INTEGRATED SERVICES OF KALAMAZOO

ADMINISTRATIVE PROCEDURE 02.02_01

Subject:	Provider Grievance and Appeals (non-clinical)	**Section:**	Provider Network Management
Applies To: ☒ ISK Staff ☒ ISK Contract Providers ☐ ISK CCBHC Services ☐ ISK CCBHC DCO Contract Providers		**Page:**	1 of 4
Revised:	08/01/2023	**Supersedes:**	09/24/2020

PURPOSE

To provide a mechanism for providers to lodge complaints (grievances) and request reconsideration of (appeal) decisions related to non-clinical issues.

DEFINITIONS

Adverse Notification
A notice, by any means, that documents a denial of authorization or claim, a reduction, suspension or adjustment to a claim, or the denial of participation as a panel provider.

Appeal
A formal process which is established so that providers may request reconsideration of an action or decision that has been made by ISK.

Grievance
An expression of dissatisfaction by a provider regarding a perceived inequitable issue, aspects of interpersonal relation or other related issues.

PROCEDURE

I. FILING AN APPEAL OR GRIEVANCE

A. Providers are asked to communicate concerns and grievances with the appropriate ISK staff before making a formal appeal. If providers are still unable to reach resolution or a satisfactory agreement, they may file an appeal in writing using the attached procedures and form (02.02_01B Provider Appeal). All appeals should be sent directly to the Provider Network Work Group (PNWG) Administrative Assistant.

B. Appeals for credentialing decisions and any services (other than claims or authorization) must be filed within 30 calendar days after receiving an adverse notification from ISK.

C. As stated in ISK policy 08.08 (Claims Management), all claims are permanently denied after one year (365 days) from the date of service. Appeals involving claims or authorizations must be filed within 180 calendar days after receiving an adverse notification in order to allow the entire appeal process to occur, if needed.

D. First Level

The ISK department overseeing the area the appeal addresses will review all first level appeals and a decision will be issued within 30 calendar days. All appeals involving more than $5,000 will automatically be moved to a second level appeal in order to help expedite the appeals process on questions of large dollar amounts.

Appeals resulting in the potential use of ISK General Fund dollars will automatically be considered a Second Level Appeal, bypassing the First Level Appeal process.

Provider must complete the Provider Appeal (exhibit 02.02_01B), document the reason for the appeal (i.e., service was in Person-Centered Plan, but not matching authorization; covered dates of service within the Person-Centered Plan), and include the following information:

1. Service activity code
2. Total number of units
3. Date range involved in the appeal
4. Claim line not paid

E. Second Level

If the provider is dissatisfied with the First Level decision, a second appeal can be filed within 20 calendar days.

Provider must complete the Provider Appeal (exhibit 02.02_01B) and include both of the following:

1. Information contained in the First Level
2. Supporting information for the Second Level Appeal that includes additional information relevant to the decision criteria outlined in Policy 02.02 (Provider Grievance and Appeals [non-clinical]), Section I. C.
3. Is the initial decision consistent with ISK contract language
4. Does the ISK contract language contain confusing or contradictory language
5. Has there been other communication from ISK staff that contradicts or adds confusion to the ISK contract language
6. Is there additional information that impacts the appeal situation that was not available or considered in the original determination

7. Does the impact of the original determination result in harm or extreme hardship for the individuals served

F. Third Level
If an appellant is not satisfied with the decision of the Second Level, they may make a third appeal within 20 calendar days.
Provider must complete the Provider Appeal (exhibit 02.02_01B) and include both of the following:
1. Information contained in the First and Second Level
2. Additional supporting information for the Third and final Level Appeal that includes information relevant to the decision criteria outlined in Policy 02.02 (Provider Grievance and Appeals [non-clinical]), Section I. C.

G. Fourth Level
Providers within the Southwest Michigan Behavioral Health (SWMBH) region, as a final step, may appeal Medicaid claims dispute decisions to the SWMBH Director of Operations within 14 calendar days.

H. At any level of appeal, ISK may use an on-site claims, utilization or quality monitoring review to assist in making an accurate decision.

I. Any level of appeal, if there are unforeseen circumstances which cause delay of a response, adequate notification will be sent to the provider including timeframes for determination.

J. If the appeal is not filled out in its entirety upon receipt, it will be sent back to the provider for completion.

II. RESPONSIBILITY

A. All ISK staff are responsible to ensure that providers and prospective appellants are assisted as needed and that their requests are directed to the appropriate individual in accordance with established procedures.

B. Responsibility for resolving First Level Appeals is assigned to the Accounting Manager for appeals related to claims payments and to the Utilization Management Program Manager for claims related to authorizations.

C. Responsibility for resolving Second Level Appeals is assigned to the Senior Executive, Deputy Director of Program Services, and Deputy Director of Administrative Services.

D. Responsibility for resolving Third Level Appeals is assigned to the Chief Executive Officer in conjunction with the Deputy Director of Program Services, Deputy Director of Administrative Services and Legal Counsel, as needed.

E. The Provider Network Work Group is responsible to ensure that:
1. All of the available information is reviewed
2. Provide any needed clarification of policies and/or procedures
3. Refer to other staff for information and/or problem solving as needed
4. There is a response to the appellant according to the established time frames
5. The appellant is informed of the next level of appeal if appropriate

REFERENCES

- Medicaid and General Fund Specialty Supports and Services Contract with the Michigan Department of Health and Human Services

- MDHHS/PIHP Medicaid Managed Specialty Supports and Services Contract – 6.4.B.

- Southwest Michigan Behavioral Health Policy (and/or same named/theme policies if SWMBH alters the numbering system or name of document in their policy manual)
  - 02.14 (Non-Clinical Provider Grievances and Appeals)

EXHIBITS

A. Provider Grievance and Appeals Process (non-clinical) Flowchart

B. ISK Provider Appeal