MCCMH MCO Policy 9-171

Chapter: **RECIPIENT RIGHTS**
Title: **LOCAL APPEAL PROCESS (MEDICAID)**

Prior Approval Date: 02/26/2014
Current Approval Date: 11/21/17

Approved by: BOARD ACTION

Executive Director — Date 11/21/17

I. Abstract

This policy establishes the standards and procedures for the investigation and resolution of the Macomb County Community Mental Health (MCCMH) Prepaid Inpatient Health Plan (PIHP) Consumers' appeals regarding denial, suspension, reduction or termination of Medicaid services and supports, or other Medicaid Adverse Benefit Determinations.

II. Application

This policy shall apply to MCCMH administrative staff, including but not limited to the MCCMH Access Center, as well as to directly-operated and contract network providers of the MCCMH Board, and Medicaid Enrollees who are consumers of services provided through the MCCMH Prepaid Inpatient Health Plan (PIHP).

III. Policy

It is the policy of the MCCMH Board that a direct mechanism for timely local appeal of Medicaid Adverse Benefit Determinations be accessible to Medicaid Enrollees who are Consumers of the MCCMH PIHP.

IV. Definitions

A. Medicaid Adverse Benefit Determination: Any of the following:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

2. The reduction, suspension, or termination of a previously authorized service;

3. The denial, in whole or in part, of payment for a service;

4. Failure to make a standard Service Authorization decision and provide notice about the decision within fourteen (14) calendar days from the date of receipt of a standard request for service (note: this timeframe may be extended up to an additional 14-calendar days in certain circumstances, as provided in MCCMH MCO 2-090, "Service Authorizations.")

5. Failure to make an expedited Service Authorization decision within seventy-two (72) hours after receipt of a request for expedited Service Authorization (note: this timeframe may be extended up to an additional 14-calendar days in certain circumstances, as provided in MCCMH MCO 2-090, "Service Authorizations.").

6. The failure to provide services in a timely manner, as defined by the State – fourteen (14) calendar days of the start date agreed upon during the Person Centered Planning and as authorized by the PIHP;

7. Failure of the PIHP to resolve standard appeals and provide notice within thirty (30) calendar days from the date of a request for aa standard appeal;

8. Failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal;

9. Failure of the PIHP to resolve grievances and provide notice within ninety (90) calendar days of the date of the request;

10. For a resident of a rural area with only one MCO, the denial of a Medicaid Enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network; or

11. The denial of a Medicaid Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Medicaid Enrollee financial liabilities.

B. Appeal: A review at the local level by the PIHP of a Medicaid Adverse Benefit Determination, done at the request of the Medicaid Enrollee or their authorized representative.

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

D. Medicaid Enrollee: A Medicaid beneficiary who is currently a Consumer enrolled in the MCCMH PIHP.

E. Medicaid Grievance: An expression of dissatisfaction about any matter other than a Medicaid Adverse Benefit Determination. Medicaid Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or Consumer, or failure to respect the Consumer's rights regardless of whether remedial action is requested. Medicaid Grievance includes a Consumer's right to dispute an extension of time proposed by MCCMH to make an authorization decision. The local grievance process is conducted pursuant to MCCMH MCO Policy 2-009, "Medicaid Grievances; Non-Medicaid Grievances."

F. Grievance and Appeal System: The processes implemented by MCCMH to handle appeals of Medicaid Adverse Benefit Determinations and Medicaid Grievances, as well as the processes to collect and track information about them.

G. LAP/LDR Hearing Officer: Individual designated by the LAP/LDR Office to resolve Appeals as part of the Local Appeals Process. The LAP/LDR Hearing Officer must ensure that the person who makes the Appeal decision meets the following standards: (i) was not involved in any previous level of review or decision-making, nor a subordinate of any such individual; (ii) takes into account all comments, documents, records, and other information submitted by the Medicaid Enrollee or their representative without regard to whether such information was submitted or considered in the initial Medicaid Adverse Benefit Determination; and (iii) when deciding an Appeal that involves either clinical issues, or a denial based on lack of medical necessity, is an individual who has the appropriate clinical expertise, as determined by the State, in treating the Medicaid Enrollee's condition or disease.

