KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

ADMINISTRATIVE POLICY & PROCEDURE 02.02

Subject: Provider Grievance and Appeals (non-clinical)	**Section:** Provider Network Management	
Applies To: ☒ KCMHSAS Staff ☒ KCMHSAS Contract Providers		**Page:** 1 of 5
Approved: (Jeff Patton, Chief Executive Officer)		
Revised: 08/18/2017	**Supersedes:** 03/20/2015	**First Effective:** 11/08/2001

PURPOSE

To provide a mechanism for providers to lodge complaints (grievances) and request reconsideration of (appeal) decisions related to non-clinical issues.

DEFINITIONS

Adverse Notification
A notice, by any means, that documents a denial of authorization or claim, a reduction, suspension or adjustment to a claim, or the denial of participation as a panel provider.

Appeal
A formal process which is established so that providers may request reconsideration of an action or decision that has been made by KCMHSAS.

Grievance
An expression of dissatisfaction by a provider regarding a perceived inequitable issue, aspects of interpersonal relation or other related issues.

POLICY

It is the intent of Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) that relationships with providers be positive and mutually supportive. Therefore, exploration of problems and disagreements is welcomed.

STANDARDS

I. APPLICATION

A. The provider grievance and appeals process applies only to non-clinical related issues including:
   1. Suspension or termination of a provider with cause
   2. Credentialing or re-credentialing decisions
   3. A sanction or decision to place the provider on a provisional status
   4. Claims payment and authorizations
   5. Reduction, suspension or adjustments to provider payments
   6. Results reported on performance indicators
   7. Results reported through Quality Monitoring Reviews (QMR)
   8. Other non-clinical issues

B. The appeal of an immediate contract termination shall have no effect on the immediate termination of the contract or any services provided under the contract. If appealed, the termination will remain in effect until the appeal process has been completed and will be rescinded only if the termination is not upheld on appeal.

C. Criteria used to determine the outcome of an appeal:
   1. Is the initial decision consistent with KCMHSAS contract language
   2. Does the KCMHSAS contract language contain confusing or contradictory language
   3. Has there been other communication from KCMHSAS staff that contradict or adds confusion to the KCMHSAS contract language
   4. Is there additional information that impacts the appeal situation that was not available or considered in the original determination
   5. Does the impact of the original determination result in harm or extreme hardship for individuals served

D. Notification of the Right to Appeal
   1. The right to appeal will be included in each provider agreement.
   2. Providers will be informed of a progressive appeal process as part of the notification of a negative appeal result.

PROCEDURE

I. FILING AN APPEAL OR GRIEVANCE

A. Providers are asked to communicate concerns and grievances with the appropriate KCMHSAS staff before making a formal appeal. If providers are still unable to reach resolution or a satisfactory agreement, they may file an appeal in writing using the attached procedures and form (Provider Appeal Request). All appeals should be sent directly to the PNWG Administrative Assistant.

B. Appeals for credentialing decisions and any services (other than claims or authorization) must be filed within 30 calendar days after receiving an adverse notification from KCMHSAS.

C. As stated in KCMHSAS policy 08.08 (Claims Management), all claims are permanently denied after one year (365 days) from the date of service. Appeals involving claims or authorizations must be filed within 180 calendar days after receiving an adverse notification in order to allow the entire appeal process to occur, if needed.

D. First Level

The KCMHSAS department overseeing the area the appeal addresses will review all first level appeals and a decision will be issued within 30 calendar days. All appeals involving more than $5,000 will automatically be moved to a second level appeal in order to help expedite the appeals process on questions of large dollar amounts.

Appeals resulting in the potential use of KCMHSAS General Fund dollars will automatically be considered a Second Level Appeal, bypassing the First Level Appeal process.

Provider must complete the Provider Appeal Request and include, but not inclusive, the following information:

1. Reason for the appeal (i.e., service was in Person-Centered Plan, but not matching authorization; covered dates of service within the Person-Centered Plan)
2. Service activity code
3. Total number of units
4. Date range involved in the appeal
5. Claim line not paid

E. Second Level

If the provider is dissatisfied with the First Level decision, a second appeal can be filed within 20 calendar days.

