

ATTACHMENT D

CMHSP LOCAL DISPUTE RESOLUTION PROCESS

I. SUMMARY BACKGROUND

All consumers have the right to a fair and efficient process for resolving complaints regarding their services and supports managed and/or delivered by Community Mental Health Services Programs (CMHSPs) and their provider networks. A recipient of or applicant for public mental health services may access several options to pursue the resolution of complaints. These options are defined through the Recipient Rights requirements referenced in the Michigan Mental Health Code (hereafter referred to as the Code) for all recipients of public mental health services, and the MDCH/CMHSP contract. Additional options for Medicaid beneficiaries are explained in the Appeal and Grievance Technical Requirement located in Attachment P.6.3.2.1 of the MDCH contracts with the Pre-paid Inpatient Health Plans (PIHPs). It is important to note that an individual receiving mental health services and supports may pursue their complaint within multiple options simultaneously.

Chapters 7, 7a, 4 and 4a of the Code describe the broad set of rights and protections for recipients of public mental health services as well as the procedures for the investigation and resolution of recipient rights complaints. For the purposes of this requirement, the focus will be on those complaints related to the denial, reduction, suspension or termination of services and supports. Specifically, the purpose of this document is to provide operational guidance to CMHSPs to meet the requirements of the MDCH/CMHSP contract regarding grievance and appeal systems for recipients who are not Medicaid eligible, contained in Section 6.3.2 - Recipient Rights and Grievance/Appeals.

This requirement is based upon the premise that all recipients of, or applicants for, public mental health services will receive notice of their rights and an explanation of the grievance and appeal processes. This requirement in no way requires the exhaustion of grievance or alternative dispute resolution processes prior to the filing of a recipient rights complaint pursuant to Chapter 7 and 7a of the Code.

II. UNDERLYING VALUES AND PRINCIPLES

Properly structured grievance and appeal processes for consumers should promote the resolution of consumer concerns, as well as support and enhance the overall goal of improving the quality of care. The internal and external grievance and appeal processes should be:

- * Timely
- * Fair to all parties
- * Administratively simple
- * Objective and credible
- * Accessible and understandable to consumers
- * Cost and resource efficient
- * Subject to quality review

In addition, the process should:

- * Not interfere with communication between consumers and their CMHSP service providers.
- * Assure that service providers who participate in a grievance and appeal process on behalf of enrollees should be free from discrimination or retaliation.
- * Assure that consumers who file a grievance should be free from discrimination or retaliation.

(Adapted from the Consumer Bill of Rights and Responsibilities, A report to the President of the United States, prepared by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, November 1997.)

III. RECIPIENT RIGHTS REQUIREMENTS REGARDING THE DENIAL OF SERVICES

A. Denial of Hospitalization

1. If a pre-admission screening unit or children's diagnostic and treatment service of the CMHSP 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 executive director of the CMHSP.

The request for the second opinion shall be processed in compliance with Sections 409(4), 498e(4) and 498h(5) of the Code. If the conclusion of the second opinion is different from the conclusion of the children's diagnostic and treatment service or the pre-admission screening unit, the executive director, in conjunction with the medical director, shall make a decision based upon all clinical information available within one business day.

2. If the request for a second opinion is denied, the individual or someone on his/her behalf may file a recipient rights complaint with the CMHSP Office of Recipient Rights.
3. 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 may file a Chapter 7 complaint alleging a violation of his/her right to treatment suited to condition.
4. If the second opinion determines the individual is not clinically suitable for hospitalization **and** the individual is a current recipient of other CMHSP 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 CMHSP Rights Office for processing under Chapter 7A.

B. Denial of Access to Community Mental Health Service Program Services

1. If an initial applicant for CMHSP services is denied such services, 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 executive director. The request

shall be processed in compliance with Section 705 of the Code and must be resolved within five 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 or she may, however, file a rights complaint if the request for a second opinion is denied.

C. Denial of Family Support Subsidy

1. Pursuant to Section 159(3) of the Code, "if an application for a family support subsidy is denied or a family support subsidy is terminated by a community mental health services program, the parent or legal guardian of the affected eligible minor may demand, in writing, a hearing by the community mental health services program. The hearing shall be conducted in the same manner as provided for contested case hearings under Chapter 4 of the Administrative Procedures Act of 1969, Act No. 306 of the Public Acts of 1969, being Sections 24.271 to 24.287 of the Michigan Compiled Laws."