H. Local Appeals Process (LAP): The process through which Appeals from Medicaid Enrollees are reviewed and resolved locally, at the PIHP level; a subpart of the Grievance and Appeal System. The Local Appeal Process provides a single level of Medicaid Adverse Benefit Determination review,

after which a Medicaid Enrollee may further appeal utilizing the State Fair Hearing process.

I. Legal Representative: An adult Consumer's legal guardian, a minor Consumer's parent or legal guardian.

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

K. Notice of Medicaid Adverse Benefit Determination: "Advance" or "Adequate" notice sent by the PIHP to the Medicaid Enrollee in the event of a Medicaid Adverse Benefit Determination. See MCCMH MCO 4-020, "Notice of Medicaid Adverse Benefit Determination (Advance or Adequate) & Appeal Rights."

L. Recipient Rights Complaint: An allegation filed with the MCCMH Office of Recipient Rights that a right protected by the Michigan Mental Health Code or the Administrative Rules of the Michigan Department of Health and Human Services (MDHHS) or other applicable law has been violated with respect to a MCCMH Consumer.

M. Service Authorization: PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law.

N. State Fair Hearing: Impartial state level review of a Medicaid Enrollee's appeal of a Medicaid Adverse Benefit Determination presided over by a State fair hearing officer; also referred to as an "Administrative Hearing." (A Consumer with Medicaid coverage has the right to request a MDHHS Medicaid Fair Hearing to review a Medicaid Adverse Benefit Determination only after exhausting the Local Appeal Process.)

V. Standards

A. MCCMH will maintain a Grievance and Appeal System that will include processes that are uniquely available to Medicaid Enrollees, including:

1. A Local Appeal Process (one level, only) which enables Medicaid Enrollees to appeal Medicaid Adverse Benefit Determinations;

2. A Grievance Process (MCCMH MCO 2-009, "Medicaid Grievances; Non-Medicaid Grievances");

3. The right to concurrently file an Appeal of a Medicaid Adverse Benefit Determination, a Medicaid Grievance regarding other service complaints, and/or any other Recipient Rights Complaints.

4. Access to the State Fair Hearing process to further appeal a Medicaid Adverse Benefit Determination, after receiving notice that the Medicaid Adverse Benefit Determination has been partially or entirely upheld by the PIHP level Appeal.

5. The right to request and receive continued Medicaid Services pending resolution of the Appeal or State Fair Hearing;

6. The right to have a provider or other authorized representative, acting on the Medicaid Enrollee's behalf and with the Medicaid Enrollee's written consent, file an Appeal or Medicaid Grievance to the PIHP, or request a State Fair Hearing. Punitive action may not be taken by the PIHP against a provider who acts on the Medicaid Enrollee's behalf with the Medicaid Enrollee's written consent to do so.

B. Upon receipt of a Notice of Medicaid Adverse Benefit Determination (including, but not limited to notice of Service Authorization that constitutes a Medicaid Adverse Benefit Determination), Medicaid Enrollees shall have the right to Appeal the Medicaid Adverse Benefit Determination through the Local Appeal Process, if the following conditions are satisfied:

1. The Medicaid Enrollee requests an appeal within **60-calendar days** from the date on the notice of Medicaid Adverse Benefit Determination.

2. The Medicaid Enrollee requests the Appeal either orally or in writing, with an oral request followed and confirmed by a written, signed request for Appeal (Unless the Medicaid Enrollee or provider requests and expedited resolution). Oral inquiries seeking to appeal a Medicaid Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal).

C. MCCMH Responsibilities when Medicaid Enrollee Requests an Appeal:

1. Provide Medicaid Enrollees any reasonable assistance to complete forms and take other procedural steps related to Medicaid Grievance or Appeal. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.

