NORTHCARE NETWORK

POLICY TITLE: Provider Appeal Process – Medicaid Adverse Benefit Determination (Medical Necessity) and Payment Policy	**CATEGORY:** Provider Network Management (PNM)	
EFFECTIVE DATE: 11/10/21	**BOARD APPROVAL DATE:** 11/10/21	
REVIEW DATE: 11/16/22	**REVISION(S) TO POLICY STATEMENT:** ☐ **Yes** ☒ **No**	**OTHER REVISION(S):** ☒ **Yes** ☐ **No**
RESPONSIBLE PARTY: Senior Clinical Director/Compliance Officer	**CEO APPROVAL DATE:** 12/6/22 Dr. Tim Kangas, CEO	

APPLIES TO
NorthCare Personnel
Network Providers

POLICY
NorthCare Network supports due process and offers contracted providers with an appropriate mechanism to appeal adverse benefit determinations and denial of payment in whole or in part. This procedure is intended to assure that a uniform process is utilized.

PURPOSE
To outline a mechanism for provider appeals related to adverse benefit determinations and denial of payment in part or in full.

DEFINITIONS
1. **Adverse Benefit Determination:** A decision that adversely impacts the Medicaid Enrollee's claim for services. (*42 CFR 438.400)*
2. **Appeal:** A review at the local level by the PIHP of an Adverse Benefit Determination, as defined above. (*42 CFR 438.400*)
3. **Enrollee:** A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or CCM entity in a given managed care program.

REFERENCES
- MDHHS Policies & Practices Guidelines - Appeal and Grievance Resolution Processes Technical Requirement https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html
- NorthCare Enrollee Grievance and Appeals Policy
- NorthCare Notice of Adverse Benefit Determination Policy
- NorthCare MHL Program-Authorizations Policy
- NorthCare Service Authorization Policy
- NorthCare Provider Grievance and Appeal Policy – Administrative

HISTORY
NEW POLICY: 11/10/21
REVISION DATE: 11/16/22
REVIEW DATE: 11/16/22
CEO APPROVAL DATE: 11/2/21, 12/6/22
BOARD APPROVAL DATE: 11/10/21

PROCEDURES FOR PAYMENT DENIALS

Providers may file an Appeal in writing to PNM@northcarenetwork.org as outlined in this policy. Other policies that address consumer and non-clinical provider grievance and appeals are noted under the reference section herein.

A. **Administrative Process**

With the written consent from the member, a provider or an authorized representative may request an appeal on behalf of an enrollee; with the exception that providers cannot request continuation of benefits as specified in § 438.420(b)(5). When a provider or authorized representative requests an appeal on behalf of the enrollee the Enrollee Grievance & Appeal Process Policy will be followed. Only one level of appeal is provided.

1. A provider has sixty (60) calendar days from the date of the notice of Adverse Benefit Determination to request an appeal. This request for appeal may be done in writing or orally, all oral appeals will be treated as appeals.
2. Upon receipt of a request by a provider for an appeal, NorthCare's Provider Network Specialist will:
    - forward adverse benefit determination or denial of payment appeal request to NorthCare's QI Coordinator/Compliance Officer.
    - schedule a review with pertinent NorthCare staff to establish the respective Appeal Review Team;
    - will gather, or assist in gathering, relevant documentation for the appeal.
    - create a folder for each appeal for proper filing at: N:\Confidential\Provider Appeals with the following naming convention: Date_MCO-Initials in folders organized by fiscal year.
3. Administrative appeals are based on NorthCare following the correct administrative processes and are not based on the clinical rationale for determinations. Administrative appeals will be conducted by another reviewer who is qualified to conduct initial clinical reviews.

B. **Denial of Service Authorization Appeal Process**

NorthCare Network maintains a formal appeal process to consider clinical appeals for denial of authorization. There are options for both a standard appeal as well as an expedited appeal for cases involving urgent care. NorthCare Network provides the consumer, provider, or facility rendering the service the opportunity to submit written comments, documents and records related to the case. All such information is taken into account regardless of whether the information was available at the time of the initial consideration of the case. If the local level appeal results in overturning the initial denial, the service is authorized.

