MCCMH MCO Policy 4-030

Chapter: **CUSTOMER RELATIONS / MEMBER SERVICES**
Title: **MI HEALTH LINK SERVICES - NOTICES, GRIEVANCES, AND APPEALS**

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I. ABSTRACT

This policy establishes the standards and procedures of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, to address and resolve grievance and appeal requests from enrollees receiving MI Health Link services in compliance with federal and state laws, rules, and regulations.

II. APPLICATION

This policy shall apply to MCCMH staff and all directly operated, contract, and out of network providers of MCCMH who serve MI Health Link enrollees.

III. POLICY

MCCMH is committed to ensuring fair and efficient grievance and appeal systems for enrollees authorized to receive MI Health Link services. Such systems shall promote the resolution of enrollee concerns while supporting the goal of improving care under standards of best practice.

IV. DEFINITIONS

A. Administrative Law Judge (ALJ)
A judge and trier of fact who both presides over trials and adjudicates the claims or disputes involving administrative law. Enrollees can request review of the case if the Independent Review Entity (IRE) partially or fully denies coverage for an item/service that is covered by Medicare only or by Medicare and Medicaid and thus upholds the original determination. The dispute must meet or exceed the established dollar threshold from the Centers for Medicare and Medicaid Services (CMS).

B. Adverse Benefit Determination

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 service;
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. The failure to provide service in a timely manner, as defined by the State;
5. The failure of MCCMH to act within the required timeframes for the standard resolution of grievances and appeals; or
6. The denial of an enrollee's request to dispute a financial liability.

C. Adverse Benefit Determination Notice/ Adverse Action Notice
A written notification of an adverse action provided to the enrollee.

D. Appeal
As defined in 42 C.F.R. § 438.400(b). A review at the local level of an adverse benefit determination.

E. Enrollee
An individual enrolled in an Integrated Care Organization (ICO) participating in the MI Health Link Demonstration, including the duration of any month in which his/her eligibility for the Demonstration ends.

F. Expedited Appeal
The accelerated process by which MCCMH must respond to an enrollee's appeal if a denial of care decision by MCCMH may jeopardize life, health, or ability to attain, maintain, or regain maximum function.

G. External Appeal
An appeal, subsequent to MCCMH's appeal decision, to a specified external entity.

H. Expedited Grievance
A complaint that MCCMH refused to expedite a determination or reconsideration or invoked an extension to an MCCMH determination or reconsideration timeframe.

I. Grievance
Any dispute, other than an MCCMH determination or an appeal of an adverse action or an adverse benefit determination, expressing dissatisfaction with any aspect of MCCMH's operations, activities, or behavior, regardless of whether any remedial action can be taken. Grievances may include but are not limited to quality of care or services provided, aspects of interpersonal relationships such as rudeness of a primary care provider (PCP) or employee of MCCMH, or failure to respect the enrollee's rights.

J. Independent Review Entity (IRE)
An entity contracted by CMS to review Medicare health plan adverse reconsideration determinations. IRE's review a case if MCCMH partially or fully denies coverage for an item/service that is covered by Medicare only or by Medicare and Medicaid upholding the original determination. MCCMH will automatically forward the case for review to the IRE.

K. Inquiry
Any verbal or written request for information to MCCMH or a delegated entity that does not express dissatisfaction or invoke a grievance, MCCMH determination, or appeals process such as a routine question about a benefit.

L. Judicial Review
A constitutional doctrine that gives a court system the power to annul legislative or executive acts which the judges declare to be unconstitutional. Enrollees can request review of the case if the Medicare Appeals Council (MAC) partially or fully denies coverage for an item/service that is covered by Medicare only or by Medicare and Medicaid upholding the original determination and it meets or exceeds the established CMS dollar threshold.

M. Medicare Appeals Council
Enrollees can request review of the case if the ALJ partially or fully denies coverage for an item/service that is covered by Medicare only or by Medicare and Medicaid upholding the original determination and it meets or exceeds the established CMS dollar threshold.

N. Medicare Covered Services
Medicare Parts A and B services provided to an enrollee pursuant to the MI Health Link - Macomb County/MCCMH managed care contract.

O. Post-Service Appeal
A request to change an adverse determination for care or services that have already been received by an enrollee.

P. Pre-Service Appeal
A request to change an adverse determination for care or service that MCCMH must approve, in whole or in part, in advance of the enrollee obtaining care or services. In this case, the enrollee may not receive coverage for the requested care or service unless MCCMH approves it.