2. Acknowledge receipt of each request for Appeal in writing.

3. Maintain a record of Appeals for review by the State as part of its quality strategy and to allow reporting to the MCO/PIHP Quality Improvement Program.

4. Ensure that the individual(s) who make the decisions on Appeals:

    i. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual;

    ii. Take into account all comments, documents, records, and other information submitted by the Medicaid Enrollee or their representative without regard to whether such information was submitted or considered in the initial Medicaid Adverse Benefit Determination.

    iii. When deciding an Appeal that involves either (i) clinical issues, or (ii) a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the Medicaid Enrollee's condition or disease.

5. Provide the Medicaid Enrollee a reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing, and inform the Medicaid Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals (standard or expedited, as applicable).

6. Provide the Medicaid Enrollee and his/her representative the Medicaid Enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP in connection with the Appeal of the Medicaid Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for Appeals (standard or expedited, as applicable).

7. Provide opportunity to include as parties to the Appeal the Medicaid Enrollee and his or her representative, or the Legal Representative of a deceased Medicaid Enrollee's estate.

8. Provide the Medicaid Enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one.

D. Appeal Resolution Timing and Notice Requirements:

1. Standard Appeal Resolution (timing): The PIHP must resolve the Appeal and provide Notice of Resolution of Appeal to the affected parties as expeditiously as the Medicaid Enrollee's health condition requires, not later than **30-calendar days** from the day the PIHP receives the Appeal.

2. Expedited Appeal Resolution (timing):

i. Available where the PIHP determines (when the Appeal request comes directly from the Medicaid Enrollee, without provider support) or the provider indicates (in making a request on the Medicaid Enrollee's behalf or supporting the Medicaid Enrollee's request) that the time for a standard resolution could seriously jeopardize the Medicaid Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

ii. The PIHP may not take punitive action against a provider who requests an expedited resolution or supports a Medicaid Enrollee's appeal.

iii. If a request for expedited resolution is denied, the PIHP must:

a. Transfer the appeal to the timeframe for standard resolution.

b. Make reasonable efforts to give the Medicaid Enrollee **prompt oral notice** of the denial.

c. Within 2-calendar days, give the Medicaid Enrollee written notice of the reason for the decision and inform

the Medicaid Enrollee of the right to file a Medicaid Grievance if they disagree with the decision**.**

d. Resolve the Appeal as expeditiously as the Medicaid Enrollee's health condition requires.

iv. If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide Notice of Resolution of Appeal to the affected parties no later than **72-hours** after the PIHP received the request for expedited resolution.

3. Extension of Timeframes: The PIHP may extend the standard or expedited timeframe for reaching resolution and providing notice by up to **14-calendar days** if the Medicaid Enrollee 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 Medicaid Enrollee's interest.

i. If the PIHP extends resolution/notice timeframes not at the request of the Medicaid Enrollee, it must complete all of the following:

a. Make reasonable efforts to give the Medicaid Enrollee prompt oral notice of the delay;

b. Within 2-calendar days, give the Medicaid Enrollee written notice of the reason for the decision to extend the timeframe and inform the Medicaid Enrollee of the right to file a Medicaid Grievance if they disagree with the decision.

c. Resolve the Appeal as expeditiously as the Medicaid Enrollee's health condition requires and not later than the date the extension expires.

4. Notice of Resolution of Appeal – Content & Format:

i. Format:

a. The PIHP must provide Medicaid Enrollees with written Notice of Appeal Resolution, and must also make

reasonable efforts to provide oral notice in the case of an expedited resolution.

b. Medicaid Enrollee notice must meet the requirements of 42 CFR 438.10 (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency). (Refer to MCCMH MCO 4-010, "Provision and Distribution of Information to Consumers").

ii. Content:

a. The Notice of Appeal Resolution must include the results of the Appeal and the date it was completed.

