Community Mental Health Affiliation
of Mid-Michigan

PROCEDURE: 3.2	Page 1 of 8	**SUBJECT:** Medicaid Beneficiary Appeals/Grievances
Related Policy: 3.0		**SUBJECT:** Recipient/Enrollee Rights
Issuing Directors: Director of Quality, Customer Service, and Recipient Rights, and Director of Affiliation Operations		**Original Effective Date:** 07-23-05

REVISED DATE

07/02/09
07/02/08
03/06/08

Review Date(s)

04-04-06					
02-16-07					

I. PURPOSE:

To ensure notification of the recipient of his/her right to file appeals and grievances, including local appeals and grievances and Fair Hearings. To provide a fair and efficient process for resolving appeals and grievances from recipients of Medicaid services or applicants for Medicaid services, related to suspension, termination, reduction or denial of services and supports and/or grievances related to services delivered by Community Mental Health Affiliation of Mid-Michigan (CMHAMM) Providers/contractors.

II. STANDARDS:

The following federal and state statutes establish the standards for CMHAMM's Appeals and Grievance procedures for Medicaid Recipients:

A. Social Security Act:
42 CFR 431.200 et seq. (Fair Hearings).
42 CFR 438.400 et seq. (Local Appeals).
42 CFR 438.400 et seq. (Local Grievances).

B. Michigan Department of Community Health, Grievance and Appeal Technical Requirement, July, 2004.

C. Michigan Mental Health Code (MHC) MCL 330.1772 (Recipient Rights Complaints).

D. Michigan Mental Health Code (MHC) MCL 330.1705 (Medical Second Opinion).

III. DEFINITIONS:

A. **Action:**

1. The denial or limited authorization of a requested Medicaid service including the type or level of service.
2. The reduction, suspension, termination of a previously authorized Medicaid service.
3. The denial, in whole or in part, of payment for a Medicaid covered service.
4. The failure to provide Medicaid covered services in a timely manner.
5. The failure to act within the appeal and grievance time frames as established in this procedure.

B. **Additional Mental Health Services:**
Supports and services available to Medicaid beneficiaries who meet the criteria for Specialty Services and Supports, under the authority of Section 1915 (b)(3) of the Social Security Act. Also referred to as “B3” waiver services.

C. **Adequate Notice of Action:**
Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid services requested. Notice is provided on the same day the action takes effect, or at the time of the signing of the individual plan of services/supports.

D. **Advance Notice of Action:**
Written statement advising the beneficiary of a decision to suspend, reduce or terminate Medicaid covered services that are currently provided. Notice must be mailed at least 12 calendar days in advance of the date of action.

E. **Appeal:**
Request for a review of an action.

F. **Authorization of Services:**
The process for approving first and on-going services.

G. **Beneficiary:**
A person who is eligible for Medicaid and who is receiving or may be eligible to receive mental health services through a PIHP/CMHSP.

H. **Consumer:**
A person requesting or receiving mental health services delivered and/or managed by the PIHP including persons with Medicaid and all others.

I. **Expedited Appeal:**
A speedy review requested by the beneficiary or the beneficiary’s provider when the time for the normal appeal process would jeopardize the beneficiary’s life, health or ability to maintain, attain, or regain maximum function. If requested by the beneficiary, the PIHP determines if an expedited appeal is warranted. If the beneficiary’s provider makes or supports the request, the PIHP **MUST** grant the request.

J. **Fair Hearing:**
Impartial state level review of a Medicaid beneficiary’s appeal of an action presided over by a Michigan Department of Community Health (MDCH) Administrative law Judge. Also referred to as an “administrative hearing”.

K. **Grievance:**
An expression of dissatisfaction about any PIHP/CMHSP service issue other than an action. This term may also refer to the general system of appeals and grievances handled at the PIHP level and access to the fair hearing process.

L. **Limited authorization:**
Specified services authorized from CMHAMM Service List.

M. **Local Appeal Process:**
Impartial local level PIHP review of a Medicaid beneficiary’s appeal of an action presided over by individuals not involved with decision-making or previous level of review.