1. Pursuant to the Administrative Rules: Copies of blank application forms, parent report forms, the forms for changed family circumstances, and appeal forms shall be available from the community mental health services program. (R330.1616 Availability of forms) (Note: It is acceptable to ask families to write a letter to the CMHSP requesting an appeals hearing, in lieu of a standardized form.)

A community mental health services program 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, the CMHSP shall identify the insufficiency. (Rule R330.1641 Application review)

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. (R330.1643 Appeal)

IV. REQUIRED LOCAL DISPUTE RESOLUTION PROCESS

- A. The CMHSP must have a local dispute resolution process, to address decisions by the CMHSP and/or their provider networks that impact the consumer's access to, or satisfaction with, services and supports.

Each CMHSP must have a written description of its local dispute resolution process available for review by MDCH. The description must reflect all of the requirements below and indicate if the CMHSP ORR system is to be used, and if so, any modifications

or additions to the CMHSP ORR system to be implemented. CMHSPs are encouraged to utilize their local ORR system for this purpose rather than establishing another process that would be duplicative.

B. The local dispute resolution process at a minimum must possess the following characteristics:

1. It provides for prompt resolution.

The Code provides for up to 90 days for a recipient rights complaint to be resolved (Section 778).

2. It assures the participation of individuals with the authority to require corrective action.

Someone with the authority to act upon the recommendations of the dispute resolution process must be involved. This would include the executive director or designee.

3. It assures that the person reviewing the grievance, complaint or dispute will not be the same person(s) who made the initial decision that is subject to the dispute, complaint or grievance.

4. It has a mechanism for expedited review of a grievance, complaint or dispute involving emergency situations as defined by the Code and further operationalized below.

Sections 409(4), 498e(4) and 498h(5) of the Code provide an opportunity for an individual denied hospitalization to request a second opinion from the CMHSP executive director. The executive director shall arrange for an additional evaluation to be performed within three days, excluding Sundays and legal holidays, after he/she receives the request. If the conclusion of the second opinion is different from the conclusion of the children's diagnostic and treatment service or the pre-admission screening unit, the executive director, in conjunction with the medical director, shall make a decision within one business day based upon all clinical information available.

5. It provides the individual with written notification of the local dispute resolution process decision and subsequent avenues available to the individual if he or she is not satisfied with the result, including the right of individuals without Medicaid coverage to access the MDCH Alternative Dispute Resolution process after exhausting local procedures.

6. It provides reports of disputes, complaints and grievances periodically to the CMHSP governing body.

7. Reports of disputes, complaints and grievances will be reviewed by the CMHSP Quality Improvement Program to identify opportunities for improvement.

8. Records of disputes, grievances, and complaints must be made available to the MDCH for review upon request.

V. DISPUTES, GRIEVANCES AND COMPLAINTS PROCESS—FOR NON-MEDICAID RECIPIENTS

A. Background

A principle reflected throughout the MDCH/CMHSP contract is that all recipients of mental health services and supports shall be treated in the same manner, wherever possible. With respect to appeals and grievances, there is a fundamental difference between Medicaid-funded services and those funded through state funds.

Public formula funded mental health services are not an entitlement programs. The Code describes broad groups of individuals with certain qualifying conditions to whom public mental health services shall or may be directed, with priority always given to individuals with severe conditions and impairments. The Code does not establish an individual entitlement to mental health services in the way that the Federal Medicaid program does for health insurance, but rather it indicates that persons with certain qualifying conditions and impairments must have the first priority for available resources and services within the public mental health system.

The Code provides protections, second opinions and dispute resolution mechanisms for all individuals receiving public mental health services, with the expectation that all disputes will be resolved locally, with the ability to appeal to the MDCH in only those instances where it is alleged that the investigative findings of the local office of recipient rights are not consistent with the facts or with law, rules, policies or guidelines (Section 786). To implement the principle that all consumers are to be treated in the same manner whenever possible, this requirement expands the non-Medicaid individual's ability to appeal to the MDCH.

