PerformCARE®	Policy and Procedure
Name of Policy:	Appeals of Administrative Denials
Policy Number:	FI-027
Contracts:	☒ All counties ☐ Bedford / Somerset ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Finance
Related Stakeholder(s):	Claims, Provider Network
Applies to:	Provider Network
Original Effective Date:	05/06/16
Last Revision Date:	01/07/19
Last Review Date:	02/25/19
Next Review Date:	02/01/20

Policy: All providers both network and out of network are expected to follow all prior authorization requirements as defined in the Provider Manual and Provider Notices. This policy is intended to apply to administrative denials and is not applicable to level of care denials.

This policy does not apply to any claim outside of 365 days from the date of service. These submissions will be automatically denied.

Reversal of administrative denials should be regarded as an exception and will not be routinely approved without new and compelling evidence from the Provider. PerformCare will evaluate all requests and take into consideration factors which caused the procedural error as well as remedies in place to prevent future occurrences.

Purpose: To approve retroactive authorization and payment when appropriate to reverse administrative denials and establish a procedure for administrative appeal requests.

Definitions: **Administrative Appeals Committee:** Members of PerformCare's Provider Relations, Clinical, Claims, Quality Improvement, Finance and Contracting Departments who determine the outcome of appeal requests valued under $10,000 and submitted within 365 days of the requested dates of service.

Administrative Denial: Requests that are not approved because they do not meet contractual or administrative requirements. Administrative denials are NOT denied based on medical necessity guidelines.

American Society of Addiction Medicine (ASAM): Documentation for child/adolescent and adult Members that identifies guidelines for the levels of care related to Substance Abuse.
Eligibility Verification System (EVS): System utilized to check the status of a Member's dates of eligibility related to insurance coverage.
Executive Management Team: Members of PerformCare's senior management team who determine the outcome of appeal requests valued at or greater than $10,000 and/or submitted within 365 days of the requested date(s) of service.
Senior Management: PerformCare's Executive Director, Medical Director, VP of Operations, Chief Financial Officer, Director of Clinical Services, Director of Claims Management, Compliance Director, and Director of Quality Improvement.

Acronyms: None

Procedure:

1. Data Collection
   - 1.1. Historical information regarding the Provider requests for retroactive authorization and payment will be maintained in an Excel spreadsheet called the Administrative Appeals Log. Senior Management and the Administrative Appeal Committee will have access to the database. The Appeals Log will be maintained by the Claims department. The Administrative Appeals Log will be used to review the appeal information as needed in order to render decisions and also track PerformCare's timeliness in processing administrative appeals.
2. Process
   - 2.1. All provider (both network and out of network) requests for review of administrative denial must be submitted in writing within 60 days of receipt of the denial notice. A request form, entitled "Administrative Appeal Request" should be used and is available on the PerformCare website at www.performcare.org. A claims denial must occur before a review may be requested.
   - 2.2. Providers requesting review of administrative denial will be instructed to send the administrative appeal request form along with appropriate supporting documentation, if necessary, to the attention of PerformCare Admin Appeals stating the following:
     - 2.2.1. Member name, MAID and Social Security numbers, dates of service, Provider's mailing address, dollar value of the request and claim(s) numbers
     - 2.2.2. Reason for denial

2.2.3. An explanation stating why the provider was unable or failed to comply with the reason for denial

2.2.4. Steps taken to correct and prevent future occurrences

2.2.5. Documentation for dates of service(s) provided. For requests related to non-Outpatient services that have not been authorized, clinical notes as well as the treatment plan must be submitted. In any case where the service was provided without medical necessity review, all medical documentation that is relevant to the request (e.g. medical records, treatment plan, progress notes, ASAM, etc.) must be included.

2.2.6. Desired action from PerformCare

2.2.7. Documentation relevant to the request (i.e., EVS documentation verifying that eligibility was checked and wrongly indicated enrollment status, fax confirmation sheets, etc.)

2.2.8. ALL relevant information should be submitted with the appeal since the decisions of the Committee are final.

2.3. The Claims department will review submissions for completeness. Any submission missing documentation or relevant information will be considered incomplete. The request will be logged as incomplete and a request for re-submission will be sent to the provider within 3 days of the incomplete determination. The provider re-submission request outlines the information missing from the original appeal. Submissions must be received within 30 days from the date of the appeal rejection letter. Completed submissions will be logged and forwarded to the appropriate committee for review.

2.4. Medical necessity reviews will be conducted by a designee of the Director of Clinical Services, if indicated. The record will be tracked on the Administrative Appeals Log. Referral to a Physician Advisor (PA) will occur as clinically indicated. Only a PA may issue a medical necessity denial.

3. Decision-Making

3.1. The Administrative Appeals Committee will evaluate the administrative appeal request if the value is under $10,000 and submitted within 365 days of the requested date(s) of service. If the request is approved, the following conditions apply:

3.1.1. If an approved request is for the prior fiscal year and would require restatement, the request must be sent to

the Primary Contractor for their approval. Specific Contractor conditions for appeal approval are as follows:

3.1.1.1. All BHSSBC approved requests regardless of amount or fiscal year must be sent for final approval.

3.1.1.2. TMCA and CABHC will be sent any approved request over $10,000 for final approval.

3.2. The Executive Management Team will evaluate the administrative appeal request if the value is over $10,000 and submitted within 365 days of the requested date(s) of service. If the request is approved, the following conditions apply:

3.2.1. If an approved request is for the prior fiscal year and would require restatement, the request must be sent to the Primary Contractor for their approval.

3.2.2. All BHSSBC approved requests regardless of amount or fiscal year must be sent for final approval.

3.2.3. TMCA and CABHC will be sent any approved request over $10,000 for final approval.

3.3. Both the Administrative Appeals Committee and the Executive Management Team will render a recommendation within 30 days of receipt of the complete request. If Primary Contractor approval needed, the Primary Contractor will render a decision within 15 days of receipt of recommendation from PerformCare. A decision letter will be mailed to the Provider within 5 days of Primary Contractor decision. If Primary Contractor approval not needed, PerformCare will mail letter to Provider within 5 days of decision.

3.4. Any approval that requires Primary Contractor final approval must include the following documentation:

3.4.1. All information and documentation that is included in Section 2.2 above; and

3.4.2. The basis and reasons for the Administrative Appeal Committee and/or Executive Management Team approval recommendation.

Related Policies: *CM-MS-003 Outpatient Treatment Requests, Denials and Authorizations*

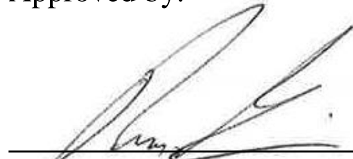
Related Reports: None

Source Documents and References: *PerformCare Provider Manual*
PerformCare Provider Notices

Superseded Policies and/or Procedures: *PR-017 Appeals of Administrative Denials*
QI-041 Appeals of Administrative Denials

Attachments: *Attachment 1 Administrative Appeal Request Form*

Approved by:



____
Primary Stakeholder