b. When the Appeal is not resolved wholly in favor of the Medicaid Enrollee, the Notice of Resolution of Appeal must also include notice of the Medicaid Enrollee's: (i) right to request a State Fair Hearing, and instructions on how they can do so; (ii) right to request to receive continuation of Medicaid benefits while the State Fair Hearing is pending, and instructions on how to timely and properly make the request; and (iii) potential liability in the amount of the cost of those continued Medicaid benefits, if the hearing decision upholds the PIHP's Medicaid Adverse Benefit Determination

5. In any case where MCCMH fails to adhere to the notice and timing requirements for resolution of Appeals, the Medicaid Enrollee will be deemed to have exhausted the Local Appeal Process, and the Medicaid Enrollee will be permitted to initiate a State Fair Hearing.

E. Continuation / Reinstatement of Medicaid Services Pending Appeal:

1. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered/requested by an authorized provider, the PIHP MUST continue the Medicaid Enrollee's benefits if all of the following occur:

i. The Medicaid Enrollee files the request for Appeal timely (within 60-calendar days from the date on the Medicaid Adverse Benefit Determination Notice);

ii. The Medicaid Enrollee files the request for continuation of benefits on or before the latter of (i) 10 calendar days from the date of the notice of Medicaid Adverse Benefit Determination, or (ii) the intended effective date of the proposed Medicaid Adverse Benefit Determination; and

iii. The period covered by the original authorization has not expired.

2. Duration of Continued or Reinstated Benefits. If benefits are continued or reinstated at the Medicaid Enrollee's request while the Appeal or State Fair Hearing is pending, they must be continued until one of following occurs:

   i. The Medicaid Enrollee withdraws the Appeal or request for State Fair Hearing;

   ii. The Medicaid Enrollee fails to request a State Fair Hearing and continuation of benefits within 10-calendar days after PIHP sends the Medicaid Enrollee notice of an adverse resolution to the Medicaid Enrollee's Appeal;

      a. NOTE: This means that in order for a Medicaid Enrollee to receive continuation of Medicaid benefits pending a State Fair Hearing, the Medicaid Beneficiary must request the State Fair Hearing and request continuation of benefits within 10-calendar days after the PIHP sends notice of adverse resolution to the Medicaid Enrollee's Appeal.

   iii. A State Fair Hearing office issues a decision adverse to the Medicaid Enrollee.

3. If the final resolution of the Appeal or State Fair Hearing upholds the PIHP's Medicaid Adverse Benefit Determination, the PIHP may, consistent with the state's usual policy on recoveries and as specified in the PIHP's contract, recover the cost of services furnished to the Medicaid Enrollee while the Appeal and State Fair Hearing was

pending, to the extent that they were furnished solely because of these requirements.

4. If the Medicaid Enrollee's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.

5. If the PIHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the Medicaid Enrollee 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.

6. If the PIHP, or the State fair hearing officer 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 Medicaid Enrollee's health condition requires, but no later than 72-hours from the date it receives notice reversing the determination.

F. State Fair Hearing Process (Second Level of Appeal):

1. Medicaid Enrollees have the right to an impartial review by a state level administrative law judge (a State Fair Hearing), of a Medicaid Adverse Benefit Determination, in the following circumstances:

    i. After receiving notice that the PIHP is, after Appeal, upholding a Medicaid Adverse Benefit Determination.

    ii. When the PIHP fails to adhere to the notice and timing requirements for resolution of Medicaid Grievances and Appeals. (See above, Section V(E), and MCCMH MCO Policy 2-009, “Medicaid Grievances; Non-Medicaid Grievances”).

2. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if the review is: (i) optional to the Medicaid Enrollee; (i) free to Medicaid Enrollee (iii) independent of both the State and PIHP; (iv) not an event that causes any Medicaid Grievance and/or Appeal resolution timeframes to extend or disrupts the continuation of Medicaid benefits to the Medicaid Enrollee).

3. The PIHP may not limit or interfere with a Medicaid Enrollee's freedom to make a request for a State Fair Hearing.

4. Medicaid Enrollees have **120-calendar days** from the date from the date of the Notice of Resolution of Appeal to file a request for a State Fair Hearing.