N. **Medicaid Services:**
Services provided to a beneficiary under the Medicaid state plan, Habilitation Supports Waiver and/or 1915(b)(3) waiver.

O. **Notice of Disposition:**
Written statement of the decision for each appeal and/or grievance, provided to the beneficiary.

P. **Recipient Rights Complaint:**
Written or verbal statement by a consumer, or anyone acting on their behalf, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the Recipient Rights process (Chapter 7a).

IV. PROCEDURES:

A. Responsibility for the appeals/grievance processes is delegated to the CMHSPs/CAs.

B. Characteristics of complaint resolution system:

1. All processes will promote the resolution of concerns and improvement of the quality of care.
2. Complaints should be resolved at the level closest to service delivery when possible but information regarding access to all complaint resolution processes will be provided to the beneficiary of services
3. Applicants/recipients may access more than one process simultaneously or sequentially.
4. A local appeal may be filed orally or in writing. If an appeal is filed orally, a written appeal must follow unless it is an expedited appeal. At the time an oral appeal is filed, the provider receiving the appeal shall determine if the beneficiary needs assistance completing a written appeal. If the beneficiary does not need assistance, the beneficiary will be informed that resolution of the complaint will be initiated but that a written appeal must be received within 14 days in order to reach resolution. *The date that an oral request for an appeal is received will be considered the filing date.*
5. Local grievances and Administrative Hearing requests (Fair Hearings) must be filed in writing. Upon request, staff will assist the individual in filing the appropriate forms to access appeal/grievance processes.
6. Local grievances must be reviewed for possible rights violations. If it is determined that a grievance is more appropriately a rights complaint, with the permission of the recipient, the written complaint will be referred to the Office of Recipient Rights Office.
7. Health care professionals with appropriate clinical expertise in treating a beneficiary's condition or disease will review grievances involving clinical issues and grievances regarding the denial of expedited resolution of an appeal.
8. Written notification of complaint resolution will be provided to the individual with information about additional appeals/grievance processes.
9. The CMHSP Hearings Officer will be the contact point for the appeals/grievance system.
10. Medicaid appeals/grievances will be reported to the PIHP Hearings Officer by the CMHSP Hearings Officer including:
    a. Grievance Request.
    b. Local Appeal Request.
    c. Second Opinion Request.
    d. Fair Hearing Request.

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11. A Medicaid Beneficiary has the right to have services continued when a local PIHP appeal and/or a state fair hearing is pending. *The beneficiary must be informed that he/she may be responsible for the costs of the services provided while the appeal is pending based on his/her ability to pay.*
12. A provider may file an appeal and represent a beneficiary with the beneficiary's written consent.
13. A provider may file a grievance or request for state fair hearing on behalf of the beneficiary only if the State permits the provider to act as the beneficiary's authorized representative in doing so.

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C. Service Authorization Decisions
1. The PIHP delegates to the member CMHSPs/CA the responsibility for providing each Medicaid beneficiary a written service decision as required in this procedure and as quickly as the beneficiary's health requires (standard or expedited written notice).
2. Service Authorizations must:
   a. Be in writing in the primary language of the beneficiary and at a level that can be understood by the beneficiary.
   b. Be provided to the requesting provider if the requested service is denied or authorized in an amount, scope and duration that is less than requested. The notice to the provider does not have to be in writing.
   c. Any decision to reduce, suspend or terminated or suspended without advance notice of action.
   d. If authorized services were reduced, terminated or suspended without advance notice, the services must be reinstated to the level before the action.
   e. Medicaid beneficiaries who request a PIHP local appeal or a Fair Hearing within 12 calendar days of the date of action may continue to receive the services until the disposition of the appeal is received.

D. Notice of Action (adequate or advance):
The PIHP delegates the responsibility to the member CMHSPs/CAs to provide notice of action to a Medicaid beneficiary when the authorized service is less in amount, scope or duration than requested, is reduced terminated or suspended, or when the authorization decision is not timely. As appropriate, the notice will include:
1. How to request that the services be continued.
2. When a beneficiary may be required to pay for the services.

