

Denials

Provider Appeal Process for Claims Denials

A practitioner may appeal decisions of the MercyCare Insurance Company (MCIC) claims payment/denial via telephone or letter to the MCIC Provider Relations Representatives. All appeals must be requested within 90 days of receiving their Explanation of Payment, or within their contractual timely filing limit. Upon receipt of a written appeal request the Provider Relations Representatives will send out a letter notifying the provider the appeal was received. The Provider Relations Representative will then investigate all supporting documentation regarding the appeal. If the Provider Relations Representative cannot overturn the appeal, it will then be forwarded to the Practitioner Appeals Committee. A letter of determination will be sent to the provider notifying them of the final decision. All appeals will be decided within 45 days.

Provider Appeal Process for Denials Based on Medical Necessity

MercyCare Insurance Company (MCIC) is accountable for its Utilization Management (UM) decisions. When MCIC denies coverage of a service, accountability requires that it clearly explain the reasons for the denial to the member as well as to the practitioner. This ensures that both the practitioner and the member receive sufficient information to understand the determination and to make informed decisions to appeal or accept a MCIC determination.

By including information on how to initiate an appeal in its letters, MCIC hopes to ensure the practitioner understands their appeal rights and demonstrates its commitment to a fair and thorough process of making utilization decisions. To ensure fair decision making, MCIC gives practitioners the opportunity to discuss decisions that are based on medical necessity with the MCIC Medical Director, Behavioral Health Medical Director, or designated Physician Advisor.

PURPOSE:

To provide a mechanism by which a network practitioner may appeal an adverse decision based on medical necessity.

POLICY STATEMENT:

Any disagreement between the attending physician and the Health Plan will not affect immediate patient care issues.

No adverse decision will be made without the attending practitioner's knowledge. He/She will be given every opportunity to provide additional information to support his/he

PROCESS:

If you wish to appeal a denial based on medical necessity, you may do one of the following:

- You may submit your appeal request in writing to your provider relations representative who will then forward it to MCIC's Medical Director or Behavioral Health Medical Director on your behalf.

OR

- You may submit your appeal in writing directly to MCIC's Medical Director or Behavioral Health Medical Director.

If the adverse decision is upheld, the practitioner will be notified in writing of the decision and of their further right of appeal.