of additional units requested for each date of service.

For requests involving services that require **pre-authorization**:

- ✓ Member's medical records or progress notes must be submitted.
- ✓ Medical necessity criteria (MNC) must be met.
- ✓ Authorization from the primary insurer must be included (if applicable).

For requests related to **primary claims denials**:

- ✓ Explanation of Benefits (EOBs) or denial letters from the primary insurer must be included.
- ✓ Appeal request must be submitted within sixty (60) days of the date on the primary insurer's EOB/denial letter.

Why Was My Appeal Rejected?

PerformCARE®

Rejection reasons may include but are not limited to the following:

- The claim was not billed and/or the denial notice was not received before submitting the appeal.
- The Provider failed to include the claim number on the request.
- The Provider submitted incorrect and/or insufficient information.
- The claim was paid already.
- The Member was ineligible for PerformCare coverage on the requested dates of service.
- For medical necessity denials, please follow the Complaint and Grievance process — a grievance must be requested by a Member or a Member's guardian/personal representative (if the Member is less than 14 years of age). The Member has 45 days from the date of the original denial to file a grievance.
- Rejected appeals may be resubmitted for review, if instructions noted on the decision letter are followed by the Provider and the resubmission is received within 30 days of the date of the appeal rejection letter.

Why Was My Appeal Approved?

PerformCARE®

Approval reasons may include but are not limited to the following:

- Documentation of eligibility verification issues beyond the control of the Provider.
- Documentation of MNC concurrent review issues beyond the control of the Provider.
- Documentation of processing errors by PerformCare beyond the control of the Provider
- Unavoidable delay caused by another provider (i.e., BHRS evaluations)
- Timely notification and resolution of the issue —If all PerformCare protocols were met **and** the appeal was submitted timely, appeal will be approved.

Why Was My Appeal Denied?

PerformCARE®

Denial reasons may include but are not limited to the following :

- Failure in authorization management by the Provider.
- Failure in claims and billing management by the Provider.
- Failure to provide documentation of eligibility check prior to service delivery.
- Submission of the request for review beyond 60 days of denial notice or the service delivery date (if claim was never billed).
- Untimely filing - claims submitted are outside 365 days from the date of service
- Denied appeals may not be resubmitted for review. These decisions are final.

Multiple Administrative Appeal Requests

PerformCARE®

- Providers must utilize the Multiple Administrative Appeals spreadsheet (available on our website) when appealing ten (10) or more claims related to the same denial issue. Be sure to include the timeframe for the dates of service of all claims. The dollar value (must be PerformCare's contracted amount, not the billed amount) and the # of units of all claims must be listed.

- The completed template, the appeal request form, and all supporting documentation must then be securely emailed back to your Account Executive.

The Administrative Appeal Process

PerformCARE®

- Provider submits an administrative appeal request to PerformCare, PO Box 7301, London, KY 40742 with a completed Administrative Appeal Request form included as well as supporting documentation, if needed.
- PerformCare receives and reviews the request.
- An appeal that is valued at less than $10,000 and is submitted within 365 days from the dates of service will be reviewed by the Administrative Appeal Committee and will be decided within 30 days of the receipt of the appeal submission.
- An appeal that is valued at $10,000 or more and has dates of service within 365 days will be reviewed by executive management and will be decided within 30 days of the receipt of the appeal submission.
- Possible outcomes of each request are rejection, approval and/or denial.

  ✓ Rejected appeals may be resubmitted for review, if instructions noted on the decision letter are followed by the Provider and the resubmission is received within 30 days of the date of the appeal rejection letter.
  ✓ Denied appeals may not be resubmitted for review. These decisions are final.
  ✓ Payments related to approved appeals will be processed by PerformCare at the time of the decision.

Additional Resources

PerformCare®

- The Administrative Appeals Request form can be found on our website at http://pa.performcare.org/providers/claims-billing/admin-appeals.aspx.
- PerformCare Policy and Procedure *FI-027 Appeals of Administrative Denials* can be found on our website http://pa.performcare.org/providers/claims-billing/admin-appeals.aspx.
- PerformCare Provider Manual can be found on our website http://pa.performcare.org/providers/index.aspx.
- PerformCare Claims Department is available to answer questions about administrative appeals at 1-888-700-7370, option 1.
- PerformCare Account Executives (AEs) are available to answer questions about administrative appeals at **1-888-700-7370, option 3.** Dial this number and request to speak with your Account Executive.

Thank you

PerformCare®

We at PerformCare sincerely thank you for attending this administrative appeal training session.

We admire and appreciate your ongoing dedication to offer improved services to our Members.

PerformCARE®