

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN		<i>Policy and Procedure</i>	
Department Provider Relations Unit		# of Pages: 8	
Policy Name Provider Appeals		Type of Policy: <input type="checkbox"/> WCHO <input checked="" type="checkbox"/> Regional <input type="checkbox"/> Network	
Policy Number 11.010	Effective Date	Revision Date April 2006	Approval Date
Administrative/Board of Directors Sign Off			
Administrative Signature:			Date:
Board of Directors Signature:			Date:

I. PURPOSE

To establish policy and procedures for network providers to appeal when dissatisfied with Community Mental Health Partnership of Southeast Michigan (CMHPSM) decisions.

II. APPLICATION

Providers on the CMHPSM network provider panel, and individuals or organizations applying to the CMHPSM provider panel.

III. DEFINITIONS

None

IV. POLICY

A. Final Decision on Appeals: The Board with jurisdiction over the appeal will make a final decision on appeals submitted by CMHPSM network providers, unless otherwise specified in this policy.

B. Appealable Decisions/Actions:

The following may be appealed:

- The decision to deny an application submitted under a Request for Proposal (RFP)/denial of appointment to the CMHPSM network provider panel. The provider will receive written notice of this decision, including the reason for denial;

- The decision to deny a provider for specific sole source services. The provider will receive written notice of this decision, including the reason for denial;
- The score of a provider site visit conducted by the CMHPSM or any of its affiliates. The provider will receive written notice of this score when the site visit report is issued;
- The decision to place a contracted provider on provisional status. The provider will receive written notice of this decision, including the reason(s) for the action;
- The termination of a contract with cause. The provider will receive written notice of this decision, including the reason(s) for termination;
- The outcome of a submitted claim. The provider will receive a Remittance Advice (RA) indicating the reason(s) for non- or partial payments of a claim;
- If the provider believes it was discriminated against for inclusion on the network panel, for reimbursement, or for indemnification - this includes decisions based on either of the following reasons: the provider is acting within the scope of their license/certification and the decision is based solely on that license/certification; or the decision is based on the fact that the provider serves high-risk populations or specializes in conditions that require costly treatment;
- The decision to deny an authorization for continued stay/services or to authorize less than the amount, duration, or scope of services requested. The provider will receive verbal or written notice of this decision, including the reason for the denial. Documentation of all such decisions shall be maintained within the local Utilization Management Department;
- Adverse CMHSPM decisions about granting, renewing, or revising clinical responsibilities to licensed independent practitioners;
- Actions that adversely affect a consumer's access to services or a consumer's receipt of current/ongoing services if the provider is acting on behalf of a consumer and with the consumer's written consent.

The appeal of an immediate contract termination shall have no effect on the immediate termination of the contract or the immediate termination of any service site or any type of service 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. Non-Appealable Decisions/Actions:

The following may not be appealed:

- A late bid submission under a selective procurement process;
- A decision to not issue a contract to a provider;
- Termination of a contract without cause;
- Negotiated rates (during the term of a contract) unless there has been a substantial change in the scope or intensity of services being provided under the contract;
- Compliance issues;
- The language of a contract that has been fully executed by both parties.

D. Provider Grievances and Complaints: Provider grievances and complaints, including those involving service delivery, budgets, compliance issues, or contract language, shall be brought to the contract manager. The contract manager will attempt to resolve these matters informally, and may include other relevant staff in the resolution process as necessary. If the matter is not resolved informally, the parties will follow the dispute resolution process outlined in the contract. A grievance or complaint related to an appealable decision/action as set forth in Section B of this policy may be formally appealed.

E. Board Jurisdiction:

The Regional Subcommittee of the WCHO Board has jurisdiction over the following types of appeals:

- The decision to deny an application submitted under a Request for Proposal (RFP)/denial of appointment to the CMHPSM network provider panel;
- The decision to deny a provider for specific sole source services when such services are regionally procured;
- The score of a regional site visit;
- Discrimination against a provider for inclusion on the network panel, reimbursement, or indemnification if such discrimination was the result of a regional Board decision/action;
- A licensed independent practitioner's appeal of an adverse CMHSPM decision about the granting, renewing, or revising of clinical responsibilities.

The local CMH Board has jurisdiction over the following types of appeals:

- The decision to deny a provider for specific sole source services when such services are procured locally by a CMHPSM affiliate;
- The score of a local site visit;
- The decision to place a contracted provider on provisional status;
- The termination of a contract with cause;
- The outcome of a submitted claim;
- The decision to deny an authorization for continued stay/services (utilization management decisions);
- Discrimination against a provider for inclusion on the network panel, reimbursement, or indemnification if such discrimination was the result of a local Board decision/action.

