SUMMIT POINTE HANDBOOK OF POLICIES & PROCEDURES			
Chapter 4	Fiscal Policies & Procedures	Effective	11/1/18
Section 4.1	External Claims	Version	1.0
Policy 4.1.6	Provider Appeal Process	Responsibility - Finance Director	

PURPOSE:
Establish a process for external providers to submit an appeal associated with the denial of reimbursement for external claims.

POLICY:
It is the policy of Summit Pointe to establish and maintain procedures for the timely submission and processing of claims for external contractors within its provider network that meet regulatory standards and encompass an avenue for claims appeal and dispute resolution.

DEFINITIONS:
External Provider: Contracted provider of authorized services for Summit Pointe customers.

PROCEDURES / REQUIREMENTS:
Appeals

- External providers may appeal adverse decisions in which they are being held financially responsible for charges on the basis of non-clinical issues.
  Frequent examples of claim denials are:
  a) Claim denied because customer not eligible;
  b) Claim denied due to contract / benefit plan limitation;
  c) Claim denied for no authorization;
  d) Claim denied for missing information;
  e) Claim denied for delayed filing;
  f) Claim underpaid due to billing/processing error; and
  g) Disagreement regarding payment methodology.
- All provider appeals of claim payment should be made within 30 days of denial and will not be accepted after 180 days from the denial. Any denied claim beyond this time frame is considered to have reached a final resolution.
- All provider appeals should be submitted to Provider Claims using the Summit Pointe appeal form.

- Within 10 days after a provider appeal request, a preliminary review of the claim and appeal details will be conducted to determine if additional information from the provider is required. If additional information is required, the provider will be notified in writing.
- The provider must submit all documents, written statements, and other documentation that supports the appeal within 10 days from receipt of the additional documentation request.
- Final determination of claim status will be made within 30 days of receipt of all requested information. The final determination will be made in writing and explain the facts upon which the determination was made.
- An appeal determination can be authorized by the CEO, Finance Director, Operations Director, or Clinical Director.
- If the appeal is denied, providers may submit a written request for an additional review within 30 days of the denial notification.

- Written notice of disposition of the secondary review of the appeal shall be complete within 30 days of receipt of the request.
- Providers within the SWMBH region may, as a final step, appeal any Medicaid claims dispute decision to the SWMBH Director of Operations. Providers should submit a written request for a third level review to Summit Pointe within 30 days of the denial notification. Summit Pointe will forward the request to SWMBH for review.
- Appeal must be *received* by Summit Pointe by the applicable deadline. All time limits for the submission of an appeal are non-waivable deadlines. The failure to meet an appeal deadline at any stage shall result in a final, non-appealable resolution to the claim.

REFERENCES:
MDHHS PIHP Contractual Requirements – Section 6.6.3.

ATTACHMENTS:
Provider Appeal Form
External Claims – Provider Appeal Process Map – Level 1
External Claims – Provider Appeal Process Map – Level 2 + 3