PerformCARE®	Policy and Procedure

Name of Policy:	Appeals of Administrative Denials
Policy Number:	FI-027
Contracts:	☒ All counties ☐ 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:	03/29/24
Last Review Date:	11/01/24
OMHSAS Approval Date:	11/01/24
Next Review Date:	11/01/25

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 medical necessity level of care denials.

This policy does not apply to any claim outside of 365 calendar days from the date of service except as noted below. Submissions not subject to exceptions will be automatically denied.

Exceptions to the 365 calendar days from date of service rule may occur under specific events. Instances which may lead to an exception include an improper rejection, resulting from a claim submission error by the Behavioral Health Managed Care Organization (BH MCO), or a Secondary/third party liability (TPL) primary payor issue.

An improper claim rejection due to a processing error created by the BH MCO claim submission vendor or PerformCare may invalidate the 365 calendar days from date of service rule. Specific information, including the initial submission and submission record, is required to substantiate the rejection error.

Secondary/TPL claims can supersede the 365 calendar days from date of service rule if the Primary Payor's policy causes the claim to exceed 365 calendar days from date of service. The notice of the Primary payor rejection is required to substantiate the exception Claims.

Reversal of administrative denials, known as reconsiderations, 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: Unapproved requests that 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.
Psychiatrist/Psychologist Advisor: Licensed Clinical Professional contracted or employed by the BH MCO to conduct reviews and offer recommendations.
Primary Contractor: Organization holding the Behavioral Contract with the state agency. PerformCare's Primary Contractors include Capital Area Behavioral Health Collaborative (CABHC) and Tuscarora Managed Care Alliance (TMCA).
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:
BH-MCO: Behavioral Health Managed Care Organization
MAID: Member Medical Assistance Identification Number
TPL: Third Party Liability
TMCA: Tuscarora Managed Care Alliance
CABHC: Capital Area Behavioral Health Collaborative
DHS: Department of Human Services

Procedure:

1. Data Collection
   - 1.1. Historical information regarding the Provider requests via Administrative Appeal Request Form (*Attachment 1*) 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 (*Attachment 2*) will be maintained by the Claims department. The Administrative Appeals Log will be used to review the appeal information, as needed, to render decisions and 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 denials must be submitted in writing within 60 calendar days of receipt of the denial notice. A request form, entitled Administrative Appeal Request Form (*Attachment 1*), should be used and is available on the PerformCare website at www.performcare.org. In instances where an appeal contains multiple claims, a supplementary spreadsheet containing the claims may be submitted with the Appeal Request form. A claims denial must occur before an administrative review may be requested.
   - 2.2. Providers requesting review of administrative denial will be instructed to send the administrative appeal request form with appropriate supporting documentation to the attention of PerformCare Admin Appeals stating the following:
     - 2.2.1. Member name, MAID, 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 6 Dimension assessment for SUD levels of care and admission and discharge

psychiatric evaluation for mental health inpatient and partial) must be included.

2.2.6. Desired action from PerformCare.

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

2.2.8. ALL relevant information should be submitted with the appeal, as the decision of the Committee is 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 calendar days of the incomplete determination. The provider re-submission request response outlines the information missing from the original appeal. Submissions must be received within 30 calendar days from the date of the appeal rejection letter (*Attachment 3*). 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. The record will be tracked on the Administrative Appeals Log. Referral to a Psychiatrist/Psychologist 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 date(s) of service and the request is within 60 calendar days of claim denial. 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 DHS Report 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. 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 claim date(s) of service and request is within 60 calendar days of claim

denials. 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 DHS report restatement, the request must be sent to the Primary Contractor for their approval.

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

3.3. Secondary or TPL claims supersede the 365 days from date of service rule when a Primary's Payors billing policy causes the claim to fall outside of the 365-day range. The 60-calendar day rule from the denial applies. The TPL rule also applies to claims in which the Primary Payor reimbursed a claim but later processed a retraction. Providers must supply evidence of the Primary Payor billing policy which caused the claim to exceed the 365 days from date of service. Processing of claims falling under the exception will occur according to AmeriHealth Policy 484-001, Request for Action. The $10,000 Primary Contractor dollar value threshold applies as well.

3.4. Both the Administrative Appeals Committee and the Executive Management Team will render a recommendation within 30 calendar days of receipt of the complete request. If a Primary Contractor approval is needed, the Primary Contractor will render a decision within 15 calendar days of receipt of recommendation from PerformCare. A decision letter (*Attachment 4/Attachment 5*) will be mailed to the Provider within 5 days of Primary Contractor decision. If Primary Contractor approval is not needed, PerformCare will mail letter to Provider within 5 calendar days of decision.

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

3.5.1. All information and documentation that is included in Section 2.2 above, and

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

3.6. Providers must submit corrected claims within 60 calendar days from receipt of the approved appeal notice.

4. Reconsideration

4.1. A reversal of an administrative denial or reconsideration may be submitted by a Provider. The submission of a reconsideration is subject to several conditions.

4.1.1. A reconsideration must be submitted within 60 calendar days of an administrative appeal denial receipt.
4.1.2. Reconsiderations may only be submitted for original appeal denials of $1,000 in total or higher.
4.1.3. The reconsideration must include an encapsulation of the original appeal and denial reason.
4.1.4. The reconsideration must include new and compelling evidence as the pillar of the submission. Reconsiderations lacking new information will not receive a review and will be considered deficient.
4.1.5. Resubmitting only the original appeal documentation is not considered new evidence.
4.1.6. An appeal denial may only be submitted for reconsideration once.

4.2. Reconsiderations will be viewed by the Executive Management Team irrespective of the committee who initially submitted the denial.
4.2.1. The Executive Management team will review and submit a reconsideration decision within 10 calendar days of receiving the reconsideration.
4.2.2. Executive Management team can request the original detail of the appeal denial before submitting a decision.