5. The PIHP must continue the Medicaid Enrollee's Medicaid benefits, if the conditions described in Section V(F), above, are satisfied, and for the durations described therein.

    i. NOTE: While the Medicaid Beneficiary has 120-calendar days from the date of the Notice of Resolution of Appeal to request a State Fair Hearing, in order to continue benefits pending the State Fair Hearing, the Medicaid Enrollee must request continuation of benefits and request a State Fair Hearing within ten (10) calendar days after the PIHP sends the notice of an adverse resolution to the Medicaid Enrollee's Appeal.

6. If the Medicaid Enrollee's Medicaid Services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the Medicaid Adverse Benefit Determination.

7. The parties to the State Fair Hearing include the PIHP, the Medicaid Enrollee and his or her representative, or the representative of a deceased Medicaid Enrollee's estate. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.

8. Expedited State Fair Hearings are available.

9. Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at: www.Michigan.gov/mdhhs>>Assistance Programs>>Medicaid>>Medicaid Fair Hearings http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html

G. Recordkeeping Requirements:

1. MCCMH will accurately maintain a record of Appeals, in a manner that: (i) makes all records accessible to the State; (ii) makes records of Appeals separately available upon request to the State and/or CMS; (iii) which shall be reported to the MCO/PIHP Quality Improvement Program, and accessible for review by the State as part of its quality strategy; (iv) contains sufficient information to reflect at least the following information:

    i. A general description of the reason for the Appeal;

    ii. The date received;

    iii. The date of each review, or if applicable, the review meeting;

    iv. The resolution at each level of the Appeal, if applicable;

    v. The date of the resolution at each level, if applicable;

    vi. Name of the covered person for whom the Appeal was filed.

2. Such records must be accurately maintained in a manner accessible to the State and available upon request to CMS.

H. Consumer concerns that are not Appeals of Medicaid Adverse Benefit Determinations made by Medicaid Enrollees receiving Medicaid Services shall be handled according to the appropriate MCCMH MCO Policies, including but not limited to the following:

1. Medicaid Grievances shall be handled according to MCCMH MCO Policy 2-009, “Medicaid Grievances; Non-Medicaid Grievances;”

2. Requests for re-determination of fees and appeals of fee determinations shall be made in accordance with MCCMH MCO Policy 7-001, “Determination of Financial Liability;”

3. Consumer requests for reconsideration of decisions regarding hospitalization/partial hospital admission (2nd opinion) shall be conducted in accordance with the MCCMH/Michigan Department of Health and Human Services (MDHHS) contract, MDHHS Medical Services Administration policies, the Michigan Mental Health Code

and its Administrative Rules, and MCCMH MCO Policy 9-180, "Second Opinion Rights;"

4. New applicants for MCCMH services who have been denied entry into MCCMH services may request a second opinion as provided by the Michigan Mental Health Code, MCL 330.1705; MSA 14.800(705) and MCCMH MCO Policy 9-180, "Second Opinion Rights;"

5. Consumers who have a complaint relating to suspected recipient rights violations may initiate a formal complaint through the MCCMH ORR, as provided by MCCMH MCO Policy 9-510, "Recipient Rights Investigation;"

6. Consumer complaints regarding denial/termination of Family Subsidy shall be handled according to MCCMH MCO Policy 9-170, "Local Dispute Resolution (All Consumers)";

7. All Consumers of the MCCMH CMHSP/PIHP have the right to access the Local Dispute Resolution (LDR) process in order to resolve complaints relating to the denial, reduction, suspension or termination of CMHSP services and supports, and may access this appeal process pursuant to MCCMH MCO Policy 9-170, "Local Dispute Resolution (All Consumers).

I. Nothing in this policy shall limit the consumer's ability to exercise any of the dispute/complaint/grievance rights under any of the policies described in Section V(I), above.

