SOUTHERN HIGHLANDS COMMUNITY MENTAL HEALTH CENTER

POLICY AND PROCEDURE MANUAL

Date of Issue: 4/3/01 **Section Number 197**
Date Revised: 6/5/07

Policy 197 – Medicaid ASO Denial of Services Appeals Procedures for Consumers and Providers

I. POLICY

It is the policy of this Center to appeal decision by the Administrative Services Organization (ASO) to deny services requested by this agency, with or without consumer consent, for the following reasons:

- Documentation warrants the requested service(s)
- Documentation warrants the level of care requested
- Staff, with treatment team input, can clinically provide justification and/or sufficient data to the ASO to reconsider the requested services.

II. DISCUSSION

To quote the ASO Manual, Version 1.0, updated 05/04, "All consumers seeking behavioral healthcare services under the WV Medicaid ASO guidelines must be determined to meet the clinical criteria for service to which they are referred. When consumers do not meet the criteria for requested services, an alternative service may be recommended and authorized through renegotiation. If an alternative service is not acceptable to the provider or consumer, the service in question will be denied. Consumers (or their legal representative) and providers have the right to appeal all decisions regarding denials made by the WV Medicaid ASO."

III. PROCEDURES

A. Copies of the most current version of the ASO Manual will be available to all clinical staff for review. Program directors, clinic administrators, and record room personnel will maintain a copy of the ASO Manual.

B. When a service authorization is sought for a Center consumer, a review process by the ASO is initiated. After this review, one of the following may occur:

1. The service is authorized.

2. An alternative service within the level of care is recommended.

3. An appropriate non-Medicaid reimbursable service is recommended (i.e., respite, socialization, support, adult day care, etc.).

4. The service is not authorized for one of the following reasons:

   a. The consumer is ineligible for all requested services.
   b. The consumer is ineligible for the level of care requested, or the agency and/or consumer does not agree with the recommended service changes.

5. The authorization request is closed for incomplete data that was requested but not received within the timelines.

C. In the event a renegotiation of services occurs for a consumer which results in a recommendation for a higher or lower level of care, Southern Highlands staff, specifically the UM Department, is responsible for submission of the service authorization requests for the consumer's new level of care after consultation with the consumer and their case manager.

D. In the event a requested Center service is not authorized following the review process, a non-certification letter detailing the reasons and dates of service that are not authorized will be sent. Notice of the denial will be sent to this agency and it is the responsibility of the UM Department, or designee, to ensure the consumer, or their representative, is fully informed of the denial, the reasons for the denial, and their related rights. The consumer, or their representative, must sign the denial letter. A copy of the notice will be given to the consumer, or their representative, and the original denial letter with signature will be maintained in the clinical record.

E. A denial of services for a consumer is a final decision by APS Healthcare, following the review process and the reconsideration process to deny authorization for service. Service authorization may be denied for any of the following reasons:

1. The documentation does not warrant the requested service(s).

2. The documentation does not warrant the level of care requested.

3. The provider (with treatment team input) does not agree with the recommended service change.

F. To request an appeal of a denial, the UM Manager, or designee, will send a written request to the clinical manager at the ASO within five (5) working days following the receipt of the notice. The Clinical Manager, or Executive Director in their absence, will document the substance of the appeal on the Appeals Log on the day of receipt. The Clinical Manager will consult with the APS Physician within one business day of the notice.

G. The appeals process consists of three (3) levels. If the first level appeal is upheld, the UM Manager, or designee, has the right to appeal on the decision within three (3) days of notification and to review the case with the ASO physician if desired for further reconsideration.

H. The second level appeal, once requested by the UM Manager, will result in the ASO clinical manager advising the APS physician. The ASO physician will attempt to reach this agency at least three (3) times to discuss the case in dispute. These calls must be directed to the UM Manager, or designee. The UM Manager has five (5) business days to respond, beginning with the initial attempt to contact.

Once the case has been reviewed, the ASO physician will advise the UM Manager, or designee, in writing detailing the reasons and the dates of service that are not authorized. The UM Manager, or designee, is responsible to assure that the consumer and/or their representative is fully informed of the denial, the reasons for the denial, and their related rights. The consumer, or their representative, must sign the denial notice. A copy of the letter will be given to the consumer, or their representative, and the original second level denial notice with signature will be maintained in the clinical record.