B. Expedited Processes for Service Denials:

1. Whenever initial access to CMHSP services or supports are denied, the CMHSP must inform the individual, his or her guardian, or in the case of a minor, his/her parent, of their right to a second opinion consistent with Section 705 of the Code. The second opinion must be performed within five business days.
2. If access to psychiatric inpatient service is denied, the individual or, if a minor, his/ her parent or guardian, must be informed of his/her right to a second opinion consistent with Sections 409(4), 498e(4) and 498h(5) of the Code and the CMHSP Local Dispute Resolution Process as described in Section III.A above.
2. In the event that a physician or licensed psychologist external to the CMHSP 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 Code, the CMHSP must assess the individual to determine if the individual meets the inpatient admission certification criteria, as defined in the MDCH Service Selection Guidelines. If psychiatric inpatient services are denied, the individual, his/her guardian, or his/her parent in the case of a minor child, must be informed of their right to a second opinion consistent with Section III.A above and their right to further contest an unfavorable second opinion through the Local Dispute Resolution Process, with the decision from that process to be reached within three business days.

If the CMHSP does not recommend hospitalization and an alternative service requested by the individual, his/her guardian, or his/her parent is denied, the CMHSP must inform the individual, his/her guardian, or in the case of a minor, his/her parent, of his/her ability to access the Local Dispute Resolution Process. The decision from that process for these persons must be reached within three business days.

The CMHSP must communicate the decision of the Local Dispute Resolution Process and inform the individual, his/her guardian, or his/her parent of a minor child of their right to access the MDCH Alternative Dispute Resolution Process.

C. Processes for Suspension, Reduction or Termination of Existing Services:

4. Whenever an existing service or support or existing services are to be suspended, terminated, or reduced by an agency or unit performing a utilization review (UR) function, or when the action is taken outside of the person-centered planning process when the CMHSP does not have an identifiable UR unit, the CMHSP must inform the individual in writing of the change at least 10 business days prior to the effective date of the action. The notice shall include:
 - a. A statement of what action the CMHSP intends to take;
 - b. The reasons for the intended action;
 - c. The specific justification for the intended action;
 - d. An explanation of the Local Dispute Resolution Process

Actions taken as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action.

5. In the event that the individual utilizes the Local Dispute Resolution Process or the second opinion processes as described above, the CMHSP 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 MDCH Alternative Dispute Resolution Process by sending such request to:

Department of Community Health
Division of Program Development, Consultation and Contracts
Bureau of Community Mental Health Services
ATTN: Request for DCH Level Dispute Resolution
Lewis Cass Building - 6th Floor
Lansing, MI 48913

Access to the MDCH process does not require agreement by both parties, but may be initiated solely by the consumer.

The individual has 10 days from the written notice of the Local Dispute Resolution Process outcome to request access to the MDCH Alternative Dispute Resolution Process.

6. A Model Local Dispute Resolution Process for Persons without Medicaid is presented in Exhibit 1.
- D. MDCH responsibilities regarding the Alternative Dispute Resolution Process for persons not receiving Medicaid.
1. MDCH shall review all requests within two business days of receipt.
 2. If the MDCH representative, using a “reasonable person” standard believes that the denial, suspension, termination or reduction of services and/or supports will pose an immediate and adverse impact upon the individual’s health and safety, the issue is referred within one business day to the Community Services Division within Mental Health and Substance Abuse Services for contractual action consistent with Section 8.0 of the MDCH/CMHSP contract.
 3. In all other cases, the MDCH representative shall attempt to resolve the issue with the individual and the CMHSP within 15 business days. The recommendations of the MDCH representative are non-binding in those cases where the decision poses no immediate impact to the health and safety of the individual.

VI. DEFINITIONS

Resolution notice - notice to the consumer that is required within established time frames relative to the disposition of disputes, complaints and grievances, and resolution of the disputes, complaints and grievances.

Rights complaint - a written or verbal statement by a recipient or anyone acting on behalf of a recipient alleging a violation of a Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

MDCH/CMHSP Managed Mental Health Supports and Services Contract FY 09 - Attachment C6.3.2.1

Utilization Review - A process in which established criteria are used to recommend or evaluate services provided in terms of cost-effectiveness, necessity, and effective use of resources.

