WASATCH MENTAL HEALTH SERVICES
SPECIAL SERVICE DISTRICT

Medicaid Claim Payment Denial - Whole or Part F – 1.07

Purpose:

To ensure Wasatch Mental Health's Medicaid outside contracted providers, contracted hospitals and Enrollees receive due process when payments for mental health treatment services are denied in whole or in part.

Policy:

A. Wasatch Mental Health (WMH) shall establish and maintain a professional and equitable appeal process when denying provider claim payments. When a claim is denied, the provider shall receive an explanation in writing of the reason, their right to appeal, and the appeal process.

B. WMH shall send a written Notice of Action form and Appeal rights (see attachments C and D) to the Enrollee and his/her provider of the claim being denied in whole or in part when:

1. The provider was not a WMH contracted provider during the time services were rendered; or (ie. Outside provider did not have contract with WMH); or
2. The service was not prior-authorized by WMH.

C. Should the Enrollee already be engaged in a WMH Appeal of an Action, or with a Utah Department of Health, State Fair Hearing, and has asked that services be continued pending the outcome of the appeal process, WMH shall hold in abeyance the claims received during the time period in question until the Enrollee has exhausted, or had the opportunity to exhaust his/her hearing rights.

D. A Notice of Action to the Enrollee and his/her provider is not necessary if:

1. The provider billed WMH in error for a non-authorized service; or
2. The claim included a technical error such as incorrect data including billing code(s), Enrollee name, incorrect Medicaid identification number, or date(s) of service.

Procedures:

1. WMH's Claims Review Auditor and/or program manager shall initiate the first review of claims sent to WMH by outside contracted providers and make a recommendation to WMH's Administrative Services Cost Accountant to pay, partially pay, or not pay, including his/her reason for partial or nonpayment.

2. When the denial is due to technical errors that do not constitute an Action, the Claims Review Auditor will send the claim back to the provider along with an explanation of the

error found. (See attachment A). The provider will be given 90 days to correct/appeal the errors found.

3. The Claims Review Auditor shall notify the Associate Director or his/her designee of any WMH denial of Medicaid enrollee provider payments for the following reasons that constitutes an Action:
   i. The provider was not a WMH contracted provider during the time services were rendered, and/or
   ii. The provider's service was not prior-authorized by WMH.

4. The Associate Director or his/her designee shall send the Enrollee, and all affected parties, a Notice of Action letter with an explanation of the problem(s) associated with the claim, the Enrollee's right to appeal, and offer assistance regarding the claim if requested. (See Attachment C and D).

5. The Associate Director or his/her designee shall log information, as per PMHP Medicaid Contract requirements, in the Enrollee Grievance/Action/Appeal database and maintain a copy of the Notice of Action.

6. Should the Enrollee or other affected parties, decide to appeal the Action, WMH shall follow the policy and procedures in Policy C-3.08b Medicaid Actions and Appeals Process.

Right to Change and/or Terminate Policy:

Reasonable efforts shall be made to keep employees informed of any changes in the policy; however, WMH reserves the right, in its sole discretion, to amend, replace, and/or terminate this policy at any time.

Attachment A

form # A-7.59q

Administration Office
750 North 200 West, Suite 300, Provo, Utah 84601
Phone: 801-373-4760
Fax: 801-373-0639

☐ **Claim Error Correction – Claim Review** ☐ **Denial of Payment**

Date: _____

Provider Name: _____ Patient Name: _____

Date(s) of Service: _____

Account Number: _____

The attached claim(s) are being returned to you for the following reason(s):

☐ **Patient is not covered by Prepaid Mental Health Plan with Wasatch Mental Health.** Prepaid Mental Health Plan only processes claims for psychiatric services provided to Utah County Medicaid recipients enrolled in the plan. Pease bill appropriate contractor.

☐ **Eligibility.** Patient was not Medicaid eligible for the date(s) of service billed.

☐ **Contract term(s).** Provider is not contracted with Wasatch Mental Health to provide Medicaid eligible prepaid mental health benefits.

☐ **Procedure is not psychiatric related.** Submit claim to client's physical health plan or bill Medicaid directly.

☐ **Prior Authorization.** Failure to notify Wasatch Mental Health for pre-authorized services.*

☐ **Request for additional information.** Missing or incomplete information. After completing the missing information, please resubmit.

☐ **Incorrect diagnosis code.** Diagnosis code is not mental health related. Submit claim to client's physical health plan or bill Medicaid directly.

