COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY AND PROCEDURES MANUAL				
Chapter **Organizational Quality**	**Section** **Customer Services**	**Chapter** **01**	**Section** **05**	**Subject** **02**
Subject **Recipient Grievance & Appeal Process**	**Authorization** 		**Approved: 03/30/2021** **Replaces: 09/30/14** **Formerly 05-01-29**	

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I. PURPOSE: To define the structure of the grievance and appeals processes for recipients of services provided by Community Mental Health Authority (CMHA) or through its provider network, in order to promote the resolution of recipient concerns, and support to enhance the overall goal of improving the quality of care.

II. APPLICATION: All applicants, recipients, applicable parents and guardians receiving or intending to receive services through CMHA.

III. DEFINITIONS:

A. Adverse Benefit Determination for Medicaid recipients: A decision that adversely impacts Medicaid Recipient's claim for services due to:

1) The denial or limited authorization of a requested service, including the type or level of service.
2) The reduction, suspension or termination of previously authorized services.
3) Denial, in whole or part, of payment for a service.
4) Failure to make a standard authorization decision and provide notice of the decision within 14 calendar days from the date of receipt of a standard request for services.
5) Failure to make an expedited decision within 72 hours from the date of receipt of a request for expedited service authorization.
6) Failure to provide services within 14 calendar days of the start date agreed upon in the individual plan of service and following authorization by CMHA.
7) Failure of CMHA to act within 30 calendar days from the date of a request for a Local Appeal.
8) Failure of CMHA to act within 72 hours from the date of a request for an expedited Local Appeal.
9) Failure of CMHA to provide written disposition of a local grievance within 90 calendar days of the date of the request.
10) For a resident of a rural area with only one Managed Care Organization, the denial of a recipient's request to exercise his/her right to obtain services outside the network.
11) Denial of a recipient's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles and other recipient responsibility.

B. Adverse Benefit Determination for a Non-Medicaid Recipient:

1) Decision to deny initial access to services or inpatient hospitalization.
2) Decision to reduce, suspend, or terminate previously authorized services.

C. Advance Notice of Adverse Benefit Determination: Written statement advising the recipient of a decision to reduce, suspend, or terminate services currently provided.

1) **For Medicaid Recipients**: Notice to be provided/mailed at least 10 calendar days prior to the proposed date the action will take place.
2) **For Non-Medicaid Recipients**: Notice to be provided/mailed at least 30 calendar days prior to the proposed day the action is to take place, with the exception of services authorized by a physician that no longer meet established medical necessity.

D. Adequate Notice of Adverse Benefit Determination: Written statement advising the recipient of a decision to deny or limit authorization of services requested. Notice is provided to the recipient on the same date the action takes effect, or at the time of the signing of the Individual Plan of Service or Amendment when a request has been denied, in whole or in part (amount, scope or duration).

E. Administrative Hearing (State Level-MDHHS): An evidentiary hearing conducted by an Administrative Law Judge with the Michigan Department of Health and Human Services (MDHHS) Administrative System regarding a decision by CMHA to deny, terminate, reduce, or suspend a Medicaid covered service or a Habilitation Supports Waiver Service. This is also referred to as "Fair Hearing".

F. Alternative Dispute Resolution Process (State Level-MDHHS): An impartial review conducted by a MDHHS representative, regarding a decision by CMHA to deny, terminate, reduce, or suspend a non-Medicaid covered service.

G. Appeal: Request for a review of an Adverse Benefit Determination as defined above.

H. CEO: Chief Executive Officer of CMHA.

I. Customer Services Grievance/Complaint: Written or verbal statement by a recipient, or anyone acting on behalf of recipient expressing dissatisfaction with service issues other than those addressed under Chapter 7 of the Michigan Mental Health Code.

J. Denial of Service: Denial of initial access or to inpatient hospitalization.

K. Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by a recipient or a Medicaid recipient's provider when the time necessary for the normal appeal review process could seriously jeopardize the recipient's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the recipient requests the expedited review, CMHA determines if the request is warranted. If the recipient's provider makes the request, CMHA must grant the request.

L. State Fair Hearing: Impartial state level review of a Medicaid recipient's appeal of an Adverse Benefit Determination presided over by a MDHHS Administrative Law Judge. Also referred to as an "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

M. Grievance: Any expression of dissatisfaction concerning anything other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, interpersonal relationships between a service provider

and the recipient. If a rights violation, this will be forwarded to the Recipient Rights Office.

