Monterey County Behavioral Health
Policy and Procedure

Policy Number	116
Policy Title	Provider Appeal
References	Federal Waiver For Medi-cal Psychiatric Inpatient Hospital Services Consolidation DMH Information Notice 97-06, Notice 02-03 Title 9; Articles 3; Provider Problem Resolution And Appeal Process;1850.305-325
Form	Appeals Log (Attachment1)
Effective	January 1, 1995 Revised: August 17, 1995 Revised: April 29, 1997 Revised: March 1, 2009

Policy

A. Contract Provider Complaint/Grievances

1. A provider may file an appeal concerning the processing or claiming for services or may appeal a denied or reduced service for reimbursement of psychiatric inpatient hospitalization services to the County.

2. Outpatient network providers may appeal a denial or reduced request after an informal appeal.

3. Contract providers for inpatient psychiatric services, admitting physicians and the Monterey County Department of Health, Behavioral Health Division, authorizing staff for services are available to discuss problems and non-authorizations for admission during each working day.

B. Definition of Terms

1. Denied Service – A service requested on behalf of the Medi-Cal beneficiary by a physician (Treatment Authorization Request – TAR) is considered denied when:
   a. the requested services are denied prior to the beneficiary receiving the service; or,

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   b. retrospectively, an emergency admission is denied if it does not meet medical necessity criteria for reimbursement at the time of admission as per Policy No. 112 and 113. (Criteria Guidelines for Admission and

Retrospective Claims Review).

2. Reduced Service – A service is considered reduced when:
   a. the service is requested on behalf of the beneficiary by a physician (Treatment Authorization Request – TAR), and
   b. the County approves the service but the level of care required is less than acute, i.e. administrative.

3. State Fair Hearing – A State Fair Hearing is required by Title 22, which is conducted when:
   a. the Monterey County Department of Health, Behavioral Health division (Medi-Cal authorizing agency) denies or reduces services that a physician considers medically necessary and has requested (via a TAR) on behalf of a Medi-Cal beneficiary, or
   b. the hearing is requested by the Consumer/client within mandated timelines.

4. Treatment Authorization Request (TAR) – The form (18-3) that the Monterey County Department of Health, Behavioral Health Division, uses to authorize payment for services delivered.

5. Medi-Cal Authorizing Agency – For the purpose of this policy, the Monterey County Department of Health, Behavioral Health Division, is the authorizing agency which has the responsibility of approving services for payment.

Procedures

A. Inpatient Provider

A provider may file an appeal concerning the processing or payment of its claim for service or may appeal a denied or reduced reimbursement of psychiatric inpatient hospitalization services to the County. The written appeal shall be received by the Monterey County Health Department, Behavioral Health Division, claims reviewer within 90 calendar days of the postmark date of notification of the denied authorization. The provider shall submit supporting documentation, which may include all or part of the medical records, to the Monterey County Health Department, Behavioral Health Division.

B. County Behavioral Health

1. The Monterey County Department of Health, Behavioral Health Division, shall have 60 calendar days from the post mark date of the appeal to

inform the provider of the decision and the basis or the decision. If the provider's appeal is upheld, the Mental Health Division shall have 14 calendar days from the date of receipt of the provider's update or revised request for payment to approve the document or take corrective action.

2. If no basis is found for altering the decision, or remedy is not within the purview of the Behavioral Health Division, the provider shall be notified by the Behavioral Health Division of its right to submit an appeal to the State Department of Mental Health (DMH). Also, if the Behavioral Health Division does not respond to a provider appeal within 60 calendar days, the provider retains the right to appeal directly to the State Department of Mental Health.

3. The Monterey County Department of Health, Behavioral Health Division, claims reviewer records all appeals received in an Appeals Log (Attachment 1) to include:

   a. Provider/M.D.
   b. Date of receipt
   c. Nature of appeal
   d. Disposition and resolution
   e. Date of disposition and/or resolution
      (1) The Monterey County Department of Health, Behavioral Health Division, claims reviewer documents resolution/disposition within 60 days of receipt of grievance or the reason why it could not be resolved.
      (2) The Monterey County Department of Health, Behavioral Health Division, claims reviewer transmits a dated explanation of the appeal resolution to the provider/M.D.

   a. The new TAR forms will be approved by the Behavioral Health Division Medical Director within 10 calendar days of receipt, and

   b. The new TAR forms will be processed following the same procedure as the original TAR (Attachment 2).

C. State Department of Mental Health

1. Providers requesting an appeal to the State Department of Mental Health (DMH) shall submit their appeal in writing to:

   Deputy Director, Program Compliance
   Department of Mental Health
   1600 9th St.
   Sacramento, CA 95814

2. The appeal must be submitted within 30 calendar days from the day of the Behavioral Health Division's written notification of denial, or within 30 calendar days after expiration of the 60 calendar day limit after submitted to the Mental Health Division, if no decision has been rendered.

3. The provider should include the following documentation:

   a. an official request for a second level appeal to DMH (Form #90-1, revised 4/94);
   b. clinical records that support reimbursement criteria for medical necessity;
   c. a summary of the reason why payment should have been authorized;
   d. a statement by the Behavioral Health Division to the provider of the decision to deny the appeal;
   e. a contact person (name, address, and telephone number).

4. DMH Procedure

   a. DMH will notify the MHP by certified mail of a provider appeal within seven calendar days of receipt of the provider's appeal package. That notification will include a copy of the second level appeal letter sent to the Department by the provider and a request for documentation supporting the MHP's decision to deny payment to the provider.
   b. The MHP must submit that supporting documentation to DMH within 21 calendar days of receipt of the request from DMH. If the MHP fails to provide that documentation within the established time lines, the appeal will be decided in favor of the provider.
   c. All issues involving questions of medical necessity and emergency psychiatric conditions shall be forwarded to a psychiatrist for review and opinion. The psychiatrist's opinion will be definitive for all clinical issues.
   d. A Hearing Officer, appointed as a designee of the Director, shall review supporting documentation of both sides and the psychiatrist's written opinion, if appropriate. The Hearing Officer may render an opinion or present a compromise solution to both parties.
   e. The Hearing Officer may convene an informal conference at a place convenient to all parties with representatives of the provider and the MHP present, if requested by either party of the Hearing Officer.
   f. DMH has 60 calendar days from the receipt of the MHP's documentation to notify the provider and the MHP in writing of the decision on the appeal and the basis for the decision. If that period exceeds 60 calendar days, the appeal is considered denied. The 60-day period for rendering a decision may be extended if necessary and is agreed upon by all concerned parties.
   g. If DMH modifies or overturns the MHP denial, the MHP must approve the provider's revised request for payment or corrective action within 14 calendar days of receipt.

D. Outpatient Network of Providers

A. Provider Problem Resolution

a. The responsible clinician shall be notified of the URC action (attachment 1). A provider shall not bill MHP for reimbursement without prior and appropriate authorization. When the Utilization Review staff and physician reviewer denies a continued authorization request, the clinician will be notified. If the clinician is not satisfied with the committee decision, he/she may make an informal appeal to the QI Program Manager within 5 working days of receipt of request denial or letter of denial.

b. Providers may appeal denied requests, after an informal appeal, by submitting a written appeal to the MHP within 30 calendar days of the date of receipt of the non-approval of the request for authorization. The providers shall provide MHP with all or part of the medical records.

ATTACHMENT 1

NEW PROCESS TARS

	TAR#	Adm	DC	Sent to Review	Due from	Given to	Received from	Initials