VIII. REFERENCES

PA 516 of 1996

PA 258 of 1974, as amended

S.353-Health Insurance Bill of Rights of 1997

42 CFR Chapter IV, Subpart E, Sections 431.200 et seq

Exhibit 1

Model CMHSP Local Dispute Resolution Process

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 a written dispute with the CMHSP Recipient Rights Office within five business days of receipt of the advance notice.
2. The Recipient Rights Office shall then:
 - a. Log receipt of the written dispute for reporting to the CMHSP Quality Improvement Program.
 - b. Submit the written dispute to appropriate staff including a CMHSP administrator with the authority to require corrective action, none of whom shall have been involved in the initial determination.
 - c. Facilitate resolution of the dispute within 15 business days of receipt.
 - d. Assure an expedited review of the dispute involving an emergent situation where the standard 15-day time frame would seriously jeopardize the individual's health or safety. Such a review shall be completed within 24 hours of receipt of all necessary information by relevant CMHSP staff involved in the dispute resolution process.
 - e. Upon a decision by CMHSP staff involved in the local dispute resolution process and within the 24-hour or 15-day time frame, provide written notification of the outcome of the process to the individual, guardian, or parent of a minor child. The written notification shall include:
 - (1) Information regarding the individual, guardian, or parent of a minor child's ability to access the MDCH Alternative Dispute Resolution Process and an offer of assistance in doing this;
 - (2) 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 consumer's right to treatment suited to his/her condition.

ATTACHMENT E

GRIEVANCE AND APPEAL TECHNICAL REQUIREMENT PIHP GRIEVANCE SYSTEM FOR MEDICAID BENEFICIARIES

July 2004

Amendment #2 - Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P6.3.2.1

I. PURPOSE AND BACKGROUND

This Technical Advisory is intended to facilitate Prepaid Inpatient Health Plan (PIHP) compliance with Medicaid Beneficiary Grievance System requirements for grievances and appeals contained in Part II, 6.3.2 of the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Community Health (DCH). These requirements are applicable to all PIHPs, affiliate Community Mental Health Services Programs (CMHSPs), Substance Use disorder Coordinating Agencies (CAs) and their Provider networks.

Although this technical advisory specifically addresses the federal Grievance System processes required for Medicaid beneficiaries, other dispute resolution processes available to all Mental Health consumers are identified and referenced.

The term "Grievance system," as used in the federal regulations refers to the overall system for Medicaid beneficiary grievances and appeals, required in the Medicaid managed care context. Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, as defined in this document, and those challenging anything else. A challenge to an action is called an **appeal**. Any other type of complaint is considered a **grievance**.

The Due Process Clause of the U.S. Constitution guarantees that Medicaid beneficiaries must receive "due process" whenever benefits are denied, reduced or terminated. Due Process includes: (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.

Consumers of mental health services who are Medicaid beneficiaries 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 and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid beneficiaries who participate in managed care. Grievance and appeal process requirements for Medicaid beneficiaries were significantly expanded through federal regulations implementing the Balanced Budget Act (BBA) of 1997.

Medicaid beneficiaries have rights and dispute resolution protections under federal authority of the Social Security Act, including:

- State fair hearings through authority of 42 CFR 431.200 et seq.
- Local appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid Beneficiaries, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, (hereafter referred to as the "Code") Chapters 7, 7A, 4 and 4A, including:

- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.)
- Medical Second Opinion through authority of the Mental Health Code (MCL 330.1705)

II. DEFINITIONS

The following terms and definitions are utilized in this Technical Requirement.

- Action:** A decision that adversely impacts a Medicaid beneficiary's claim for services due to:
- Denial or limited authorization of a requested service, including the type or level of service.
 - Reduction, suspension, or termination of a previously authorized service.
 - Denial, in whole or in part, of payment for a service.
 - Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
 - Failure to make an expedited authorization decision within **three (3) working days** from the date of receipt of a request for expedited service authorization.
 - Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the PIHP.
 - Failure of the PIHP to act within **45 calendar days** from the date of a request for a standard appeal.
 - Failure of the PIHP to act within **three (3) working days** from the date of a request for an expedited appeal.
 - Failure of the PIHP to provide disposition and notice of a local grievance/complaint within **60 calendar days** of the date of the request.

Note: The term "action" is also referred to as an "adverse action" in this document.

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.

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

Advance Notice of Action: Written statement advising the beneficiary of a decision to reduce, suspend or terminate Medicaid services **currently provided**. Notice to be provided / mailed to the Medicaid beneficiary at least **12 calendar days prior** to the proposed date the action is to take effect.

Appeal: Request for a review of an "action" as defined above.

Authorization of Services: The processing of requests for initial and continuing service delivery.

Beneficiary: An individual who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid services through a PIHP/CMHSP.