Q. Quality of Care Complaint
A quality-of-care complaint may be filed through the Medicare health plan's grievance process and/or a quality improvement organization (QIO). A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

R. Quality Improvement Organization (QIO)
An organization under contract with CMS to monitor and improve the quality of care given to Medicare enrollees. QIOs review complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, ambulatory surgical centers, and review continued stay denials for enrollees receiving care in inpatient hospitals.

S. Reconsideration
An enrollee's first step in the appeals process after an adverse internal determination. MCCMH or an Independent Review Entity may re-evaluate an adverse internal determination or

termination of services decision, the evidence, and findings upon which it was based, and any other evidence submitted or obtained.

T. Regulatory Complaint
A complaint that originates from a state or federal agency concerning the plan's products and/or services. This includes but is not limited to complaints received through the MI Ombudsman's Office and those received from CMS through the Complaint Tracing Module (CTM).

U. Representative
An individual appointed by an enrollee or other party, or authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in an appeal or grievance. The representative includes the estate representative of a deceased enrollee as a party to the appeal. Unless otherwise stated, the representative will have all the rights and responsibilities of an enrollee or party on obtaining a MCCMH determination, filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described at 42 CFR Part 405.

V. State Fair Hearing
An impartial review of a decision made by MDHHS or one of its contract agencies which is conducted by a Michigan Administrative Hearings System (MAHS) Administrative Law Judge under the oversight, supervision, and authority of MDHHS to provide due process rights required by applicable law.

V. STANDARDS

A. ENROLLEE RIGHTS AND PROTECTIONS

1. MCCMH informs MI Health Link enrollees of their rights and protections at least annually and in a manner that supports cultural considerations, functional status, and language needs.

2. MCCMH informs MI Health Link enrollees in writing of their following rights:

   a. To be treated with dignity and respect.

   b. To be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.

   c. To be provided a copy of their medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. Part 164.

   d. To not be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.

   e. To have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.

   f. To access an adequate network of primary and specialty providers who can meet the enrollee's needs with respect to physical access, communication and scheduling

needs, and are subject to ongoing assessment of clinical quality including required reporting.

g. To choose a plan and provider at any time, including a plan outside of the demonstration, and have that choice be effective the first calendar day of the following month. When that application is received during the last five (5) calendar days of the month it will result in the effective date being the first calendar day of the next month after the following month. For example, an application received on March 28th will only be effective May 1st.

h. To have a voice in the governance and operation of the integrated system, provider, or health plan, as detailed in the Three-Way-Contract.

i. To participate in all aspects of care, including the right to refuse treatment and exercise all rights of appeal.

3. MCCMH provides all staff with enrollee rights and protection training including, but not limited to, role specific training on enrollee appeal rights and processes from the initial denial at the time of coverage determination through the final adverse determination.

4. MCCMH proactively includes information and reminders about the availability of the Ombudsman and routinely refers enrollees to the Ombudsman's Office. The referral may include direct outreach or a warm transfer to the Ombudsman's office.

B. NOTICES

1. MCCMH shall provide MI Health Link enrollees written notice of any adverse action or adverse benefit determination.

2. Notice shall be provided to enrollees at least ten (10) calendar days in advance of the date of its action.

3. The Notice form shall include:

   a. A statement of what action is being taken in understandable language which:

      i. Does not include abbreviations or acronyms that are not defined;

      ii. Is culturally and linguistically sensitive to enrollee needs; and

      iii. Does not have health care procedure codes that are not explained.

   b. An explanation of the action including the denial of services in amount, scope, and duration if less than what is requested;

   c. The specific justification that supports, or the change in the federal or state law that requires, the action including a reference to the benefit provision, guideline, protocol or other similar criterion on which the action is based and the option of the enrollee and/or provider to have a copy of the benefit provision, guidelines or protocol, upon request;

d. A statement that there is only one (1) internal level appeal process for all pre-service, concurrent, and/or post-service provider/practitioner medical necessity or benefit denials and a description of the expedited and standard appeal processes including time frames;

e. A statement that the enrollee has a right to an external Medicaid State Fair Hearing and an explanation of how to file a Medicaid State Fair Hearing;

f. A statement that the enrollee has a right to continue receiving services and an explanation of the procedures of how to request services be continued to the end of currently approved treatment or final decision whichever comes first, if the enrollee requests an internal and/or external State Fair Hearing within ten (10) calendar days from the date of notice;

