

Behavioral HealthCare, Inc.

155 Inverness Drive West • Suite 201 • Englewood, CO 80112

Administrative

Subject: Reconsideration Procedure for Claims Payment Decision		Effective Date: 8/1/1995
Authorized by: Susan James-Padilla LCSW Director of Utilization Management	Page: 1 of 2	Review Date: 4/1/00, 6/05/01, 12/1/01, 6/05/02, 11/1/03, 3/23/04, 6/1/05, 11/27/06, 12/31/07, 2/20/09

Policy:

It is the policy of BHI to have a consistent and fair process by which providers can appeal decisions to deny claims payment.

Purpose:

To establish a procedure for the appeal of denied claims by providers that is fair, consistent, and in compliance with federal and state regulations.

Procedure:

1. Provider claims may be denied for several reasons, including but not limited to:
 - a) lack of prior authorization
 - b) the client was not eligible on the date of the service per State Medicaid eligibility information
 - c) the claim was not filed timely
 - d) the diagnosis is not covered
 - e) the service was not medically necessary.
2. All denials are subject to appeal and reconsideration. However, all appeal requests must include new information that was not provided at the time of the initial claim, including the reason for appeal.
3. If the claim was denied for timely filing, the provider may attach a copy of an EOB from a third party to explain the delay in filing.
4. Providers may submit appeals by mail, facsimile or e-mail within thirty (30) days of the date of EOB denial.
5. First level appeals are processed within thirty (30) days of the receipt of the appeal by the Director of Utilization Management. If the denial is upheld, an EOB and/or letter will be sent to the provider with an explanation. If the appeal is overturned, an EOB will accompany the check for payment to the provider.
6. Providers may request a second level appeal within thirty (30) days of receiving notification that a denial has been upheld upon first level appeal. All appeal requests must include new information that was not provided at the time of the first level appeal, including the reason for appeal. Second level appeals are

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processed within thirty (30) days of the receipt of the appeal.

7. All appeals related to clinical issues such as medical necessity will be reviewed by the BHI Medical Director or designee. Second level appeals related to non-clinical issues such as timely filing or Medicaid eligibility will be reviewed by the BHI Chief Executive Officer or designee. If the denial is upheld, an EOB and/or letter will be sent to the provider with an explanation. If the appeal is overturned, an EOB will accompany the check for payment to the provider. This is the final BHI level of appeal.
8. Appeals submitted without additional information including the reason for appeal will be returned to the provider.
9. These procedures do not in any way prohibit the provider from accessing the full array of regulatory appeal mechanisms available under various rules and regulations. However, denials of claims can occur due to error or misunderstanding and providers are encouraged to utilize the BHI appeal process as a means of resolving these issues at the lowest level.
10. If providers have questions about the status of claims or appeal, they may contact the Claims Coordinator at (720) 490-4454. If a provider has questions about the reason for a denial being upheld on appeal, they may contact the BHI Director of Utilization Management at (720) 490-4402.