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

Expedited Appeal: The expeditious review of an action, requested by a beneficiary or the beneficiary's Provider, when the time necessary for the normal appeal review process could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. If the beneficiary requests the expedited review, the PIHP determines if the request is warranted. If the beneficiary's Provider makes the request, or supports the beneficiary's request, the PIHP must grant the request.

Fair Hearing: Impartial state level review of a Medicaid beneficiary's appeal of an action presided over by a DCH Administrative Law Judge. Also referred to as "Administrative Hearing".

Grievance: Medicaid Beneficiary's expression of dissatisfaction about PIHP/CMHSP service issues, **other than an action**. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service Provider and the beneficiary.

Grievance Process: Impartial local level review of a Medicaid Beneficiary's grievance (expression of dissatisfaction) about PIHP/CMHSP service issues other than an action.

Grievance System: Federal terminology for the overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process.

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.

Medicaid Services: Services provided to a beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Support waiver, and/or Section 1915(b)(3) of the Social Security Act.

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

Recipient Rights Complaint: Written or verbal statement by a consumer, or anyone acting on behalf of the consumer, 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.

III. GRIEVANCE SYSTEM GENERAL REQUIREMENTS

Federal regulation (42 CFR 438.228) requires the state to ensure through its contracts with PIHPs, that each PIHP has an overall grievance system in place for Medicaid beneficiaries that complies with Subpart F of Part 438.

The grievance system must provide Medicaid beneficiaries:

- A local PIHP appeal process for challenging an "action" taken by the PIHP or one of its agents.
- Access to the state level fair hearing process for an appeal of an "action".
- A local PIHP grievance process for expressions of dissatisfaction about any matter other than those that meet the definition of an "action".
- The right to **concurrently** file a PIHP level appeal of an action, and request a State fair hearing on an action, **and** file a PIHP level grievance regarding other service complaints.
- The right to request a State fair hearing **before exhausting** the PIHP level appeal of an "action".
- The right to request, and have, Medicaid benefits continued while a local PIHP appeal and/or state fair hearing is pending.
- The right to have a Provider, acting on the beneficiary's behalf and with the beneficiary's written consent, file an appeal to the PIHP. The Provider may file a grievance or request for a 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.

IV. SERVICE AUTHORIZATION DECISIONS

When a Medicaid service authorization is processed (initial request or continuation of service delivery) the PIHP **must** provide the beneficiary written service authorization decision within specified timeframes and as expeditiously as the beneficiary's health condition requires. The service authorization must meet the requirements for either **standard** authorization or **expedited** authorization:

- **Standard Authorization:** Notice of the authorization decision must be provided as expeditiously as the beneficiary's health condition requires, and **no later than 14 calendar days** following receipt of a request for service.

If the beneficiary or Provider requests an extension **OR** if the PIHP justifies (to the state agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP may extend the **14 calendar day** time period by up to **14 additional calendar days**.

- **Expedited authorization:** In cases in which a Provider indicates, or the PIHP determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, the PIHP must make an expedited authorization decision and provide notice of the decision as expeditiously as the beneficiary's health condition requires, and **no later than three (3) working days** after receipt of the request for service.

If the beneficiary requests an extension, or if the PIHP justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP may extend the three (3) working day time period by up to **14 calendar days**.

When a **standard or expedited** authorization of services decision is extended, the PIHP must give the beneficiary written notice of the reason for the decision to extend the timeframe, and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision. The PIHP must issue and carry out its determination as expeditiously as the enrollee's beneficiary's health condition requires and no later than the date the extension expires.

V. NOTICE OF ACTION

A Notice of Action must be provided to a Medicaid beneficiary when a service authorization decision constitutes an "**action**" by authorizing a service in amount, duration or scope less than requested or less than currently authorized, or the service authorization is not made timely. In these situations, the PIHP **must** provide a notice of action containing additional information to inform the beneficiary of the basis for the action the PIHP has taken, or intends to take and the process available to appeal the decision.