N. Hearing Coordinator: Clinical Director and/or designee, who will coordinate the local or state appeal process.

O. Local Appeals Process: Impartial local review of a recipient's appeal of an Adverse Benefit Determination presided over by individuals not involved with decision-making or previous level of review.

P. Recipient Rights Complaint: Written or verbal statement made by a recipient, or anyone acting on behalf of the recipient (a recipient identified as co-occurring/42 CFR must file a Recipient Rights Complaint themselves-no other person, i.e., guardian, parent, advocate, etc., can file such a complaint on their behalf), alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

Q. Resolution: Written statement, provided to a recipient, within established time frames relative to CMHA's disposition of a Grievance or Appeal.

R. Second Opinion: The process to address a recipient's request for review of denial or initial access to CMHA's service or inpatient hospitalization per Chapters 4, 4A, and 7 of the Michigan Mental Health Code. Second opinions occur face-to-face or through teleconference.

IV. POLICY: All recipients have the right to a fair and efficient process for resolving disagreements regarding their services and supports managed and/or delivered by CMHA and its provider networks. A recipient of or applicant for public mental health services may access several options simultaneously to pursue the resolution of complaints.

CMHA will comply with all regional provisions pertaining to recipient grievance and appeals as directed by NorthCare policies.

V. PROCEDURE:

A) Recipients will be informed of their grievance and appeal rights at the time of their initial application for services and throughout their care.

B) All staff/providers, direct and contractual, must have training on recipient grievance and appeals within 30 days of hire or contract.

C) Due Process

1. Medicaid Enrollees – Under the Due Process Clause of the U.S. Constitution, Medicaid Enrollees are entitled to "Due Process" whenever their Medicaid benefits are denied, reduced, or terminated. Due Process requires that Enrollees receive: (1) prior written notice of the adverse action; (2) a fair hearing before an impartial decision maker; (3) continued benefits pending a final decision; and (4) a timely decision measured from the date the complaint is first made. Nothing about managed care changes these Due Process

requirements. The Medicaid Enrollee Appeal and Grievance Resolution Process provides a process to help protect the Medicaid Enrollee Due Process rights.

Consumers of mental health services, who are Medicaid Enrollees eligible for specialty supports and services, have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act (SSA) and its federal regulations that articulate federal requirements regarding appeals and grievances for Medicaid beneficiaries who participate in managed care:

• Local grievances through authority of 42 CFR 438.400 et seq.
• The PIHP appeals through authority of 42 CFR 438.400 et seq.
• State Fair Hearings through authority of 42 CFR 431.200 et seq.

Medicaid Enrollees, as public mental health consumers, also have rights and dispute resolution protections under authority of the Michigan Mental Health Code (MMHC), Chapters 7,7A, 4, and 4A, including:

• Recipient Rights complaints through authority of the MMHC (MCL 330.1772 et seq.).
▪ Medical Second Opinion through authority of the MMHC (MCL 330.1705 and 42 CFR 438.206(b)(3).)

2. Non-Medicaid Enrollees – Grievances and appeals filed by non-Medicaid consumers will be handled by the provider according to provider's local dispute resolution process.

D) Every effort must be made to provide notices written at a 6.9 grade reading level.

E) Customer Services Coordinator is responsible for managing customer services grievances and appeals and will enter each grievance and/or appeal into the Customer Services Grievance and Appeals modules in ELMER.

F) Customer Services Coordinator will provide the quarterly customer services grievances and appeals data to the Quality Improvement (QI) Coordinator. The QI Coordinator will then share the data at the QI/Utilization Management Committee meetings, on a quarterly basis.

G) Recipient Rights staff will report recipient rights complaints to NorthCare as required.

H) Recipient Rights staff will report recipient rights complaints and appeals (from complaints) to the QI/Utilization Management (UM) Committee, on a quarterly basis.

I) CMHA will track the number of denials of services at preadmission screening for inpatient hospitalization. CMHA will also track denials after clinical assessments, whether the assessment is done by phone or face-to-face. For initial clinical assessments and UM decisions that result in denials, Access and Utilization Management staff will issue written notification to the recipient and requesting provider/facility of the decision that includes:

1) A statement that explains the primary reasons why a requested service is not medically necessary; and

2) A statement that the specific reasons why a denial was issued (clinical rationale) will be provided in writing upon request; and
Instructions for:

3) Initiating an appeal of the denial; and

4) Requesting a clinical rationale for the denial.