g. A statement that the enrollee may have to pay for the continuation of services if the result of the internal appeal or external State Fair Hearing is to uphold the denial;

h. Informs the enrollee of their right to designate an authorized representative to act on their behalf if the enrollee has provided written permission by completing and forwarding the standardized Appointment of Representative form to MCCMH;

i. A statement that the enrollee, their legal representative and/or provider can submit written comments, documents, or other information relevant to an appeal;

j. A statement that the enrollee, their legal representative, and/or provider can request copies of all documents relevant to an appeal, free of charge; and

k. Includes the title and qualification, including specialty of the reviewer participating in the appeal review for a medical necessity determination and the reviewers title for a benefit determination. The reviewer's name does not have to be included in the enrollee's written notification. The name of the reviewer will be provided upon request from the enrollee.

C. GRIEVANCES

MCCMH maintains a formally structured grievance process for addressing enrollee grievances. Instructions for filing grievances are included in the Member Handbook which is accessible on the MCCMH website at www.mccmh.net.

a. An enrollee or their authorized representative may file a written or verbal grievance at any time with MCCMH.

b. MCCMH will assist enrollees with completing any forms, as needed.

c. MCCMH will acknowledge all grievances within thirty (30) calendar days, or as expeditiously as an enrollee's health requires.

d. Expedited response, orally or in writing will occur within twenty-four (24) hours of MCCMH receiving the grievance.

e. MCCMH will investigate and notify the enrollee of the resolution of a standard grievance as quickly as the enrollee's health requires but no later than thirty (30) calendar days after MCCMH received the grievance.

D. APPEALS

1. An enrollee, provider, or authorized representative acting on behalf of an enrollee and with the enrollee's written consent may appeal MCCMH's decision to deny, terminate, suspend, or reduce services.

2. An enrollee, provider, or authorized representative acting on behalf of an enrollee and with the enrollee's consent may also appeal the entity's delay in providing or arranging for a covered service.

3. An enrollee or an enrollee's authorized representative, including a provider acting on behalf of the enrollee, must file an appeal no later than sixty (60) days from the date on the written notice.

4. An enrollee/representative will be notified of the resolution as expeditiously as the case requires based on the enrollee's health status, but no longer than thirty (30) calendar days after the date MCCMH received the standard pre-service reconsideration appeal, sixty (60) calendar days for a post-service standard appeal, and within seventy-two (72) hours for an expedited appeal.

5. If the first level/internal appeal review is not fully favorable or the decision is not made within the required timeframes and the decision is for services where Medicare and Medicaid overlap, enrollees may file an external appeal through either the Medicaid or Medicare appeals processes or both.

E. SECOND OPINIONS

1. Enrollees have the right to a second opinion review under the authority of the State of Michigan's Mental Health Code and the Balanced Budget Act. The second opinion review process may be requested for denial of inpatient hospitalization and denial of initial services under Section 40 and 704 of the Michigan Mental Health Code.

2. For each denial of inpatient care or eligibility for services, at the time of the denial, MCCMH shall provide the enrollee with written adequate notice of action and a notice of the rights to a second opinion. The notice shall contain all information as identified in this policy. In addition, the notice must also indicate that the enrollee is entitled to request a second opinion and the process for doing so.

3. Second opinions are made available at no cost to enrollees. For more information on this process, see MCCMH MCO Policy 4-005, "Second Opinion Rights."

F. MCCMH shall provide information regarding the enrollee grievance and appeal processes to all MCCMH MI Health Link service providers. In-network service providers shall receive the information at the time of contracting and out of network providers shall receive the information within ten (10) calendar days of a service authorization.

G. MCCMH shall comply with the Americans with Disabilities Act (ADA) by providing reasonable accommodations, access, and any reasonable assistance in completing forms and taking other procedural steps, including providing alternate formats, interpreter services, and toll-free numbers that have adequate TTY/TTD and interpreter capability.

H. A physician with a current and unrestricted license to practice is responsible for ensuring the clinical accuracy of adverse determinations and reconsiderations involving medical necessity.

I. When a complaint involves emergency services, the reviewer utilizes the prudent layperson standard.

J. MCCMH shall maintain procedures for tracking and maintaining records about the receipt and disposition of grievances and appeals. Grievance or appeal information at a minimum will include:

1. Date received,
2. Enrollee demographic information,
3. Substance of grievance or appeal and its resolution,
4. Date resolved, and
5. Date the notification of resolution was provided to enrollee.