PIHP Notice of Action requirements include:

- The notice of action to the beneficiary must be in writing and meet language format needs of the individual to understand the content (i.e. the format meets the needs of those with limited English proficiency and or limited reading proficiency).
- The requesting Provider, in addition to the beneficiary, must be provided notice of any decision by the PIHP to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice of action to the Provider is not required to be in writing.
- **If** the beneficiary or representative requests a local appeal or a fair hearing not more than **12 calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the appeal.
- **If** the beneficiary's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.
- **If the utilization review function is not performed within part of an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an action, and requires a written notice of action.**

The notice of action must be either Adequate or Advance:

- **Adequate notice:** is a written notice provided to the beneficiary at the time of EACH action. The individual plan of service, developed through a person-centered planning process and finalized with the beneficiary, must include, or have attached, the adequate notice provisions.
- **Advance notice:** is a written notice required when an action is being taken to reduce, suspend or terminate services that the beneficiary is currently receiving. The advance notice must be mailed **12 calendar days** before the intended action takes effect.

The content of both adequate and advance notices must include an explanation of:

- What action the PIHP has taken or intends to take,
- The reason(s) for the action,
- 42 CFR 440.230(d) is the basic legal authority for an action to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures,
- The beneficiary's or Provider's right to file a PIHP appeal, and instructions for doing so,
- The beneficiary's right to request a State fair hearing, and instructions for doing so,
- The circumstances under which expedited resolution can be requested, and instructions for doing so,
- An explanation that the beneficiary may represent himself or use legal counsel, a relative, a friend or other spokesman,

The content of an advance notice must also include an explanation of:

- The circumstances under which services will be continued pending resolution of the appeal,
- How to request that benefits be continued, and
- The circumstances under which the beneficiary may be required to pay the costs of these services.

NOTE: Examples of adequate and advance notices containing required content are in Exhibits A and B at the end of this document.

There are limited exceptions to the advance notice requirement. The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, **IF:**

- The PIHP has factual information confirming the death of the beneficiary.
- The PIHP receives a clear written statement signed by the beneficiary that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.
- The beneficiary has been admitted to an institution where he/she is ineligible under Medicaid for further services.
- The beneficiary's whereabouts are unknown and the post office returns PIHP mail directed to him/her indicating no forwarding address.
- The PIHP establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
- A change in the level of medical care is prescribed by the beneficiary's physician
- The date of the action will occur in less than **10 calendar days**.

The Notice of Action must be mailed within the following timeframes:

- **At least 12 calendar days before** the date of an action to terminate suspend or reduce previously authorized Medicaid covered services(s) (Advance)
- **At the time of the decision** to deny payment for a service (Adequate)
- **Within 14 calendar days** of the request for a standard service authorization decision to deny or limit services (Adequate).
- **Within three (3) working days** of the request for an expedited service authorization decision to deny or limit services (Adequate).

If the PIHP is unable to complete either a standard or expedited service authorization to deny or limit services within the timeframe requirement, the timeframe may be **extended up to an additional 14 calendar days**.

If the PIHP extends the timeframe, it must:

- Give the beneficiary written notice, no later than the date the current timeframe expires, of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision; and
- Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

VI. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

The PIHP **must** continue Medicaid services previously authorized while the PIHP appeal and/or State fair hearing are pending **if**:

- The Beneficiary specifically requests to have the services continued, and
- The Beneficiary or Provider files the appeal timely; and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, and
- The services were ordered by an authorized Provider, and
- The original period covered by the original authorization has not expired.

When the PIHP continues or reinstates the beneficiary's services while the appeal is pending, the services must be continued until one of the following occurs:

- The beneficiary withdraws the appeal.
- **Twelve calendar days** pass after the PIHP mails the notice of disposition providing the resolution of the appeal against the beneficiary, **unless** the beneficiary, within the **12 day** timeframe, has requested a State fair hearing with continuation of services until a State fair hearing decision is reached.
- A State fair hearing office issues a hearing decision adverse to the beneficiary.
- The time period or service limits of the previously authorized service has been met.

If the PIHP, or the DCH fair hearing administrative law judge **reverses a decision** to deny authorization of services, and the beneficiary **received the disputed services** while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations.

If the PIHP, or the DCH fair hearing administrative law judge **reverses a decision** to deny, limit, or delay services that were **not furnished** while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires.

VII. STATE FAIR HEARING APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to an impartial review (fair hearing) by a state level administrative law judge, of a decision (action) made by the local agency or its agent.