J) Denials will be reported quarterly to the QI/UM Committee.

K) Recipient's Notice: During the initial contact, the recipient shall be informed of the Grievance and Appeals process and the right to access the process (either orally or in writing), including the ability to express dissatisfaction at any point in services. CMHA's staff shall assist individuals with grievances and/or appeals at any point in the process. Individuals will be given assistance in completing forms and taking procedural steps; this includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

L) Second Opinion: When an individual is denied initial access to services, or denied access to inpatient psychiatric hospitalization, the individual shall be informed of this denial. When inpatient hospitalization is denied, Notice must be given to the individual or his/her guardian or authorized representative at the time of the denial unless specific circumstances dictate other wise and these circumstances are documented by the clinician. In this situation, the form must be mailed to the individual by the next business day. CMHA's staff shall provide instructions on requesting a Second Opinion. If an individual is assessed and found not to be clinically suitable for hospitalization, the preadmission screening unit shall provide information regarding alternative services and the availability of those services and make appropriate referrals.

M) Denial of Inpatient Hospitalizations

1) If CMHA's preadmission screening unit or children's diagnostic and treatment service denies hospitalization, the individual, his/her guardian or his/her parent in the case of a minor child, may request a Second Opinion from the CMHA's CEO.

2) The CEO or designee shall arrange for an additional evaluation by a psychiatrist, other physician, or licensed psychologist to be performed within three (3) days, excluding Sundays and legal holidays, after the CEO receives the request for the Second Opinion. If the conclusion of the Second Opinion is different from the conclusion of the preadmission screening unit, the CEO, in conjunction with the Medical Director, shall make a decision based on all clinical information available within one (1) business day.

3) The CEO's decision shall be confirmed in writing within three (3) business days to the individual who requested the Second Opinion. The confirming document shall include the signatures of the CEO and Medical Director or verification that the decision was made in conjunction with the Medical Director.

4) If the request for a Second Opinion is denied, the individual or someone on his/her behalf may file a Recipient Rights Complaint with CMHA's Recipient Rights Office.

5) If the initial request for inpatient admission is denied and the individual is a current recipient of other CMHSP services, the individual or someone on his/her behalf is

informed that they may file a Recipient Rights Complaint with the Recipient Rights Office alleging a violation of his/her right to treatment suited to condition.

6) If the Second Opinion determines the individual is not clinically suited for hospitalization and the individual is a current recipient of other CMHA's services, and a Recipient Rights Complaint has not been filed previously on behalf of the individual, the individual or someone on his/her behalf may file a complaint with the Recipient Rights Office.

7) In the event that a physician or licensed psychologist external to CMHA's attests in writing that the individual (applicant or current recipient) meets the definition of an emergency situation as defined in Section 100a (23)(a) or (c) of the Michigan Mental Health Code, CMHA must assess the individual to determine if the individual meets the inpatient admission certification criteria, as defined in the MDHHS Service Selection Guidelines. If psychiatric inpatient services are denied, the individual, his/her guardian, or parent in the case of a minor child, must be informed of their right to a Second Opinion.

N) Denial of Access to Community Mental Health Services Program

1) If an initial applicant for CMHA services is denied such services, an appropriate referral may be provided. In addition, the applicant or his/her guardian, or the applicant's parent in the case of a minor, must be informed of their right to request a Second Opinion of the CEO or designee. The request shall be processed in compliance with Section 705 of the Michigan Mental Health Code and must be resolved within five (5) business days.

2) The applicant may not file a Recipient Rights Complaint for denial of services suited to condition, as he/she does not have standing as a recipient of mental health services. He/she, may, however, file a Rights Complaint if the request for a Second Opinion is denied.

O) Denial or Termination of Family Support Subsidy

1) Pursuant to Section 159(3) of the Michigan Mental Health Code: If an application for Family Support Subsidy is denied or a Family Support Subsidy is terminated by CMHA, the parent or legal guardian of the affected eligible minor may demand, in writing, a hearing by CMHA.

2) CMHA shall review an application and promptly approve or deny the application and shall provide written notice to the applicant of its action and of the opportunity to administratively appeal the decision if the decision is to deny the application. If the denial is due to the insufficiency of the information on the application form or the required attachments, CMHA shall identify the insufficiency.