E. Exceptions to Advance notice:
1. Factual evidence of the death of the beneficiary.
2. Signed statement by the beneficiary that he/she no longer wishes the services.
3. Beneficiary gives information that must result in reduction or termination of service.
4. Beneficiary has been admitted to an institution and is no longer eligible for the service(s).
5. Beneficiary's whereabouts are unknown and/or the post office returns mail indicating no forwarding address.
6. Beneficiary is receiving services elsewhere.
7. The beneficiary's physician prescribes a change in level of medical care.
8. The date of the action will occur in less than 10 calendar days.

F. Timeframes for mailing Notice of Action:
1. **At least 12 calendar days** before the date of action to terminate, suspend, or reduce previously authorized Medicaid covered service(s) (**Advance**)
2. **At the time of the decision** to deny payment for a service **(Adequate)**
3. **Within 14 calendar days** of the request for a standard service authorization decision to deny or limit services **(Adequate).**
4. **Within 3 working days** of the request for an expedited service authorization decision to deny or limit services **(Adequate)**

G. Extension of timeframes
If the standard or expedited service authorization cannot be completed within required timeframes, the timeframe may be extended up to 14 days. If an extension is needed, the following must happen:
1. Give the beneficiary written notice, not later than the date the original timeframe expires, of the reason for the decision to extend the timeframe and the right of the beneficiary to appeal the decision if he/she disagrees with the decision.
2. Carry out the authorization process as quickly as possible but not later than the extended timeframe allows.

H. Medicaid Services Continuation or Reinstatement
1. The CMHSP must continue Medicaid services previously authorized while a Local Appeal or State Fair Hearing is pending if:
   a. The beneficiary requests that the services are continued, and
   b. The appeal is filed timely, and
   c. The appeal involves a termination, suspension or reduction of a previously authorized service, and
   d. The services were ordered by any authorized provider, and
   e. The period covered by the original authorization has not expired.
2. If reinstated, the services must continue until:
   a. The beneficiary withdraws the appeal, or
   b. 12 calendar days have passed since the notice of action was mailed and an appeal has not been filed, or
   c. An appeal decision is reached that is adverse to the beneficiary, or
   d. The authorization has expired.
3. **<u>If the appeal results in a decision to reverse an action by the CMHSP/CA, the CMHSP/CA must pay for those services.</u>**
4. **If the outcome of an appeal reverses a decision by the CMHSP/CA to deny, limit or delay services,** those services must be provided promptly and as quickly as the beneficiary's health status requires.

I. Appeal processes

1. **<u>Local Appeal</u>**
   a. The PIHP delegates responsibility for hearing Local Appeals to the CMHSP/CA.
   b. A beneficiary/consumer may request a local appeal within 45 calendar days from the date of the notice of action.
   c. The request may be oral but must be confirmed in writing unless expedited resolution was requested.
   d. If the beneficiary/representative requests the local appeal within 12 calendar days of the notice, the service must be reinstated until a determination is reached.
   e. CMHSP/CA responsibility includes:
      - Give reasonable assistance to the beneficiary/consumer to complete forms, access his/her records, and other procedural steps including but not limited to interpreter services.
      - Acknowledge receipt of appeal.
      - Maintain a log of appeal requests and report to the PIHP and Affiliation QI Steering Committee quarterly.
      - Ensure that persons hearing the local appeal do not have previous involvement in review or decision-making and are clinicians with an appropriate background.
      - Provide the beneficiary the opportunity to present information in person and/or in writing.
      - Medical records and other relevant documents should be considered before and during the appeal.