J. MCCMH will provide a State-developed or State-approved description of the Grievance and Appeal System to all providers and subcontractors at the time they enter into a contract with the PIHP, including the same information provided to Medicaid Enrollees' in the Enrollee Handbook about:

1. The right to file Medicaid Grievances and Appeals.
2. The requirements and timeframes for filing a Medicaid Grievance or Appeal.
3. The availability of assistance in the filing process.
4. The right to request a State Fair Hearing after the PIHP has made a determination on a Medicaid Enrollee's Appeal which is adverse to the Medicaid Enrollee.
5. The fact that, when requested by the Medicaid Enrollee, benefits that the PIHP seeks to reduce or terminate will continue if the Medicaid

Enrollee timely requests benefit continuation and files an Appeal or a request for State Fair Hearing, and that the Medicaid Enrollee may be required to pay the cost of such services if the final decision is adverse to the Medicaid Enrollee.

K. MCCMH shall not discriminate or retaliate against any Consumer who files an Appeal, or against any provider who participates in any Appeal process on behalf of a Consumer.

VI. Procedures

A. Notices of Medicaid Adverse Benefit Determinations will instruct the Medicaid Enrollees, to contact the MCCMH Ombudsman for help relating to any of the following: (i) information regarding the Adverse Benefit Determination; (ii) requests for documentation related to the Adverse Benefit Determination; (iii) assistance requesting standard and/or expedited appeals; (iv) information regarding the internal grievance and appeal system, generally; and (v) assistance designating a representative to act on the Medicaid Enrollee's behalf in the appeal process.

B. Upon receipt of any oral or written request for an Appeal hearing, the Local Appeal / Dispute Resolution Office (LAP/LDR Office) shall ensure that the following steps are promptly taken:

1. Log receipt of the request for Appeal;

2. Ensure that Medicaid Enrollee is provided a reasonable opportunity in-person and in writing, to present evidence and testimony and make legal and factual arguments, and document whether or not the Medicaid Enrollee requests an in-person hearing;

3. Send written notice to the Medicaid Enrollee acknowledging receipt of the request for Appeal, and requesting written confirmation of oral requests for Appeal;

4. Send the Medicaid Enrollee a "Notice of your Right to Request State Level Review (Second Tier Appeal) of the Local Appeal/Dispute Resolution Results;" and

5. Ensure that the Medicaid Enrollee and his or her representative is mailed (or otherwise provided) their case file, including medical records, other documents and records, and any new or additional

evidence considered, relied upon, or generated in connection with the appeal of the Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits).

C. At any time during the Local Appeal Process, the Medicaid Enrollee may request assistance from the LAP/LDR Office or the MCCMH Ombudsman, either by phone or in writing. The LAP/LDR Office and/or the MCCMH Ombudsman must provide reasonable assistance with completing forms and taking other procedural steps related to the Local Appeals Process, including but not limed to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.

D. The LAP/LDR Office will organize a pool of potential individuals qualified to make Appeal decisions that involve clinical issues, to ensure availability of options that will satisfy the requirements described in Section V(C)(4)(i)-(iii) of this policy.

E. The LAP/LDR Hearing Officer will screen the Appeal to ensure an appropriate individual makes the Appeal decision, and submit the disputed issue(s), accompanied by all pertinent information, to such individual.

F. The LAP/LDR Hearing Officer will:

1. Facilitate notice of the Appeal hearing to the Medicaid Enrollee within ten (10) business days after receipt of necessary information, and facilitate resolution and notice of resolution according to the timeframes for Standard and Expedited Appeals described in Section V(D)(1)-(3), above.

2. Extend the standard timeframe for resolving an Appeal by up to fourteen (14) calendar days if the Medicaid Enrollee requests the extension or the LAP/LDR Hearing Officer can demonstrate that there is need for additional information and how the delay is in the Medicaid Enrollee's interest. In the case of such an extension, the LAP/LDR Hearing Officer will:

    i. Document the reason for the extension;

    ii. Make reasonable efforts to give the Medicaid Enrollee prompt oral notice of the delay;

iii. Within two (2) calendar days give the Medicaid Enrollee written notice of the reason for the decision to extend the timeframe and inform the Medicaid Enrollee of the right to file a Medicaid Grievance if he or she disagrees with that decision; and

iv. Resolve the appeal as expeditiously as the Medicaid Enrollee's health condition requires and no later than the date the extension expires.