3) If an application is denied or the subsidy terminated, a parent or legal guardian may file an appeal. The appeal shall be in writing and be presented to the community mental health service program within two months of the notice of denial or termination.

4) If an appeals hearing is held at the CMHSP and the presiding officer upholds the family's appeal in violation of Mental Health Code language, MDHHS shall require that the CMHSP reimburse MDHHS the disputed amount.

5) Families wishing to appeal the decision of the CMHSP hearings officer may do so through circuit court in their county of residence.

6) If a CMHSP approves an application in violation of Mental Health Code language or without full documentation proving eligibility, MDHHS shall require that the CMHSP reimburse MDHHS the disputed amount.

P) Dispute Resolution during the Individual Plan of Service Process

1) If the individual requests a specific mental health support or services for which appropriate alternatives for the individual exist that are of equal or greater effectiveness the staff should:

a) Identify and discuss the underlying reasons for the request/preference;
b) Identify and discuss alternatives with the individual; and
c) Negotiate toward a mutually acceptable support, service and/or treatment.

2) In the event that a mutually acceptable alternative cannot be reached, the staff should:

a) Document the individual's preference, the support, service, and/or treatment offered and the reason for not accepting that preference;

b) Upon completion of the IPOS, Adequate Notice of Adverse Benefit Determination will be provided if a service requested by the recipient has been denied, in whole or in part (amount, scope, or duration). Notice will include:

i. What Action CMHA has taken or intends to take.
ii. The reason(s) for the Action.
iii. Basic legal authority used in making the determination.
iv. The right to request an appeal and instructions for doing so.
v. The circumstances under which expedited resolution can be requested and instructions for doing so.
vi. An explanation that the recipient may represent him or herself or use legal counsel, a relative, a friend, or other spokesperson.

Q) CMHA Grievance Process: A recipient, his/her legal representative may file a grievance either verbally or orally with CMHA's Customer Services Coordinator. The Customer Services Coordinator logs receipt of such in the ELMER Customer Services Database and processes the Grievance through Customer Services. While not responsible for resolving the grievance, Customer Services is responsible for referring the grievance to the proper department or person and making sure the issue is resolved within 90 days. If the grievance is a violation of a Mental Health Code protected right, the Customer Services Coordinator is responsible for forwarding the information to the Recipient Rights Office. At this time, the Recipient Rights Office is responsible for following standards of Chapters 7 and 7A of the Michigan Mental Health Code.

R) Local Appeal Process for Persons with Medicaid

1) The recipient has 60 calendar days from the date of the Notice of Adverse Benefit Determination to request a Local Appeal.

2) A request for a Local Appeal shall be made through the Customer Services Coordinator.

3) An oral request for a Local Appeal of an Adverse Benefit Determination is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the recipient requests an expedited appeal.

4) CMHA will give recipients reasonable assistance to complete forms and to take other procedural steps; this includes but is not limited to providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

5) CMHA must reinstate the Medicaid services until a disposition of the Appeal if the recipient or representative files a request for a Local Appeal and for continuation of benefits not more than 10 calendar days from the date of the Advance Notice.

6) The Customer Services Coordinator shall:

- **a)** Log receipt of the Local Appeal request for reporting to NorthCare Appeal Database; and
- **b)** Send an acknowledgment letter within five (5) days of receipt of Local Appeal request; and
- **c)** Submit the Local Appeal to the appropriate staff, including the administrator or designee with the authority to require corrective action, all of whom were not involved in the initial determination to deny, suspend, terminate, or reduce the service.

7) CMHA Administrator will:

- **a)** Provide the appellant a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. If the appellant has requested an expedited resolution, staff shall inform the appellant of the limited time available to present evidence.
- **b)** Provide the appellant or his/her representative opportunity, before and during the appeals process, to examine the appellant's case file including medical records, and any other documents and records considered during the appeals process.
- **c)** Facilitate resolution of the appeal within ten (10) business days of receipt; assure an expedited review of a local appeal involving an emergent situation where the standard ten (10) business day timeframe would seriously jeopardize the health or life of the individual. Such a review shall be completed within seventy-two (72) hours of receipt of appeal.

8) If CMHA denies a request for an expedited resolution of an Appeal, it must:

- **a)** Transfer the Appeal to the ten (10) business day timeframe; and
- **b)** Make reasonable efforts to give the recipient prompt oral notice of the denial; and
- **c)** Give the recipient follow up written notice within two (2) calendar days.