Appeal considerations are conducted by appropriate clinical/medical professionals who are clinical peers in the service requested, hold a current, active, valid unrestricted Michigan license, are board certified (when applicable), are in the same profession/specialty as typically manages the treatment, and are neither the individual who made the initial denial determination or a subordinate of this individual. For each appeal case they accept, reviewers attest to 1) having a scope of licensure that typically manages the issue under review, and 2) current relevant experience and/or knowledge to render a determination in the matter that is the subject of the appeal review.

Written notification of an adverse appeal determination is provided to the consumer, ordering provider, and/or facility rendering the service. The written notification includes all the following information:

- Date the decision was made
- Principal reason(s) for upholding the denial.
- A statement that the clinical rationale used to make the determination is available, in writing, upon request.
- Information about further appeal mechanisms. (if any).

NorthCare Network maintains records for each appeal which includes:

- Name of consumer, provider, and facility rendering the service.
- Copies of all correspondence between NorthCare and the consumer, provider, and facility rendering service regarding the appeal
- Dates of appeal reviews, documentation of actions taken, and final resolution.
- Minutes or transcripts of appeal proceedings (if any).
- Name and credentials of clinical peer that rendered the appeal determination.

The type of appeal and time frames for responding are described in the following table:

Type of Appeal	Time Frame
Expedited Appeal	Expedited appeals if **approved** by the PIHP, the appeal must be resolved and notice provided to all the affected parties within 72 hours. If a request for an Expedited appeal is **denied**, the PIHP must make reasonable effort to give Enrollee prompt oral notice of the denial and within 2 calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe to a standard appeal and inform the Enrollee of the right to file a Grievances if they disagree with the decision.
	NOTE: Punitive action must not be taken against a provider for requesting an expedited resolution or supporting a member's appeal.
Standard Appeal	Standard appeals are completed, and written notification issued within 30 calendar days of the receipt of the request for the appeal to the consumer, ordering provider and facility.

If NorthCare has not already utilized an Independent Review Organization to conduct the Peer-to-Peer clinical review of the appeal, NorthCare Network beneficiaries have access to an Independent Review process after other internal appeal mechanisms have been exhausted. NorthCare Network maintains a contract with an organization that provides Independent Review services and meets the following standards:

- Utilizes staff with appropriate clinical expertise and licensure/certification in rendering independent review determinations.
- Does not have direct financial interest in NorthCare Network or in the outcome of the independent review.
- Renders UM determinations for non-urgent cases within 30 calendar days from the date of the consumer request for independent review.

- Renders UM determinations for urgent cases within 72 hours from the date the consumer requested independent review.
- Is not involved in the original determination that is considered in the appeal.

All Michigan Medicaid beneficiaries have the right to a State Fair Hearing after first exhausting the local level appeal process or when the PIHP fails to adhere to the notice and timing requirement for resolution of Grievances and Appeals, as described in 42 CFR 438.408 and NorthCare Network's Grievance and Appeal Policy. The State Fair Hearing determination overrides any prior determination. Medicaid beneficiaries also have the right to request a Second Opinion if admission to psychiatric hospitalization or access to mental health services is denied.

C. **Denial of Payment Appeal Process**

NorthCare Network maintains a formal appeal process to consider appeals for denial, in whole or in part, of payment for a service. NorthCare provides the appellant the opportunity to submit written comments, documents and records related to the case. All such information is taken into account regardless of whether the information was available at the time of the initial consideration of the case. If the local level appeal results in overturning the initial denial, the service will be paid.

For denial of payment an Adverse Benefit Determination (ABD) Notice must be provided to the Enrollee at the time of the action affecting the claim to inform them of their appeal rights.

