WOODLANDS BEHAVIORAL HEALTHCARE NETWORK

PROVIDER NETWORK POLICIES

Subject: Provider Grievance and Appeal: non-clinical

I. Purpose

To outline the mechanism for provider complaints (grievances) and requests for reconsideration of decisions (appeal) related to non-clinical issues. This policy does not apply to medical necessity appeals which are addressed in a separate WBHN policy.

II. Policy

The intent of WBHN is to foster a positive and mutually supportive relationship with its provider network. When non-clinical problems and disagreements arise, the following policy should be used for provider grievances and appeals.

III. Standards and Guidelines:

Application

The provider grievance and appeals process applies to non-clinical issues including, but not limited to:

a. Suspension or termination of a provider with cause (issues of quality of care/service).
b. Credentialing or re-credentialing decisions
c. Contract compliance issues resulting in a sanction or decision to place the provider on a provisional status
d. Material breaches highlighted in the contract.
e. Claims payment and authorizations
f. Reduction, suspension or adjustments to provider payments
g. Results reported through provider monitoring reviews.
h. Other non-clinical issues

An appeal of contract termination shall have no effect on the immediate termination of the contract and services under contract. The termination will remain in effect until the appeal process is completed, and will be rescinded only if the termination in not upheld on appeal.

Notification of the Right to Appeal

The right to appeal will be included in each provider agreement and/or referenced by policy. Providers will be informed of a progressive appeal process as part of the notification of a negative appeal result.

Filing an Appeal or Grievance

Providers are asked to communicate concerns and grievances with the appropriate WBHN 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 (see required information below). All appeals should be sent directly to the WBHN Provider Network Manager.

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 WBHN.

Any/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.

First Level Appeal Review:

The WBHN Compliance Committee will review all first level appeals and a decision will be issued within 30 calendar days of receiving the Appeal Request. All appeals involving more than $5,000 will automatically be moved to a second level appeal.

Appeals resulting in the potential use of General Fund dollars will also automatically be considered a Second Level Appeal.

The Provider must complete a written Appeal Request including 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

WBHN will render a decision to dismiss or substantiate the appeal within 30 days of receipt of the Appeal Request.

Second Level Review:

If the provider is dissatisfied with the First Level decision, a second appeal can be filed within 15 calendar days of the First Level review decision notification. This review will be conducted by WBHN's Executive Leadership Team with a decision rendered within 15 days of receipt of the Appeal Request.

The Provider must complete a written Provider Appeal Request to include, 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.

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 of the Second level Appeal decision.

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

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

Definitions:

1. 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.

2. Appeal
   A formal process which is established so that providers may request reconsideration of an action or decision that has been made by the PIHP or contracting CMHSP.

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

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