Provider Appeals Process

An **administrative denial** is issued when there has been a failure to follow protocol for administrative procedures. For example, the requested service falls outside of those covered by the MH Waiver Program, or services rendered exceed the authorized limits. Advanced Behavioral Health, Inc (ABH) will only issue denials for claims and not for authorization request, since those requests are approved or denied by the WISE Community Support Clinicians (CSC) only.

If your denial is due to an **authorization issue**, please contact the assigned CSC prior to requesting an appeal. If you are having difficulty contacting the CSC, please contact the appropriate supervisor as appeals are time limited.

The **first level appeal** process can be initiated by submitting a *Reconsideration/Appeal Request Form* to ABH. For all claims, the appeal must be made within thirty (30) calendar days of the receipt of the denial (EOB). Appeals submitted after this deadline will not be considered for review.

The appeal should contain additional information, or should demonstrate "good cause" for the non-compliance with the required administrative procedure.

ABH will render a written appeal decision within fifteen (15) calendar days of receipt of the appeal. If the denial is overturned, ABH will reprocess the claim for the next payment cycle. In those cases where the denial is upheld, the notification will contain instructions as to how to proceed with a second level appeal.

Second level appeal requests are made directly to DMHAS/DSS, and need to be submitted to DMHAS/DSS within fifteen (15) calendar days of receiving notice that the denial has been upheld at the first level. The appeal must be accompanied by information necessary and sufficient to render a decision. In those cases where DMHAS/DSS elects to overturn the administrative denial, ABH will be instructed to reprocess the claim. In those cases where the denial is upheld on second level, the appeals process will be considered concluded.