9) Within the seventy-two (72) hours or ten (10) business day timeframe, CMHA administrator or designee will provide the individual, guardian, or parent of a minor child or his/her legal representative, a written resolution. For expedited Appeals, CMHA will make reasonable efforts to provide oral communication of the decision.

10) The written resolution shall include:

- **a)** The results of the Appeal and the date completed;
- **b)** An explanation of the individual, guardian, or parent of a minor child or his/her legal representative's rights to request a MDHHS administrative hearing and an offer of assistance in filing the request;

c) For appeals resolved not wholly in favor of the recipient, the written resolution must include:

i. The right to request a Fair Hearing and how to do so;

ii. The right to request to receive benefits while the Fair Hearing is pending – this request must be made within ten (10) calendar days of the mailing of the written resolution.

iii. Information on how to make the request;

iv. Information that the recipient may be held liable for the cost of those benefits if the hearing decision upholds the Adverse Benefit Determination made by CMHA.

v. Information on the individual, guardian, or parent of a minor child or his/her legal representative's right to file a Recipient Rights complaint with the Recipient Rights Office alleging a violation of the recipient's right to treatment suited to his/her condition.

vi. CMHA may extend time frames for the disposition of the local appeal by up to fourteen (14) calendar days if:

1. The recipient requests the extension;
2. CMHA shows (to the satisfaction of MDHHS, upon its request) that there is need for additional information on how this is in the recipient's interest.

d) In handling recipient grievances and appeals, decision making shall include:

i. Individuals who were not involved in any previous level of review or decision making; and

ii. If deciding any of the following, are health care professionals who have the appropriate clinical expertise, in treating the Recipient's condition or disease:

1. An appeal of a denial that is based on lack of medical necessity.
2. A grievance regarding denial or expedited resolution of an appeal.
3. A grievance or appeal that involves clinical issues.

S) Local Appeal Process for Persons Without Medicaid

1) The individual, guardian, or parent of a minor child or his/her legal representative may dispute the determination to suspend, terminate, or reduce services by filing an oral and/or written request for a Local Appeal with the CMHA's Customer Services Office within sixty (60) days of receipt of Notice of Adverse Benefit Determination (either Advance or Adequate).

2) The Customer Services Coordinator shall then:

a) Log receipt of the Local Appeal request in the NorthCare Appeals Database and send an acknowledgment letter to the appellant within five (5) days of receipt.

b) Submit the Local Appeal to the appropriate administrator or designee with the authority to require corrective action, none of whom shall have been involved in the initial determination.

3) The Administrator shall:

a) Facilitate resolution of the dispute within ten (10) business days of receipt.

b) Assure an expedited review of the appeal involving an emergent situation where the standard ten (10) business day timeframe would seriously jeopardize the individual's health or safety; such a review shall be completed within 72 hours of

receipt of all necessary information by relevant CMHA services staff involved in the dispute resolution process.

4) The Administrator or designee shall provide the written resolution to the individual, guardian, or parent of a minor child.

5) The written resolution shall include:

a) Information regarding the individual, guardian, or parent of a minor child's ability to access the MDHHS Alternative Dispute Resolution Process and an offer of assistance in doing this;

b) Information on the individual, guardian, or parent of a minor child or his/her legal representative's right to file a Recipient Rights complaint with the Recipient Rights Office alleging a violation of the recipient's right to treatment suited to his/her condition.

T) MDHHS Alternative Dispute Resolution Process

1) In the event that the individual utilizes the Local Dispute Resolution Process or the Second Opinion processes, CMHA must communicate in writing the outcome of that process to the individual. That communication must include notification to the individual of their ability to request access to the MDHHS Alternative Dispute Resolution Process by sending such request to:

Michigan Department of Health and Human Services
Division of Program Development, Consultation and Contracts
Bureau of Community Mental Health Services
ATTN: Request for DHHS Level Dispute Resolution
Elliott-Larsen Building – 5th Floor
Lansing, MI 48913

2) The individual has ten (10) days from the written notice of the Local Dispute Resolution Process outcome to request access to the MDHHS Alternative Dispute Resolution Process.

3) MDHHS shall review all requests within two (2) business days after receipt. An MDHHS representative shall attempt to resolve the issue with the individual and the CMHSP within 15 business days.