- A Medicaid beneficiary has the right to request a fair hearing when the PIHP or its contractor takes an "action", or a grievance request is not acted upon within 60 calendar days. The beneficiary does not have to exhaust local appeals before he/she can request a fair hearing.
- The agency must issue a written notice of action to the affected beneficiary. (See section VI above for Notice information.)
- The agency may not limit or interfere with the beneficiary's freedom to make a request for a fair hearing.
- Beneficiaries are given 90 calendar days from the date of the notice to file a request for a fair hearing.

- If the beneficiary, or representative, requests a fair hearing not more than 12 calendar days from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing by the administrative law judge.
- If the beneficiary's services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the action.
- The parties to the state fair hearing include the PIHP, the beneficiary and his or her representative, or the representative of a deceased beneficiary's estate.
- Expedited hearings are available.

Detailed information and instructions for the Fair Hearing process can be found in the DCH Administrative Tribunal Policy and Procedures Manual online at:

www.michigan.gov/documents/Manual_9658_7.pdf

VIII. LOCAL APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to a local level appeal of an action. PIHP appeals, like those for fair hearings, are initiated by an "action". The beneficiary may request a local appeal under the following conditions:

- The beneficiary has **45 calendar days** from the date of the notice of action to request a local appeal.
- An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the beneficiary requests expedited resolution.
- The beneficiary may file an appeal with the PIHP organizational unit approved and administratively responsible for facilitating local appeals.
- If the beneficiary, or representative, requests a local appeal not more than **12 calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing.

When a beneficiary requests a local appeal, the PIHP is required to:

- Give beneficiaries 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.
- Acknowledge receipt of each appeal.
- Maintain a log of all requests for appeal to allow reporting to the PIHP Quality Improvement Program.
- Ensure that the individuals who make the decisions on appeal were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on appeal are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease when the appeal is of a denial based on lack of medical necessity or involves other clinical issues
- Provide the beneficiary, or representative with:
 - o Reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;
 - o Opportunity, before and during the appeals process, to examine the beneficiary's case file, including medical records and any other documents or records considered during the appeals process;
 - o Opportunity to include as parties to the appeal the beneficiary and his or her representative or the legal representative of a deceased beneficiary's estate;
 - o Information regarding the right to a fair hearing and the process to be used to request the hearing.

Notice of Disposition requirements:

- The PIHP must provide written notice of the disposition of the appeal, and must also make reasonable efforts to provide oral notice of an expedited resolution.
- The content of a notice of disposition must include an explanation of the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the beneficiary, the notice of disposition must also include:
 - o The right to request a state fair hearing, and how to do so;
 - o The right to request to receive benefits while the state fair hearing is pending, if requested within 12 days of the PIHP mailing the notice of disposition, and how to make the request; and
 - o That the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP's action.

The Notice of Disposition must be provided within the following timeframes:

- **Standard Resolution:** The PIHP must resolve the appeal and provide notice of disposition to the affected parties as expeditiously as the beneficiary's health condition requires, but not to exceed **45 calendar days** from the day the PIHP receives the appeal.
- **Expedited Resolution:** The PIHP must resolve the appeal and provide notice of disposition to the affected parties no longer than **three (3) working days** after the PIHP receives the request for expedited resolution of the appeal. An expedited resolution is required when the PIHP determines (for a request from the beneficiary) or the Provider indicates (in making the request on behalf of, or in support of the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.
- The PIHP may extend the notice of disposition timeframe by up to **14 calendar days** if the beneficiary requests an extension, or if the PIHP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the beneficiary's interest.
- If the PIHP denies a request for expedited resolution of an appeal, it must:
 - o Transfer the appeal to the timeframe for standard resolution or no longer than 45 days from the date the PIHP receives the appeal;
 - o Make reasonable efforts to give the beneficiary **prompt oral notice** of the denial, and
 - o Give the beneficiary follow up **written notice** within **two (2) calendar days**.

IX. LOCAL GRIEVANCE PROCESS

Federal regulations provide Medicaid beneficiaries the right to a local grievance process for **issues that are not "actions"**.

Beneficiary grievances:

- Shall be filed with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating resolution of the grievance.
- May be filed at any time by the beneficiary, guardian, or parent of a minor child or his/her legal representative.
- **Do not** have access to the state fair hearing process **unless**, the PIHP fails to respond to the grievance within **60 calendar days**. This constitutes an "action", and can be appealed for fair hearing to the DCH Administrative Tribunal.