4.3. After receiving an Executive Management team decision, the Reconsideration is routed to the appropriate Primary Contractor for final ruling.
4.3.1. The Primary Contractor will submit a decision within 10 calendar days of the reconsideration receipt.

4.4. The submitting Provider will receive the reconsideration decision within 10 calendar days after receipt of the Primary Contractor's decision.

4.5. The reconsideration decision provided by the Primary Contractor is final and not subject to further appeal or reconsideration.

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

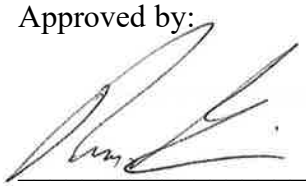
Related Reports: None

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*
Attachment 2 Appeal Log
Attachment 3 Appeal Rejection Letter
Attachment 4 Appeal Approval Letter
Attachment 5 Appeal Denial letter
Attachment 6 RFA Form PerformCare 6100
484-001 Request for Action (RFA) Process

Approved by:



Primary Stakeholder

Admin Appeal Number	Date Of Submission	Contact	Facility/Provider First Name	Provider Last Name	Address #1	Address #2	City	State	Zip Code

County	Service	CPT Code/Modifier	Service Dates Requested	Member Initials	MAID#	Summary Of Provider Reason For Error	Authorization	Claims Billed	Claims Paid	Clinical Review	Sent For Clinical Review On	Response From Clinical Review	Executive Review

Sent For Executive Review On	Response From Executive Review	Meeting Notes	Reject	Approve	Deny	Source Of PerformCare Error

Reason & Other Notes For Letter	Date Of Response Letter	TMCA Recommendations For F/F County Members	$ Amount Requested	Claim #	Missing Claims Issue?	OON Provider?	Sent For OON Review On	Response From OON Review	Reviewed For Claims Reserve Impact	Technical Assistance For Providers

PerformCARE®
P.O. Box 7301
London, KY 40742

Date

Provider Name
Provider Name
Address
City, State ZIP

Re: Administrative Appeal #
Service Type:
Plan: Health Choices
Member ID:

Dear (Provider),

Your request for reconsideration of retroactive authorization and/or payment for Services provided has been received and reviewed based upon facts indicated in your letter received for the following date(s) of service:

After further review, your request has been rejected due to:

Please resubmit the complete administrative appeal request with this appeal's original rejection letter and mail to: PerformCare Administrative Appeals, PO Box 7301, London, KY 40742.

Appeal resubmissions must be received within 60 days from the date of the appeal rejection letter.

For additional Provider information and resources, please visit our website at www.performcare.org.

Sincerely,

Administrative Appeals Committee

cc: File

PerformCARE®
P.O. Box 7301
London, KY 40742

Date

Provider Name
Provider Name
Address
City, State ZIP

Re: Administrative Appeal #
Service Type:
Plan: HealthChoices
Member ID:

Dear,

Your request for reconsideration of retroactive authorization and/or payment for Services provided has been received and reviewed based upon facts indicated in your letter received for the following date(s) of service:

After further review, your request can be accommodated due to:

Reimbursement for the approved clean claim(s) is currently being processed by the PerformCare Claims Department.

Please note, any claims with billing errors cannot be reimbursed unless corrected claims are submitted. Corrected claims must be submitted within 60 days of this notice with a copy of this appeal approval letter to the address noted below.

PerformCare PA HealthChoices
PO Box 7308
London, KY 40742

Payment can only be made to Providers who are actively enrolled with the PA Medical Assistance Program for services rendered and for persons who are eligible for PerformCare coverage at the time of service.

The decision of this review process is final.

For additional Provider information and resources, please visit our website at www.performcare.org.

Sincerely,

Administrative Appeals Committee

cc: File

PerformCARE®
P.O. Box 7301
London, KY 40742

Date

Provider Name
Provider Name
Address
City, State ZIP

Re: Administrative Appeal #
Service Type:
Plan: Health Choices
Member ID:

Dear (Provider),

Your request for reconsideration of retroactive authorization and/or payment for Services provided has been received and reviewed based upon facts indicated in your letter received for the following date(s) of service: .

After further review, your request cannot be accommodated due to:

The decision of this review process is final.

For additional Provider information and resources, please visit our website at www.performcare.org.

Sincerely,

Administrative Appeals Committee

cc: Director of Claims
File

AmeriHealth Caritas
Care is the heart of our work

Enterprise Operations Solutions
Request for Action (RFA)
Plan Business Decision Document
RFA Number: LOB6100 DDMMYYYY

Project Name:	**Submitter:**
Plan/LOB: 6100 - PerformCare	**Provider Name:** **Provider ID:** **Provider TIN:**
RFA Submission Date:	**Requested Implementation Date:**
Submission Instructions: ▪ Email notification must be sent to your Business Engagement Manager (BEM) for RFA tracking ▪ Project should be entered into CORS with the corresponding RFA number and project name	
Request Type: ☐ ***Waive Timely Filing*** ☐ ***Over 365 Days Old*** ☐ ***Waive Prior Authorization*** ☐ ***Process or Policy Change****	**Department:** ☐ ***Claims*** ☐ ***Contact Center*** ☐ ***Enrollment*** ☐ ***PNM*** ☐ ***Other:*** _____
Estimated Financial Impact:**	**Number of Claims**:**
Claim Numbers:	
Date of Service (DOS) Range Impacted:	
Root Cause of Request:	
Business Decision:	
Corrective Action Plan/Remediation:	
Adverse Impact/Justification/Benefit:	

Required Signature:
Market President or
Director, Plan Operations & Administration: _____ **Date:** _____

Your signature indicates you agree with all information contained herein, physical signature is required.