4) Requests may be received in any written form, but must include the following information:

a) Name of the consumer.

b) Name of guardian legally empowered to make treatment decisions or a parent of a minor child.

c) Daytime phone number where the recipient, legal guardian, or parent of a minor child may be reached.

d) Name of the CMHSP where services have been denied, suspended, reduced or terminated.

e) Description of the service being denied, suspended, reduced or terminated.

f) Description of the adverse impact on the consumer caused by the denial, suspension, reduction or termination of service.

g) If the recipient requests assistance with filing, CMHA Office of Recipient Rights or Customer Services Coordinator will:
   i. Provide information about the process for filing;
   ii. Offer to assist the individual with filing;
   iii. On the day the request for Alternative Dispute Resolution is received:
      1. Date stamp the request.
      2. Fax the request to MDHHS.
      3. Mail the request to MDHHS.
      4. Log the request in the NorthCare/CMHA Appeals Database.
      5. Forward a copy of the request to the CMHA's Hearing Coordinator.

U) State Fair Hearing Appeal Process for Medicaid Recipients

1) Federal regulations provide a recipient the right to an impartial review by a state level administrative law judge in certain circumstances:
   a) After receiving notice that, as resolution of a Local Appeal, CMHA is upholding an Adverse Benefit Determination. Recipients are given 120 calendar days from the date of the resolution notice to file a request for a State Fair Hearing.
   b) When CMHA fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals.

2) The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (i.e., it must be optional to the recipient, free to the recipient, independent of the State and CMHA, and not extend any timeframes or disrupt continuation of benefits).

3) CMHA may not limit or interfere with a recipient's freedom to make a request for a State Fair Hearing.

4) If the recipient's services were reduced, terminated, or suspended without Advance notice, CMHA must reinstate services to the level before the effective date of the Adverse Benefit Determination.

5) The Parties to the State Fair Hearing include CMHA, the recipient and his or her representative, or the representative of a deceased recipient's estate. A Recipient Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.

6) Expedited hearings are available.

7) The Office of Recipient Rights or Customer Services will:
   a) Provide information about the process for filing, the time frames, the circumstances where services will be continued until a hearing decision is rendered, and the process for withdrawing a hearing request;
   b) Offer to assist the individual with filing a hearing request;
   c) On the day the hearing request is made or received:
      i. Date the request;
      ii. Fax the request to MDHHS;
      iii. Mail the request to MDHHS;
      iv. Forward a copy of the request to the Hearings Coordinator;
      v. Forward a copy to the responsible Administrator;
      vi. Log the request in the NorthCare Appeal Database.

d) Maintain an accurate, secure record system for Requests for Administrative Hearings (NorthCare Appeals Database);

e) Notify the appropriate staff that a room and appropriate equipment for the hearing must be scheduled.

8) The Hearing Coordinator will:

a) Offer a pre-hearing conference to the consumer to see if the issues can be resolved;

b) Prepare a Hearing Summary and documents to be used as evidence during the hearing and submit this to MDHHS.

V) Continuing or Reinstating Medicaid Services

1) CMHA must continue Medicaid services previously authorized to a Medicaid Recipient while the Appeal is pending if:

a) The beneficiary specifically requests to have the services continued; and

b) The request for a Local Appeal and for continuation of benefits is filed within 10 calendar days from the date of the notice; and

c) The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and

d) The original period covered by the original authorization has not expired.

2) When CMHA continues or reinstates the Medicaid services while an appeal is pending, the services must be continued until one of the following occurs:

a) The Recipient withdraws the appeal;

b) The Recipient fails to request a State Fair Hearing and continuation of services within ten (10) calendar days from the date of the written resolution of the Local Appeal;

c) The Michigan Administrative Hearing System issues a Fair Hearing decision adverse to the recipient.

3) If the final resolution of the Appeal or State Fair Hearing upholds CMHA's decision to reduce, suspend, or terminate a service, CMHA may recover the cost of services furnished to the recipient while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements. 42 CFR 438.420(d).

4) If the recipient's services were reduced, terminated or suspended without advance notice, CMHA must reinstate services to the level before the effective date of the action of the Adverse Benefit Determination.

5) If CMHA or the MDHHS Fair Hearing Administrative Law Judge reverses a decision to deny authorization of services, and the recipient received the disputed services while the Appeal was pending, CMHA or the State must pay for those services in accordance with State policy and regulations.