For each grievance filed by a beneficiary, the PIHP is required to:

- Give the beneficiary 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
- Acknowledge receipt of the grievance;
- Log the grievance for reporting to the PIHP/CMHSP Quality Improvement Program.
- Ensure that the individual(s) who make the decisions on the grievance were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on the grievance are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease if the grievance:
 - o Involves clinical issues, or
 - o Involves the denial of an expedited resolution of an appeal (of an action).
- Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination.
- Provide the beneficiary a written **notice of disposition** not to exceed **60 calendar days** from the day PIHP received the grievance/complaint. The content of the Notice of disposition must include:
 - o The results of the grievance process
 - o The date the grievance process was concluded.
 - o 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 and
 - o How to access the fair hearing process.

X. RECORDKEEPING REQUIREMENTS

The PIHP is required to maintain Grievance System records of beneficiary appeals and grievances for review by State staff as part of the State quality strategy.

PIHP Grievance System records should contain sufficient information to accurately reflect:

- The process in place to track requests for Medicaid services denied by the PIHP or any of its Providers
- The volume of denied claims for services in the most recent year.

XI. RECIPIENT RIGHTS COMPLAINT PROCESS

Medicaid beneficiaries, as recipients of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health Code. Recipient Rights complaint requirements are articulated in CMHSP Managed Mental Health Supports and Services contract, Attachment C6.3.2.1 – CMHSP Local Dispute Resolution Process.

EXHIBIT A

ADEQUATE NOTICE OF ACTION (SAMPLE FORM)
ADEQUATE ACTION NOTICE

Date
Name
Address
City, State, Zip

RE: Beneficiary's Name:
Beneficiary's Medicaid ID Number:

Dear _____:

Following a review of the mental health services for which you have applied, it has been determined that the following service(s) shall not be authorized.

Service(s)	Effective Date
_____	_____
_____	_____

The reason for this action is <reason> . The legal basis for this decision is 42 CFR 440.230(d).

If you do not agree with this action, you may request a Michigan Department of Community Health fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the "Request for Hearing" form, and return it in the enclosed pre-addressed envelope, or mail to:

ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
P.O. BOX 30195
LANSING, MI 48909-7695

You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 877-833-0870.

If you do not agree with this action, **you may also request a local appeal**, either orally or in writing, with your Prepaid Inpatient Health Plan (PIHP) within 45 calendar days of the date of this notice by contacting:

<Name of PIHP office/individual responsible for local appeal process>
<Address>
<City, State ZIP>
<Phone Number – Voice>
<Phone Number – FAX>

You have a right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call your PIHP.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Administrative Tribunal, toll free, at 877-833-0870 or the PIHP if you have further questions.

Enclosures:
Hearing Request Form
Return Envelope

EXHIBIT B ADVANCE NOTICE OF ACTION (SAMPLE FORM)

ADVANCE ACTION NOTICE

Date
Name
Address
City, State, Zip

RE: Beneficiary's Name:
 Beneficiary's Medicaid ID Number:

Dear _____:

Following a review of mental health services and supports that you are currently receiving, it has been determined that the following service(s) shall be <reduced, terminated or suspended> effective <date>.

Service(s)	Effective Date

The reason for this action is <reason>. The legal basis for this decision is 42 CFR 440.230(d).

If you do not agree with this action, you may request a Michigan Department of Community Health fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the enclosed "Request for Hearing" form, and return it in the enclosed pre-addressed envelope, or mail to:

**ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
P.O. BOX 30195
LANSING, MICHIGAN 48909-7695**

You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 877-833-0870.

You will continue to receive the affected services until the hearing decision is rendered if your request for a fair hearing is received prior to the effective date of action.

If you continue to receive benefits because you requested a fair hearing you may be required to repay the benefits. This may occur if:

- The proposed termination or denial of benefits is upheld in the hearing decision.
- You withdraw your hearing request.
- You or the person you asked to represent you does not attend the hearing.

ADVANCE ACTION NOTICE

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If you do not agree with this action, you may also request a local appeal, either orally or in writing, with your Prepaid Inpatient Health Plan (PIHP) within 45 calendar days of the date of this notice by contacting:

<Name of PIHP office/individual responsible for local appeal process>
<Address>
<City, State ZIP>
<Phone Number – Voice>
<Phone Number – FAX>

You have a right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call your PIHP.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Administrative Tribunal, toll free, at 877-833-0870 or the PIHP if you have further questions.

Enclosures:

Hearing Request Form
Return Envelope