Provider must complete the Provider Appeal Request and include, but not inclusive, the following information:

1. Information contained in the First Level
2. Additional supporting information for the Second Level Appeal that includes additional information that is outlined in the decision criteria (Section A.3).

F. Third Level

If an appellant is not satisfied with the decision of the Second Level, they may make a third appeal within 20 calendar days.

Provider must complete the Provider Appeal Request and include, but not inclusive, the following information:

1. Information contained in the First and Second Level
2. Additional supporting information for the Third and final Level Appeal

G. Fourth Level
Providers within the Southwest Michigan Behavioral Health (SWMBH) region may, as a final step, appeal Medicaid claims dispute decisions to the SWMBH Director of Operations within 14 calendar days.

H. At any level of appeal, KCMHSAS may use an on-site claims, utilization or quality monitoring review to assist in making an accurate decision.

I. Any level of appeal, if there are unforeseen circumstances which cause delay of a response, adequate notification will be sent to the provider including timeframes for determination.

J. If the appeal is not filled out in its entirety upon receipt, it will be sent back to the provider for completion.

II. RESPONSIBILITY

A. All KCMHSAS staff are responsible to ensure that providers and prospective appellants are assisted as needed and that their requests are directed to the appropriate individual in accordance with established procedures.

B. Responsibility for resolving First Level Appeals is assigned to the Manager Financial Analyst for appeals related to claims payments and to the Access Program Manager for claims related to authorizations.

C. Responsibility for resolving Second Level Appeals is assigned to the Chief Operating Officer, along with the applicable Director or department head.

D. Responsibility for resolving Third Level Appeals is assigned to the Chief Executive Officer, in conjunction with the Chief Operating Officer, applicable Deputy Director and Legal Counsel as needed.

E. The Provider Network Work Group is responsible to ensure that:

1. All of the available information is reviewed
2. Provide any needed clarification of policies and/or procedures.
3. Refer to other staff for information and/or problem solving as needed
4. There is a response to the appellant according to the established time frames
5. The appellant is informed of the next level of appeal if appropriate

REFERENCES

- Medicaid and General Fund Specialty Supports and Services Contract with the Michigan Department of Health and Human Services
- MDHHS/PIHP Medicaid Managed Specialty Supports and Services Contract – 6.4.B.
- Southwest Michigan Behavioral Healthcare Policy
  - 2.14 (Provider Grievances and Appeals [non-clinical])

EXHIBITS

A. Provider Grievance and Appeals Process (non-clinical) Flowchart

B. KCMHSAS Provider Appeal

Please indicate level of Appeal you are currently filing: ____ 1 ____ 2 ____ 3

If 2 or 3 is checked above, the assigned KCMHSAS appeal number MUST be written here _____

KALAMAZOO COMMUNITY Mental Health & Substance Abuse Services

"Empowering people to succeed."

Provider Appeal

CMH ID# (if applicable): _____ Consumer Name: _____

Primary Clinician _____ Primary Provider _____

Name of Filer: _____

Name of Filing Agency: _____

Agency's Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Related to:

_____ Date of Receipt of Adverse Notice

_____ Claims Payment and/or Adjustment to Payment (**please attach a copy of the denied claim form**)

_____ Authorizations

_____ Denial or Suspension of Provider Panel Status

_____ Other Non-Clinical Issue (please explain) _____

KCMHSAS Claim #: _____

Program Code denied: _____

Date range denied: _____

# of Units denied: _____
(i.e., months, days, sessions, etc.)

Desired resolution for this Appeal:

Standard or criteria based on KCMHSAS Policy 02.02 Sections 1.D and 1.E upon which the Appeal is based and supporting information or documentation related to the criteria:

If Level II Appeal, provide new information to support a Level II Appeal:

_____ _____ Date: _____

Signature Printed Name

Note: If this appeal form contains insufficient information, it will automatically be denied.

FOR OFFICE USE ONLY

Decision: ____ approved ____ partial approval ____ denied Date of Approval/Denial: _____

Comments: Signature: _____

Cc: Population Director

Send all Appeal forms to:
Kalamazoo Community Mental Health Substance Abuse Services
Attn: Administrative Assistant, Quality Management & Contracts
2030 Portage Street
Kalamazoo MI 49001