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 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 Cost Accountant 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 Cost Accountant shall notify the Care Management Services Director (CSR) 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 CSR 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 CSR 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) is 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.

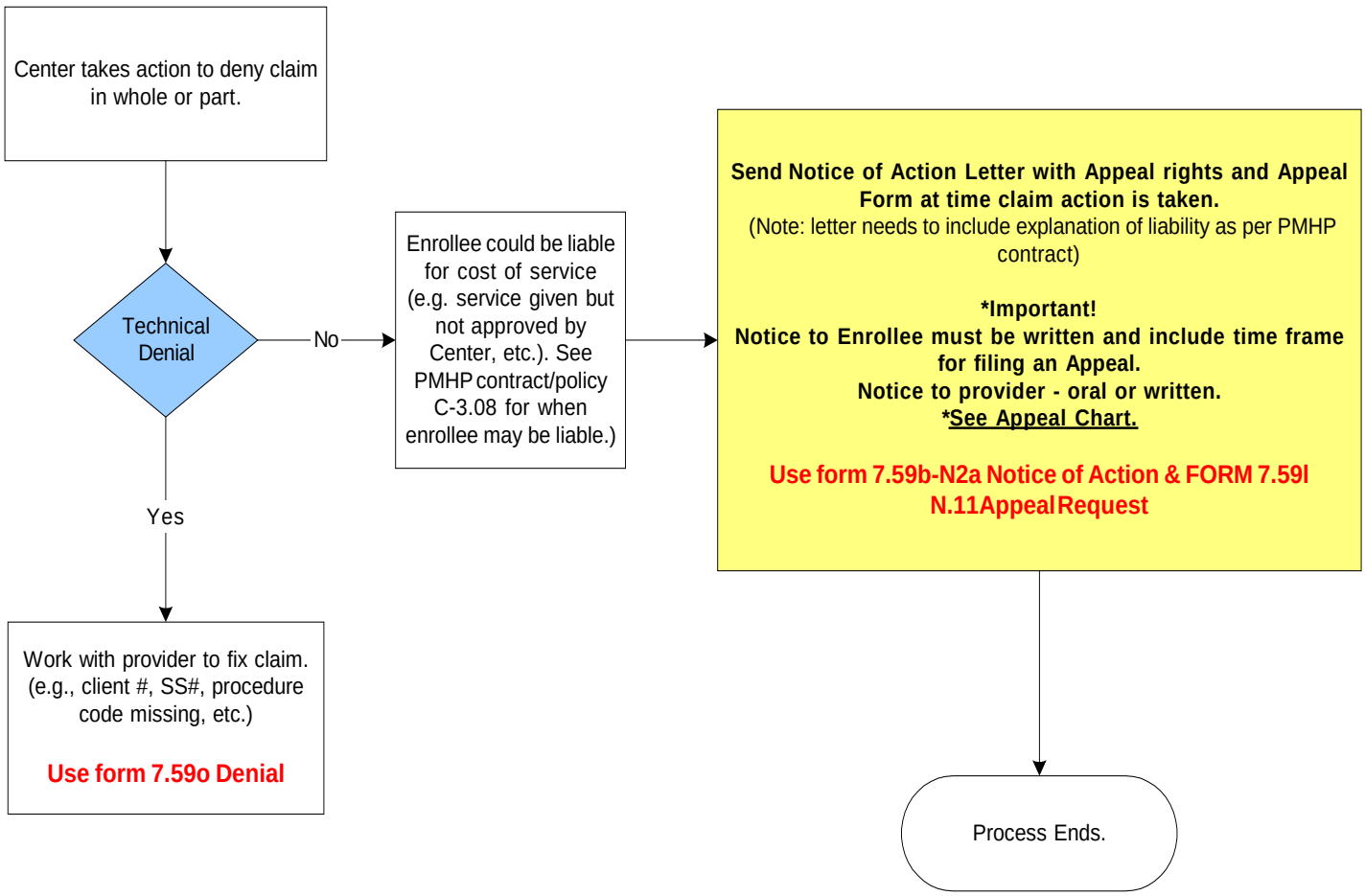
☐ Other: _____

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 Form # 7.59b-N2a (for denied payment)

If you need this letter in Spanish, call the Wasatch Mental Health customer service representative at (801) 373-4760.
Si usted necesita esta carta en español, llame a un representante de Wasatch Mental Health al (801) 373-4760.

Delete all information in red.

(The notice of action shall clearly indicate the action that has been taken and provide a clear statement of the basis for the action. The notice must be individualized to the enrollee's case and medical and legal terms must be explained if the terms cannot be simplified. The notice shall also be written in easily understood language and format. See policy C-3.10 Readability of Documents for testing procedures)

"[Click here and type date]"

"[Click here and type recipient's name]"
"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]" ,

On "[Click here and type date]" Wasatch Mental Health took the following action;

☐ We denied or limited approval of your requested service/provider.