6) If CMHA or the MDHHS Fair Hearing Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, CMHA must authorize or provide the disputed services promptly, and as expeditiously as the Recipient's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

W) Notice Requirements

1) Adequate Notice Requirements:

a) Must be mailed not later than the date of the Action;

b) State what Action the agency intends to take;

c) State the reasons for the intended Action and the policy/authority relied upon in making the determination;

d) For denial of services, explain the primary reasons why the requested service is not medically necessary. State that, upon request, the specific reasons why a denial was issued (clinical rational) will be provided in writing;

e) Provide notification of the individual's right to request a Local Appeal and how to access it;

f) Provide notification that after exhausting the local appeal process, the person has the right to request a state level hearing (for Medicaid Recipients, a State Fair Hearing; for persons without Medicaid, the MDHHS Alternative Dispute Resolution Process);

g) Description of the circumstances under which an appeal can be expedited, and how to request an expedited appeal;

h) State that the individual may represent him/herself or use legal counsel, a relative, a friend or other spokesperson.

2) Advance Notice Requirements:

a) Whenever services are suspended, reduced, or terminated as a result of the Utilization Review function or outside of a negotiated Individual Plan of Service, CMHA will issue an Advance Notice of Adverse Benefit Determination to the affected recipient.

b) For Persons without Medicaid, Advance Notice is to be provided/mailed at least 30 calendar days prior to the proposed day the action is to take place, with the exception of services authorized by a physician that no longer meet established medical necessity.

c) For Persons with Medicaid, Advance Notice is to be provided/mailed at least ten (10) calendar days prior to the proposed effective date of the Action (except as permitted under the "exception" section). Advance Notice of Adverse Benefit Determination must include the following:

i. What Action CMHA has taken or intends to take.

ii. The reason(s) for the Action.

iii. 42CFR 440.230(d) is the basic legal authority for an action to place appropriate limits on a Medicaid service based on such criteria as medical necessity or on utilization control procedures.

iv. The consumer's right to request an appeal, including information on exhausting the local appeal process, and the right to request a state level appeal (for Medicaid Recipients, a State Fair Hearing; for persons without Medicaid, the MDHHS Alternative Dispute Resolution Process) thereafter, and instructions for doing so.

v. The circumstances under which expedited resolution can be requested, and instructions for doing so.

vi. An explanation that the consumer may represent him/herself or use legal counsel, a relative, a friend, or other spokesperson.

vii. For Medicaid recipients, notification of the person's right to have benefits continue pending resolution of the appeal, instructions on how to request benefit continuation, and a description of the circumstances under which the recipient may be required to pay the costs of the continued services.

d) Exceptions to the provision of Advance Notice of Adverse Benefit Determination: CMHA may mail an Adequate Notice, no later than date of action if:

i. CMHA has factual information confirming the death of the recipient.

ii. CMHA receives a clear written statement signed by the recipient that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she is ineligible under Medicaid for further services.

iii. The recipient has been admitted to an institution where he/she is ineligible under Medicaid for further services.

iv. The recipient's whereabouts are unknown, and the Post Office returns CMHA mail directed to him/her indicating no forwarding address.

v. CMHA establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.

vi. A change in the level of medical care is prescribed by the recipient's physician.

vii. The date of the action will occur in less than ten (10) calendar days.

viii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act.

ix. CMHA has facts (preferably verified through secondary sources) indicating that action should be taken because of possible fraud by the recipient (in this case, CMHA may shorten the period of advance notice to five (5) days before the date of action).

VI. REFERENCES AND LEGAL AUTHORITY: The Federal Balanced Budget Act of 1997; 42 CFR Chapter IV, Subpart E, sections 431.200 et seq; 42 CFR Chapter IV, Subpart F, sections 438.402 to 424; Michigan Mental Health Code, Act 258 of the Public Acts of 1974 as Amended; MDHHS Contract Attachment C 6.3.2.1 CMHSP Appeal and Grievance Resolution Processes Technical Requirement; MDHHS Contract Attachment P6.3.1.1 Amendment #2 Grievance and Appeal Technical Requirement PIHP Grievance System For Medicaid Beneficiaries; Northcare Network Enrollee Grievance & Appeal Process Policy

VII. EXHIBITS: Customer Services Grievance Tracking Form; Customer Service Grievance Form; Notice of Adverse Benefit Determination (both Medicaid and Non-Medicaid); Medicaid Notices and Appeals/Non-Medicaid Notices and Appeals (flowcharts); Adverse Benefit Determination Tables