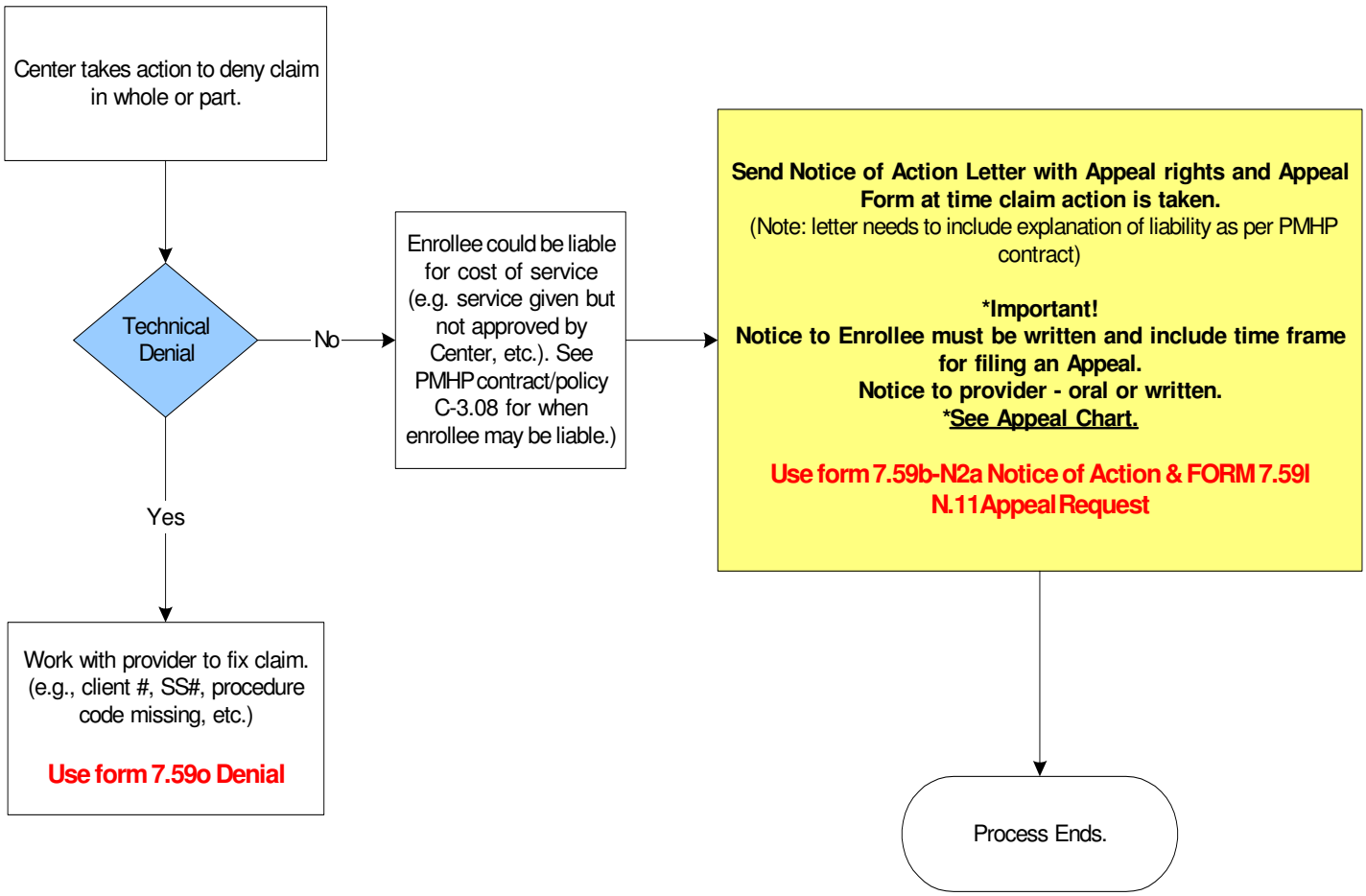
☐ Other: _____

Claims requiring correction must be submitted to Sheila Foster within 30 days from the date of notification.

If you do not agree with the identified reason(s) listed above, you may request a claim review with Wasatch Mental Health. You must file your request within 30 calendar days from the date on this letter by contacting Sheila Foster at 801-377-4668, email: SFOSTER@wasatch.org.

*For denied payment due to non pre-authorization, Wasatch Mental Health will send a written Notice Action letter and Appeal rights to both the patient and the provider.