3. Expedited Appeals:

v. Facilitate an expedited review and provide written Notice of Resolution of Appeal to the affected parties as expeditiously as the Medicaid Enrollee's health condition requires, in no event more than 72-hours after receiving the request for expedited Appeal, in any case where either of the following occurs:

a. The provider indicates (in making a request for an expedited appeal on the Medicaid Enrollee's behalf, or in supporting the Medicaid Enrollee's request for appeal) that the standard time frame (in VI.A.5.a.) would seriously jeopardize the Medicaid Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function; or

b. The PIHP determines (in any case, including when the request for Appeal comes directly from the Medicaid Enrollee without provider support) that the standard time frame (in VI.A.5.a.) would seriously jeopardize the Medicaid Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

vi. Make reasonable efforts to provide oral notice of an expedited resolution.

vii. When a request for an expedited resolution of an Appeal is denied:

a. Transfer the appeal to the timeframe for standard resolution.

b. Make reasonable efforts to give the Medicaid Enrollee **prompt oral notice** of the denial.

c. Within 2-calendar days, give the Medicaid Enrollee written notice of the reason for the denial of the request for expedited resolution and inform the Medicaid Enrollee of the right to file a Medicaid Grievance if they disagree with the decision**.**

d. Resolve the Appeal as expeditiously as the Medicaid Enrollee's health condition requires.

G. In any case where a Medicaid Enrollee files for continuation of Medicaid benefits pending resolution of their Appeal or State Fair Hearing, and the request is filed timely and otherwise in compliance with the standards described in this policy, the LAP/LDR Hearing Officer shall coordinate with Access Staff to ensure that such request is honored.

H. Upon the conclusion of the Appeal hearing, the LAP/LDR Hearing Officer will:

1. Notify the MCCMH Executive Director of the Appeal resolution. The Executive Director shall, if indicated, notify, in writing, the appropriate staff concerning any action needed to address the LAP/LDR Hearing Officer's findings.

2. Prepare and send written Notice of Resolution of Appeal, via certified mail, to the appellant (Medicaid Enrollee or Legal Guardian). The Notice of Appeal Resolution shall comply with the Standards described in Section V(D)(4), above.

I. <u>Record of Appeals</u>:

1. The LAP/LDR Office will maintain a record of Appeals which shall be available for analysis by the MCCMH Quality Assessment and Performance Improvement Program (QAPIP), and which shall comply with the standards described in Section V(G) of this policy. In addition, each record must contain the following information and supporting documentation:

i. Evidence of correspondence with the Medicaid Enrollee; and

ii. Proof that resolution was reached within the required time limits.

2. An electronic record of Appeals and supporting documentation will be maintained by the LAP/LDR Office.

J. The LAP/LDR Office shall provide annual reports of statistics and trends observed with respect to Appeals to the MCCMH Board. The annual report shall be reviewed by the MCCMH Quality Improvement Program in order to identify opportunities for improvement.

VII. References / Legal Authority

A. 42 CFR Part 438, Subpart F

B. Michigan Mental Health Code, MCL 330.1704

C. MDHHS/MCCMH Medicaid Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program Contract and Amendments

D. MCCMH MCO Policy 4-020, “Medicaid & Non-Medicaid Notice of Adverse Benefit Determination (Advance & Adequate); Notice of Appeal Rights”

E. MCCMH MCO Policy 2-009, “Medicaid Grievances; Non-Medicaid Grievances”

VIII. Exhibits

A. Notice of Receipt of Appeal/Grievance

B. Notice of Appeal Approval

C. Notice of Appeal Denial