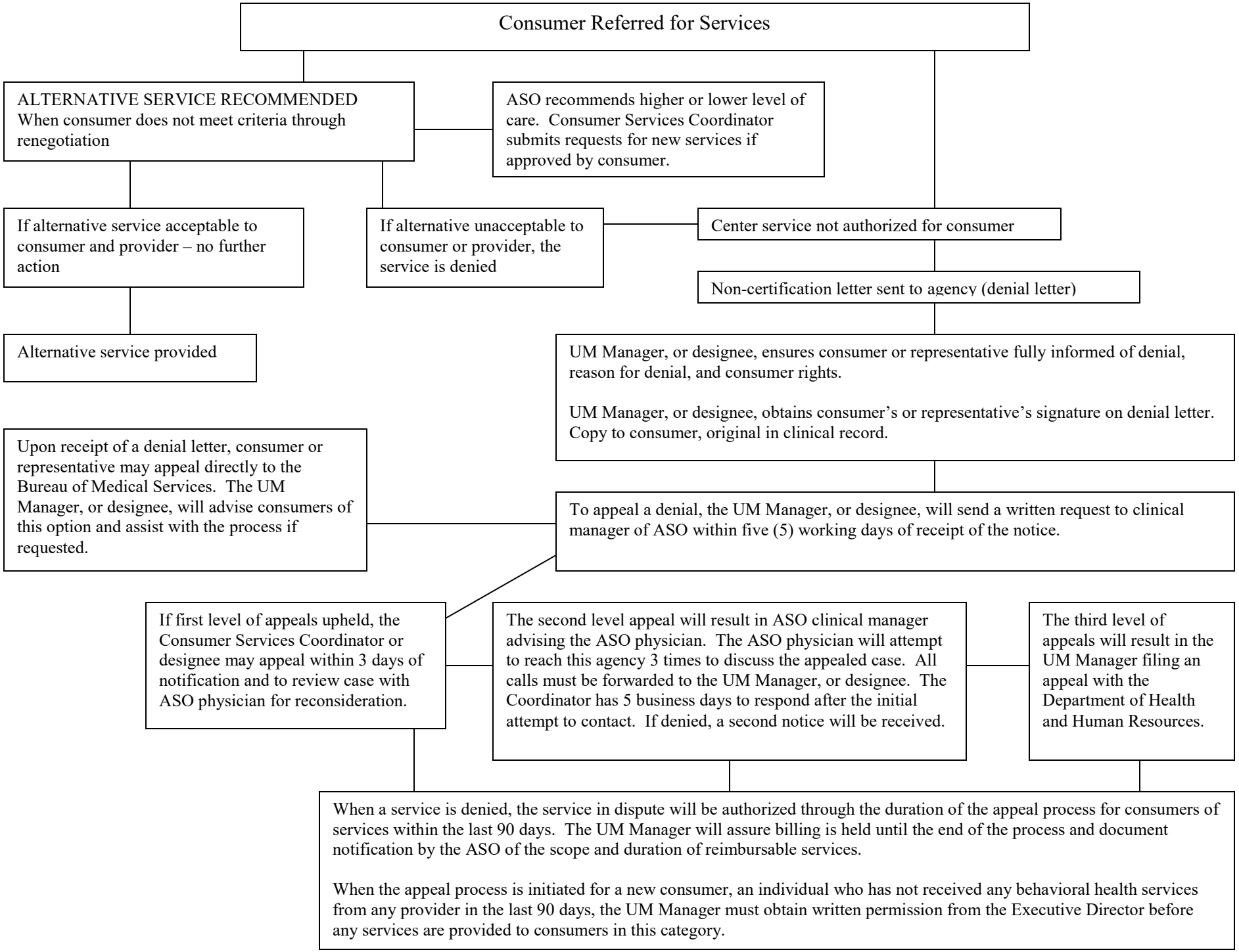
I. In the event the third level of appeals is sought, the Consumer Services Coordinator will file an appeal with the Department of Health and Human Resources upon receipt of the second level of appeals denial letter.

J. Upon receipt of a denial letter, consumers and/or their legal representative may appeal the denial directly to the Bureau for Medical Services for a fair hearing under state guidelines. The UM Manager, or designee, will advise consumers, or their representative, of this option and assist with this process if requested.

K. When a review, reconsideration and appeal process for consumers results in denied services, the service in dispute will be authorized through the duration of the appeal process for those individuals who have received behavioral health services within the past ninety (90) days. Billing will be held until the end of the appeal process, at which time notification will be provided by the ASO of the duration and scope of reimbursable services.

L. When the appeal process is initiated for a consumer new to the system, defined as individuals who have not received behavioral, clinic, or private practitioner services within the past ninety (90) days, there is no assurance that payment will be made for any services provided. As a result, before any services are provided to consumers in this category, written permission must be received by the Executive Director. Nonetheless, these services will only be covered if the appeal decision reverses the initial denial of service.

WV MEDIAID ASO APPEALS PROCESS FOR PROVIDERS AND CONSUMERS



SOUTHERN HIGHLANDS COMMUNITY MENTAL HEALTH CENTER

ASO DENIAL OF SERVICES APPEAL FORM

Consumer Name: _____ ID #: _____

Denied Services Requested: _____

Date Denial Letter Received: _____ Signed Copy Attached: Yes No (circle one)

Level of Appeal (circle correct level): LEVEL I LEVEL II LEVEL III
Dept. of Health and Human Resources

Appeal Narrative: _____

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Consumer Statement: _____

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_____ _____

Signature – UM Manager Date

cc: Consumer/Consumer Representative
Case Manager
Clinical Record

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