Attachment B
Page 4: Action #3: Denial of Claims Payment in Whole or Part
(See Policies C-3.08 and F-1.07)



Attachment C
Notice of Action
Inpatient Authorization Denial
(Junction form 7.59b-N2a)

Provider:	Provider Name Address City, State Zip
Patient Name:	Patient Name Address City, State Zip
Dates of Service:	7/17/2016 -7/20/2016
Account Number:	1234567899-1

If you are unhappy with this decision, you have the right to file an Appeal by calling Wasatch Mental Health's Claims Review Auditor, Sheila Foster, at 801-852-3324 . The attached document explains how to file an Appeal and what to do if you need help filing the Appeal. Your provider may also file the Appeal if you give your written consent. You must send the completed Appeal Request Form to Wasatch Mental Health's Associate Director within 30 calendar days from the date on this letter.

____

Wasatch Mental Health Services Special Service District provides an interpreter, if needed. Interpreters are free of charge for Medicaid enrollees, and are available in all languages, including sign language. If you need interpreter services, please call the Claims Review Auditor at 801-852-3324.

Sincerely,

Sheila Foster
Claims Review Auditor

Cc: Provider
Address
City, State Zip

Enclosure

The rest of this letter explains how to file an Appeal.
* *

Attachment D

APPEAL REQUEST FORM

(Junction form 7.59i-N.11)

1. Is the client or a provider requesting this Appeal? Client ___ Provider_____

2. Name of Client: _____
   Client's Address: _____

3. Name of Provider Involved: _____
   Provider's Address:_____

4. The reason you are requesting the Appeal: _____

You may ask for an expedited (quick) decision on your Appeal if you believe taking the regular amount of time could place your life or health in danger, or that you might have a permanent setback.

_____ Check here if you want an expedited Appeal.

5. If the Appeal is about decreasing or ending services, do you want these services continued during the Appeal process? Please remember you may have to pay for these services if the Appeal is not decided in your favor.

_____ Check here if you want these services continued

If you need help filing an Appeal, you can call us at 801-852-3324 and ask for the Claims Review Auditor.

6. If you need help filling out this form call 801-852-3324 and ask for the Claims Review Auditor. You may also ask for an interpreter if you need one.

7. REMINDER!! If you are not asking for an expedited (quick) Appeal, and you call us first to file your Appeal, you must send this form to us within 30 calendar days of the date on this letter. This is important. Your appeal will be dismissed if you do not send in the form by this deadline.

Provider Permission Statement

If your provider is filing the Appeal for you, you must give your written permission.

I_____(your name) give my permission for _____to file this appeal for me. (Provider's name)

_____ _____
Client's Signature Date

To File an Appeal:

1. If you need help filing an Appeal, you can call us at 801-852-3324 and ask for the Claims Review Auditor.

2. You may file an Appeal yourself or you can let someone else file your Appeal for you. Your provider can also file an Appeal for you and/or assist you with filing an Appeal.

3. You may tell us that you want to file an Appeal by calling us at 801-852-3324 and asking for the Claims Review Auditor.

4. If you call us to file your Appeal, you must also send us a written Appeal. Please use the enclosed Appeal Request Form. You must send us this form within ~~30~~ 90 calendar days of the date on this letter. This is important. Your appeal will be dismissed if we do not receive the written request by this deadline.

5. If you do not want to call first, just send us your Appeal using the enclosed Appeal Request Form.

6. If you want your provider to file your Appeal for you, you must give your written consent. You may give your written consent on the enclosed Appeal Request Form. This is important. If we do not receive your written permission, you lost the right to Appeal.

Send the written Appeal to:

Associate Director
Wasatch Mental Health Services Special Service District
Attn: Appeals
750 N Freedom Blvd Suite 300
Provo UT 84601

Expedited Appeal:
You may ask us to make a faster decision on your Appeal if:

1. You or your provider believes **your life is in danger because of our Action.**
2. You or your provider believes **your health is in danger because of our Action.**
3. You or your provider believes **you might have a permanent setback because of our Action.**

This is called and Expedited Appeal.

To file an Expedited Appeal:
You do not need to send us a written Appeal.

1. You may ask for an expedited Appeal by calling the Claims Review Auditor at 801-852-3324
2. Or, if you don't want to call us, you may just check the expedited Appeal box on the enclosed Appeal Request Form and send it to us.
3. Remember, you must give your written consent if your provider files your Appeal for you. You may give your written consent on the Appeal Request Form.

This is important. If we do not receive your written consent, you lose the right to Appeal.

If we agree the decision needs to be made quickly, we will make a decision in 3 working days. Sometimes we may need more information and if we need more information, we may take an additional 14 days to make our decision. You may also ask us to take more time.

If we need to take extra time, we will send you a letter telling you that.