D. **SPECIAL CONSIDERATIONS FOR INPATIENT PSYCHIATRIC APPEALS**

The individual or the provider may request an appeal at two points:

1. A clinical denial
    - A clinical appeal affords the provider or individual the opportunity to submit additional clinical information. This information is provided to the IRO for determination
2. A payment denial
    - A payment appeal identifies if claims were handled and paid appropriately. It does not consider additional clinical information. Payment denials follow the process listed above.

Depending on if a review is concurrent or retrospective, the individual may or may not be inpatient at the time of initial denial and the appeal request.

Inpatient psychiatric clinical appeal requests are filtered through Utilization Management staff and submitted to the IRO. Determination is housed outside of the appeal module. The hospital is notified of the determination via letter, and the individual is provided a notice of Adverse Benefit Determination.

NorthCare Flow chart for Inpatient Service Denials and Appeals

Inpatient continuing stay reviews (**CSR'S**) are conducted on an as needed basis, based on medical necessity, by a qualified mental health practitioner.

If the inpatient stay is thought to not meet criteria, a peer to peer consultation is offered to the provider.

If the inpatient stay is approved, the next review date is set for the last covered day (Return to top).

If the provider wants a **peer to peer** (**P2P**) consult; the name and phone number of the contact person are obtained along with best times to be reached.

If provider does not respond to a request for a **P2P** consult or decides not to participate, an administrative denial is rendered. Appeals of administrative denials can only be overturned if the **process** was not followed, it is not based on **clinical** review.

The **P2P** clinical reviewer will be the NorthCare (**NC**) Medical Director or, if not available Contracted Independent Review Organization (**ICO**) The **P2P** reviewer is contacted by **NC** and:

- given the name of the consumer and NC contact,
- the name and phone # of provider seeking a **P2P** consult along with times to reach the provider,
- **NC** will send the most recent **CSR's** to **P2P** by secure e-mail if the reviewer does not have access to the electronic medical record,
- **NC** obtains the **P2P** reviewers name, e-mail address and contact phone number

P2P reviewer contacts the provider, conducts a **P2P** consultation within 24 hours and contacts the **NC** reviewer contact person with their opinion. **P2P** reviewer will render an opinion via secure email.

If **P2P** reviewer is unable to have a **P2P** consult within 24 hours (unsuccessful attempts to contact the provider), **NC** will try to facilitate the **P2P** consult with the provider as needed and determine if the case will be pended based on extenuating circumstances. **P2P** reviewer will provide **NC** documentation of attempts to contact the provider.

P2P reviewer will notify **NC** as to their opinion by secure e-mail within 24 hours.

If it is the **P2P** reviewer's opinion that the consumer **does** meet medical necessity criteria for continued inpatient stay, the **P2P** reviewer will contact **NC** by phone to discuss the case. **NC** will notify the hospital and **CSR's** will continue to occur by **NC**. (Return at top)

If it is the **P2P** reviewer's opinion that the consumer does **not** meet medical necessity criteria for continued inpatient stay, the **P2P** reviewer renders the decision to **NC** by secure fax (1). **NC** denies further payment, notifies the hospital and sends notification to the beneficiary.

If the Provider decides to appeal the **NC** decision, they are given an opportunity to provide additional information to support their claim to **NC**. The Appeal **P2P** Reviewer with no prior involvement with the case (**NC** Medical Director or if unavailable **ICO**) is notified and will conduct an appeal after reviewing all available information.

If it is the Appeal Reviewer's opinion that the consumer does **not** meet medical necessity criteria for continued inpatient stay, the **P2P** appeal reviewer renders the decision to **NC** by secure fax (1). **NC** denies further payment and notifies the hospital. There is no further appeal process for the provider.

If it is the Appeal Reviewer's opinion that the consumer **does** meet medical necessity criteria for continued inpatient stay, the **P2P** reviewer will contact **NC** to discuss the case. **NC** will notify the hospital and **CSR's** will continue to occur by **NC.** (Return to top)

(1) The **P2P** reviewer provides reason for denial and includes a statement indicating they attest to having the scope of licensure or certification that typically manages the treatment, services or issue under review; and, that their current, relevant experience and/or knowledge allows them to render a determination for the case under review.