| | |
|---|---|
| **Origination:** | *12/2019* |
| **Effective:** | *12/2019* |
| **Last Approved:** | *12/2019* |
| **Last Revised:** | *12/2019* |
| **Next Review:** | *12/2020* |
| **Owner:** | *Deabra Hardrick-Crump: Billing/ Claims Supervisor* |
| **Policy Area:** | *Claims Management* |
| **References:** | |

# CLAIMS ADMINISTRATIVE APPEAL POLICY

## POLICY

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) to adhere to all requirements as it relates to Administrative Claim Appeals for MI health Link, Medicaid, SUD and Autism programs according to Federal/ State and contractual requirements.

## PURPOSE

The purpose of this policy is to identify an Administrative Claim Appeal process to comply with all Federal/ State and contractual requirements.



## APPLICATION

1. The following groups are required to implement and adhere to this policy: DWIHN Board, DWIHN Staff, Contractual Staff, Access Center, Network Providers, Crisis services vendor, Credentialing Verification Organization (CVO)
2. This policy serves the following populations: Adults, Children, I/DD, SMI/SEI, SED,SUD, Autism
3. This policy impacts the following **contracts/service lines**: MI-HEALTH LINK, Medicaid, SUD, Autism, Grants, General Fund

## KEYWORDS

1. **Administrative Appeals**: An administrative appeal is the process by which requestors are asking to reconsider it's position.
2. **Claims:** A form (paper or elentronic) submitted for reimbursement for health care services.
3. **Denial/Rejection:** The action taken when one or more services will not be paid on claim.
4. **Appeal/Reconsideration:** Written dispute from a provider of service on non-payment or underpayment of a claim.

## STANDARDS

1. DWIHN staff, contractors and subcontractors will:

a. Ensure that all administrative appeal processes are:
    1. Timely;
    2. Fair to all parties;
    3. Administratively simple;
    4. Objective and credible;
    5. Accessible and understandable to enrollee/members and provider;
    6. Subject to quality improvement review;
    7. Developed in a manner to assure that the individual provider who participates in the appeal process on behalf of the enrollee/member are free from discrimination or retaliation;
    8. Developed in a manner to assure that they do not interfere with communication between the enrollee/member and the receipt of services

# QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of subcontractors, and direct contractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.



# COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, contractors, and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

# LEGAL AUTHORITY

1. Michigan Department of Health and Human Services Medicaid Provider Manual (in effect, and as as amended
2. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program (PIHP/ CMHSP contracts in effect, and as amended)

# RELATED POLICIES

1. Claims Reconsideration Policy
2. Clinical Appeals Policy

# RELATED DEPARTMENTS

1. Claims Management
2. Clinical Practice Improvement
3. Compliance
4. Integrated Health Care
5. Legal

6. Managed Care Operations
7. Quality Improvement
8. Recipient Rights
9. Clinical Policy
10. Utilization Management

YES

# INTERNAL/EXTERNAL POLICY

EXTERNAL

## Attachments:

Administrative Appeal Determination Form.docx
Administrative Denial Appeal Form.doc

## Approval Signatures

| Approver | Date |
|---|---|
| Dana Lasenby: Chief Clinical Officer | 12/2019 |

| Approver | Date |
| --- | --- |
| | |
| | |
| | |
| | |

**Detroit Wayne Integrated Health Network (DWIHN)**
**707 West Milwaukee Street**
**Detroit, Michigan 48202**

# ADMINISTRATIVE APPEAL DETERMINATION FORM

**Date**

**Name**
**Address**
**City, State, Zip Code**

**Re: Member/Enrollee's Name:**

**Medicaid /Healthy Michigan/MI Health Link/ No insurance (Circle all that apply) ID#:**

**MHWIN ID#:**

We have received your request for an appeal. Following the administrative appeal review of services and supports for which you have requested, it has been determined that that the following service(s) are being:

**Authorization Request #:**

| **Service(s)** | **Effective Date(s)** |
|---|---|
| | |
| | |

**The reason for this action is:**

Member: If you receive a bill, please contact **Detroit Wayne Integrated Health Network (DWIHN) at (313) 344-9099** or **TTY (800) 630-1044**. Your services will not be denied, reduced, suspended or terminated as a result of an Administrative denial.

Provider: This is the Final Level of Appeal. If you would like to speak with the professional who rendered the determination regarding the decision, please call the UM Department.

| _____ | _____ | _____ |
|---|---|---|
| **Decision Maker (Printed Name) with Credentials/Job Title** | **Decision Maker's Signature** | **Date** |

cc: Service Provider & Member

# ADMINISTRATIVE DENIAL APPEAL REQUEST FORM

**SECTION 1 – Administrative Denial Appeal Request**

| | |
|---|---|
| ☐ Oral Request Date : _____ | ☐ Written Request Date: _____ |
| **Administrative Denial Appeal Request for ☐ Standard Resolution (30 days)** | |
| **Who is requesting Administrative Denial Appeal: ☐ Provider** | |

**SECTION 2: Enrollee/member Information**

| | | | | | |
|---|---|---|---|---|---|
| Enrollee/Member's Name | | | | Home phone# | Work or Cell phone# |
| Address (No. & Street, Apt#, etc.) | | | | City | State / ZIP Code |
| Date of Birth | Medicaid ID#: | Medicare ID # | MHWIN ID # | | |

**SECTION 3 – Provider Information**

| | | | |
|---|---|---|---|
| Name of Provider: | | Office phone# | Date of Notice |
| Address (No. & Street, Apt#, etc.) | | City | State / ZIP Code |
| Provider Contact Person: | Provider Signature | | Date Signed |

**SECTION 4 - Reason for an Administrative Appeal Request**

The following are my reason(s) for requesting an Administrative Appeal. Use Additional Sheets if Needed.

I would like an opportunity to look at case/medical file or any records that will be considered during the appeal?
□Yes □ No Date: _____ Time: _____ Staff Name: _____
I would like an opportunity to present information for review/ consideration during the appeal process?
□ Yes □ No Date: _____ Time: _____ Staff Name: _____

Form completed by: _____ Date completed: _____

**INSTRUCTIONS FOR COMPLETION**

**SECTION 1 – Administrative Denial Appeal Request**
Check off if the request is filled out by provider or if the form is being completed due to an oral request.

**SECTION 2 – Enrollee/member Information**
Enter information about the enrollee/member.

**SECTION 3-Provider Information**
Enter information about the provider who is the requesting the Administrative Denial Appeal, including the provider information.

**SECTION 4 - Reason for Administrative Denial Appeal Request**

***Special Note***:
The enrollee/member **must** continue to receive **Michigan Medicaid** services previously authorized while the Administrative Denial Appeal is pending. The enrollee/member is not to be billed or held financially responsible for this Administrative Denial.

The services received by the enrollee/member will not be reduced, suspended or terminated as a result of an Administrative Denial Appeal.

**The decision made from the Administrative Denial Appeal will be the final decision.**

*Revised 7.19.17*