

CBHNP

An AmeriHealth Mercy Company

To: All CBHNP Providers

From: CBHNP Administrative Appeals Committee

Subject: Administrative Appeals

Date: June 8, 2007

CC: Scott Suhring, CABHC
Jeff Bowman, CPBHC
Missy Reisinger, TMCA
Pam Marple, BHSSBC
Rob Labatch, Lycoming-Clinton Joinder Board

The CBHNP Administrative Appeals Committee would like to remind providers about how to properly use the Administrative Appeals process and procedure. Please note that this information is consistent with the corresponding chapter in your Provider Manual and in Provider Info #AD03-007R "Administrative Denial." Please share this information immediately with staff responsible for Administrative Appeals. We recommend that you file this memo in your CBHNP *Provider Manual*. Additionally, please check the corporate web site at www.cbhnp.org for future clarifications and information.

Additional questions related to this information may be directed to your Provider Relations Representative.

What is an administrative denial?

By Definition:

Administrative Denial: Claims, Outpatient Treatment Requests (OTR) and Pre-Certifications that CBHNP denied or did not approve because the claim, OTR or pre-certification did not meet CBHNP policies or contractual or administrative requirements (i.e. complying with time limits or not obtaining the authorization). Administrative denials are NOT denied based on medical necessity. This procedure is intended to apply to administrative denials and is not applicable to denials based on medical necessity.

Providers are expected to follow all billing, claims, OTR and prior authorization requirements as defined in the Provider Manual. The administrative appeals process is not intended to be used an alternative to proper authorization or claims procedures.

CBHNP has received numerous requests for appeals even though the provider has not actually gone through regular channels and received an administrative denial for the service dates being appealed. In

reviewing these appeals, CBHNP determined that in many instances, if the provider had submitted the claim, CBHNP would have processed the claim and no appeal would have been necessary. If you have not received notice that services will not be authorized due to administrative non-compliance or have not gotten claims denial for a service, you do not have an administrative denial to appeal.

If you have provided service without authorization, a claim should be submitted for the date and service delivered. The administrative appeal request may be submitted upon receipt of the claims denial. Again, a denial for administrative reason must be issued so there is an event to appeal.

Effective **July 15, 2007**, CBHNP will return any request for administrative appeal in cases where there is no administrative denial to appeal.

How do I submit a request for an administrative denial?

The provider must submit a request in writing within 60 days of the denied claim. The provider should attach the Administrative Appeal Request Form to each request. The request form is attached and can also be found on our website at www.cbhnp.org and in the 2007 Provider Manual. Each request should be specific to one Member and one service.

Along with the Request Form, the provider must send a letter to: CBHNP, *Administrative Appeals Coordinator* stating the following:

1. Explanation of circumstances
2. Documentation relevant to the request (e.g. EVS slip verifying that EVS was checked for eligibility and wrongly indicated enrollment status, fax confirmation page, etc...)
3. Documentation of Members seen/dates of service provided and billable amount. For BHRS or FBMH requests, all clinical notes for the month requested 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, etc.) must be included.
4. ALL relevant information should be submitted with your appeal since the decision of the Committee is final.

How will I know if my Administrative Appeal was approved?

Upon receipt of a request, the Administrative Appeals Coordinator will review the appeal request for completeness. Incomplete requests will be logged as incomplete and returned to the provider for completion. When the Appeals Coordinator receives a complete request, the item will be logged, assigned a number and forwarded to the Administrative Appeals Committee for consideration.

The Administrative Appeals Committee will make a decision within 30 days of receipt of the documentation and a written decision will be mailed within 5 days of the decision. The decision of the review process is final.

What criteria guide the approval/denial of an administrative appeal?

Appropriate reasons to approve a request (reversal of administrative claim denials) include **but are not limited** to:

1. Eligibility verification issues beyond the control of the provider.
2. Processing errors by CBHNP.
3. Concurrent review issues beyond the control of the provider.

Appropriate reason to uphold an administrative denial include **but are not limited** to:

1. Failure in authorization management by the Provider.
2. Submission of the administrative appeal request beyond 60 days of the **claim** denial or notice of non-authorization due to administrative noncompliance and/or the service delivery date.
3. Failure to check EVS, or inadequate eligibility verification by the provider, prior to service delivery.
4. Failure in claims or billing management by the Provider.

Attachment: Administrative Appeal Form