F. Appeal Committee: Unless otherwise specified in the procedures below, provider appeals will be heard by a Provider Appeal Committee convened by the Executive Director/CEO of the CMHPSM affiliate whose decision/action is being appealed, or his/her designee. The Provider Appeal Committee is an ad hoc group which may include staff, consumers/family members, and/or Board members, based on their relevance to the matter being appealed. The Provider Appeal Committee will always include a representative from the WCHO Provider Relations Unit. If the Committee

is convened by the WCHO Executive Director, a Network Management Committee member from an affiliate will be included on the Provider Appeal Committee.

The Provider Appeal Committee shall make a recommendation to the Board with jurisdiction over the matter being appealed. The Board will vote to accept or reject the recommendation. The provider/appellant will be notified of the Board's decision in a timely manner.

V. EXHIBITS

None

VI. REFERENCES

- A. Balanced Budget Act
- B. CMHPSM Claims Denial Policy
- C. CMHPSM Consumer Grievance and Appeals Policy
- D. CMHPSM Credentialing and Clinical Responsibilities for Licensed Independent Practitioners Policy
- E. CHPSM Procurement of Network Providers Policies
- F. CMHPSM Utilization Management Policy
- G. JCAHO Standards for Behavioral Health Organizations
- H. MDCH/CMHSP Managed Mental Health Supports and Services Contract
- I. Medicaid Managed Specialty Supports and Services Contract

VII. PROCEDURES

A. Appeal of a Utilization Management Decision

<u>WHO</u>	<u>DOES WHAT</u>
Network Provider	Files an appeal of a utilization management decision, following the process established by the community mental health Services Program (CMHSP) that made the decision.
CMHSP Director	Designates a qualified individual to review and decide utilization management appeals.

B. Appeal on Behalf of a Consumer

<u>WHO</u>	<u>DOES WHAT</u>
Network Provider	Files an appeal on behalf of a consumer whose access to services

or whose ongoing services are adversely affected by a CMHSP decision, or files a grievance on behalf of a consumer. Follows the procedures set forth in the CMHPSM Consumer Grievance and Appeal Policy.

CMHSP Staff Responds to the appeal or grievance in accordance with the procedures set forth in the CMHPSM Consumer Grievance and Appeal Policy.

C. Appeal of the Outcome of a Submitted Claim

WHO

DOES WHAT

Network Provider Files an appeal regarding the outcome of a submitted claim. Follows the procedures set forth in the CMHPSM Claims Denial Policy.

CMHSP Staff Responds to the appeal or grievance in accordance with the procedures set forth in the CMHPSM Claims Denial Policy.

D. Licensed Independent Practitioner (LIP) Appeal

WHO

DOES WHAT

LIP Files an appeal of an adverse CMHPSM decision about granting, renewing, or revising clinical responsibilities. Follows the procedures set forth in the Credentialing and Clinical Responsibilities for Licensed Independent Practitioners Policy.

CMHSP Staff Responds to the appeal or grievance in accordance with the procedures set forth in the Credentialing and Clinical Responsibilities for Licensed Independent Practitioners Policy

E. All Other Appeals

WHO

DOES WHAT

Network Provider Receives written notice of an appealable decision/action and the reason for the decision/action, as indicated above.

Forwards a completed Request for Appeal form to the Executive Director/CEO within ten (10) working days of receipt of the written notice. The provider must identify what specifically is being appealed.

Executive Director/CEO or Designee Convenes the Provider Appeal Committee to hear the appeal within ten (10) working days of receipt of the Request for Appeal

Provider Appeal Committee Holds a hearing on the appeal. The agenda will include: a restatement of the decision or action being appealed; opportunity for the provider to present reasons why this decision or action should be changed and to present supporting information in oral and/or written form; and an opportunity for the Committee members to ask questions.

Following this hearing, will make a recommendation to the Board with jurisdiction over the appeal.

NOTE: If the provider is appealing the score received as a result of an original bid review for an RFP issued under the selective procurement process, additional information may not be submitted to support the appeal. Only the materials submitted with the original bid package may be used to support the position. The Provider Appeal Committee will not re-interview the provider or re-score the proposal, but will review the criteria used to score the bids and determine if it was uniformly applied to all bidders.

Board with jurisdiction over the appeal Will, at the next regularly scheduled board meeting, vote to accept or reject the recommendation of the Provider Appeal Committee.

Contract Manager Sends the provider written notification of the Board's decision within three (3) working days of the board meeting.

Maintains a copy of all appeal documentation in the contract file.

**Community Mental Health Partnership of Southeast Michigan
REQUEST FOR APPEAL**

Date: _____

Appealing Provider's Name: _____

Address: _____

Contact Person for Appeal Process: _____

Contact Person's Phone Number: _____

Specific Decision/Action Being Appealed: _____

Basis for Appeal (additional pages may be attached if necessary):

**Community Mental Health Partnership of Southeast Michigan
Provider Appeal Recommendation Form**

Date: _____

Appealing Provider's Name: _____

Address: _____

Contact Person for Appeal Process: _____

Contact Person's Phone Number: _____

Specific Decision/Action Being Appealed: _____

Provider Appeal Committee Recommendation (additional pages that include the rationale for the recommendation may be attached):