(Explain why services were limited or denied. If limited, explain the details of the request and the limited approval. Limited approvals may include: a. provider asked for certain number of sessions, you approve less with no chance for approval of the remaining sessions requested; or b). provider asks for certain number of sessions and services are approved in segments and you do not end up approving the original amount requested.)

☒ We denied payment for a service you received that you may have to pay for.

(Explain what led to the action, individualized to the enrollee. Refer to your handbook section on payment liability and provide information to the enrollee as to which reason fits their situation.)

☐ We did not offer your first appointment within the required amount of time, and you were unhappy with this.

(Explain what led to the action, individualized to the enrollee)

☐ We did not make a decision about your request service within the required amount of time (28 days for a standard request or 17 days for an expedited (quick) request).

(Summarize request and explain why you were not able to make a decision within the required time frame and when you plan to make decision by- may reduce likelihood they'll appeal.)

☐ We did not make a decision about your Grievance within the required amount of time (59 days.)

(Explain why you were not able to make a decision within the required time frame and when you plan to make decision by- may reduce likelihood they'll appeal.)

If you are unhappy with this action, you have the right to appeal. The rest of this letter explains how to file

an Appeal.

To file an Appeal:
You must file your Appeal within 30 calendar days from the date on this letter.

You, your legally authorized representative or your provider may file your appeal. If you need help filing your appeal, call the Wasatch Mental Health customer services representative at (801) 373-4760. If you need an interpreter to help you file your appeal, call the Wasatch Mental Health customer services representative at (801) 373-4760. Outside of Utah County call 866-366-7987.

1. You may file your appeal by calling us at (801) 373-4760 and asking for the Wasatch Mental Health customer service representative.

2. If you call us to file your appeal, you must also send us a written appeal. Please use the enclosed written appeal request form. You must send us this form within **5 working days** of your call. If you do not send the form or written request within **5 working days** of your call, you lose the right to appeal.

3. If you do not want to call first, just send us your appeal using the enclosed written appeal form.

4. If your provider files your Appeal, the Appeal must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed written appeal request form or by sending us a separate note. This is important. If we do not receive your written permission, your provider may not appeal the action.

5. Send the complete written appeal to:

Wasatch Mental Health
c/o Care Management Department
750 North 200 West, Suite 300
Provo, UT 84601

If you call us first to file your Appeal, we plan to make a decision within **15 calendar days** from the date you call. If you send us your Appeal in writing, **we plan to make a decision within 15 calendar days from the date we get your written appeal request.**

Sometimes we'll need more time to make a decision, or you may ask us to take more time. If so, we may take an additional 14 calendar days to make our decision. If we need to take extra time, we will send you a letter telling you that.

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EXPEDITED (QUICK) APPEALS)

If you or your provider believes taking this amount of time could place your life or health in danger, or that you might have a permanent setback, you may ask for an expedited (quick) Appeal.

To file an expedited appeal:

1. You may ask for an expedited appeal by calling the Wasatch Mental Health customer services representative at (801) 373-4760. You do not also have to send your Appeal in writing.

2. If you do not want to call first, check the "expedited Appeal" box on the enclosed Appeal form and send it to us.

3. If your provider files your appeal, the appeal must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed written appeal request form or by sending us a separate note. This is important. If we do not receive your written permission, your provider may not appeal the action.

If we agree the decision needs to be made quickly, we will make a decision in **3 working days**. If you or we need more time to make the decision, we can take up to another **14 calendar days**. If we need more time, we will send you a letter telling you why.

Again if you have any questions please contact the Wasatch Mental Health customer services representative at (801) 373-4760.

Sincerely,

[Click **here** and type your name]

Cc: Private provider (if applicable)
Affected Parties (if applicable)

Enclosure: Appeal Request Form

Attachment D

Wasatch Mental Health

APPEAL REQUEST FORM # 7.59l-N11

1. Is the client or a provider requesting this ***Appeal***? Client? Or Provider? (Circle)

2. Name of Client:_____

   Client's Address:_____

3. Name of Provider Involved:_____

   Provider's Address:_____

4. The reason you are requesting the Appeal:_____

   _____

5. 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 might result in a permanent setback.

   ___ Check here if you want an Expedited Appeal.

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

   ___ Check here if you want these services continued.

7. If you need help filling out this form, an interpreter, or have any questions about the Appeal process please call (name or title) at (phone number).

8. **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 5 working days of your call, or you lose the right to Appeal.

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

_____ (Provider's name) to file this Appeal for me.

_____ _____

Client's Signature Date