- Allow the beneficiary to include his/her representative in the appeal.
  Provide written notice of disposition and oral notice if expedited that includes an explanation of the decision
- The date it was completed.
- When the disposition is not fully in the appellant's favor, notify him/her of:
  (a) The right to a fair hearing
  (b) How to request it
  (c) The right to receive disputed services while the State Fair Hearing is pending, if the hearing is requested within 12 days of the PIHP mailing and until the disposition is received,
  (d) That requests for disputed services to be continued must be made to the case manager, supports coordinator or primary therapist.
  (e) The request for a Fair Hearing must be in writing and sent to

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P.O. box 30195
Lansing, MI 48909-7695

  (f) The possibility that the beneficiary may be held liable for the costs of the disputed services if the outcome of the hearing upholds the CMHSP action.
- A standard appeal must be resolved and Notice of Disposition provided within 45 calendar days from when the appeal was received.
- An expedited appeal must be resolved and Notice of Disposition provided no longer than 3 calendar days of receipt of the request for an expedited appeal.
- The CMHSP/CA may request an extension of the timeframes if it can demonstrate to the State that the delay is in the best interest of the beneficiary.
- If the CMHSP/CA denies an expedited appeal, it must follow the timeframes for a standard appeal. The beneficiary must receive prompt oral notice of the denial and follow-up written notice within 2 calendar days.

2. **Grievance**
   a. The PIHP delegates responsibility for Grievances to the CMHSP/CA.
   b. A beneficiary/consumer, guardian or parent of a minor child or his/her legal representative, may request a grievance from the CMHSP/CA at any time.
   c. The beneficiary does not have access to a Fair Hearing unless the CMHSP/CA fails to respond to the request for a grievance within 60 calendar days. This becomes an action and then may be appealed.
   d. CMHSP/CA responsibility includes:
      - Giving reasonable assistance to the beneficiary/consumer to complete forms and other procedural steps including but not limited to interpreter services.
      - Acknowledging receipt of grievance.
      - Maintaining a log of grievance requests to report to the PIHP and the Affiliation QI Steering Committee quarterly.
      - Ensuring that health care professionals who have the appropriate clinical expertise in treating the beneficiary's condition or disease, and do not have previous involvement in review or decision-making review clinical issues.
      - Providing written notice of the disposition within 60 days from the date of filing. If expedited, the disposition may be provided verbally and then followed in written format that includes an explanation of the decision and the date it was completed.
      - If the notice of disposition is more than 60 days from the date of notice, it must include the right to a Fair Hearing and how to access the Fair Hearing process.
      - The notice must include:

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(a) The results of the grievance process
(b) The date the grievance process was conducted
(c) The beneficiary's right to request a fair hearing if the notice of disposition is more than 60 days from the date of the request for a grievance.
(d) How to access the fair hearing process.
(e) Where to mail a fair hearing request:

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Lansing, MI 48909-7695

3. **<u>Fair Hearing</u> (also known as Administrative Hearing)**
   a. The PIHP delegates responsibility for representing the CMHSP/CA in Fair Hearings to the CMHSP/CA serving the appellant.
   b. If the beneficiary requests a Fair Hearing within 12 calendar days of receiving notice, the benefits must continue unchanged until a disposition is received.
   c. CMHSP responsibilities
      - Provide adequate and advance notice and a "request for Hearing form with envelope to the beneficiary when action is taken
      - Provide the address for mailing the Fair Hearing Request:

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Lansing, MI 48909-7695

      - Provide assistance to the beneficiary in completing a request for hearing form as needed. The beneficiary may request the hearing verbally or in writing.
      - Complete and submit the CMHSP/CA hearing summary with supporting documents to the Administrative Tribunal within 6 days after the hearing is scheduled.

J. Record keeping requirements:
1. The PIHP will maintain a grievance log which includes the disposition.
2. The CMHSP/CA will submit quarterly, a log of all appeal, grievance and second opinion requests with related dispositions to the PIHP.
3. Each CMHSP/CA will record the number of requests for Medicaid services, and the number of denials of Medicaid services. This will be reported to the PIHP quarterly.

V. APPLICATION:

All CMHAMM CMHSP's/CA's and contractors who provide Medicaid Covered Services.

VI. MONITOR AND REVIEW:

The Director of Quality, Customer Service and Recipient Rights shall monitor CMHSP/CA compliance with these functions. The PIHP Director of Affiliation Operations will review this procedure annually. External review will include MDCH and CMS site visits and reporting.

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VII. RELATED POLICIES AND PROCEDURES:

CMHAMM Policy	3.0	Enrollee Rights
CMHAMM Procedure	3.7	Second Opinion