K. MCCMH shall review its adverse benefit determination/action, grievance, and appeal procedures at least annually and amend such procedures as necessary.

VI. PROCEDURES

A. Upon receipt of an appeal or grievance, MCCMH shall promptly assess and notify an enrollee/representative if there are other methods that may be used to resolve their dissatisfaction.

B. Language services shall be provided to enrollees requesting assistance through a bilingual staff or interpreter service, face to face, or telephonically to:

1. Register an appeal;
2. Notify the enrollee of their appeal resolution; and/or
3. Notify enrollees that documents are available in languages other than English.

For additional information refer to MCCMH MCO Policy 5-002, "Cultural and Linguistic Competency."

C. <u>Enrollee Grievances</u>

1. Enrollees or authorized representatives may express their grievance orally or in writing at any time.

a. The enrollee or authorized representative may file an external grievance through 1-800-Medicare. MCCMH will display a link to the electronic grievance form on the Medicare.gov Internet website located on MCCMH's main website and inform enrollees of the email address, postal address, and toll-free telephone number where enrollee grievances may be filed.

b. If an enrollee files a grievance with the State, they will enter the grievance into the CMS Health Plan Management System (HPMS) Complaints Tracking Module (CTM) which MCCMH will access.

c. Upon receipt of a complaint, MCCMH will determine and inform the enrollee/representative orally or in writing, if requested, whether the complaint is subject to grievance or appeal procedures, along with any other rights (e.g., filing a Grievance through 1-800-Medicare) and the timeframe for processing the case.

d. Grievances will be categorized by:

   i. Quality of care

      a) A quality-of-care complaint is a grievance unless it involves a denial of services. In which case, it is an appeal complaint as well as a grievance complaint that is subject to both processes.

      b) Enrollees may also request that a QIO review their quality-of-care complaint.

   ii. Service Concerns/Availability

   iii. Financial Matters

   iv. Service Environment

e. Grievances will be responded to in writing when the grievance is filed in writing, the member requests a written response, or the grievance is related to quality of care.

2. MCCMH maintains written records of all grievance activities and shall:

   a. Accept any information or evidence concerning the grievance either orally or in writing.

   b. Provide to the enrollee/representative a timely acknowledgment of its receipt of the enrollee grievance.

   c. Complete a prompt, appropriate investigation of the grievance as expeditiously as the enrollee's case requires, based on the enrollee's health status.

   d. Document all issues relevant to the grievance including any aspect of clinical care involved.

3. Standard Internal Grievance Resolution

a. All clinical grievances shall be reviewed and investigated by a clinician not previously involved in the grievance.

b. MCCMH will use health care professionals who have the appropriate clinical expertise, as determined by MDHHS, when deciding on a grievance regarding denial of expedited resolution of an appeal or a grievance that involves clinical issues.

c. MCCMH will respond to an enrollee's grievance electronically, orally, or in writing within thirty (30) calendar days after receipt of the grievance.

d. MCCMH will notify the enrollee/representative and other concerned parties of the resolution of the grievance as expeditiously as the case requires, based on the enrollee's health status, but no longer than thirty (30) days after the date MCCMH received the complaint.

e. An enrollee/representative may request up to a 14-day extension.

f. If MCCMH, not at the request of the enrollee/representative, determines that additional time is needed and the extension is in the best interest of the enrollee, MCCMH will promptly provide verbal notification of the up to fourteen (14) day extension to the enrollee/representative. Within two (2) days of the verbal notice, MCCMH will give the enrollee written notice of the reason for the extended timeframe and inform them of their right to file a grievance if they disagree with the decision that has been made.

4. Expedited Grievances

   MCCMH will respond to an enrollee's expedited grievance within 24 hours if the grievance is for one of the following reasons:

   a. MCCMH extends the appeals timeframe.

   b. MCCMH refuses to grant a request for an expedited appeal.

5. The MCCMH Quality Council is responsible for reviewing grievances filed by enrollees and grievance management reports to identify opportunities for improvement.

D. Enrollee Local/Internal Appeal (First Level)

1. MCCMH will ensure that MI Health Link enrollees receiving MCCMH authorized Medicare and/or Medicaid services have a method for addressing any MCCMH Adverse Benefit Determination with which the enrollee disagrees.

2. The enrollee, or an enrollee's authorized representative, including a provider acting on behalf of the enrollee, must file an appeal no later than sixty (60) days from the date on the written notice for items/services. The expiration date to file an appeal is included on the written notice.

3. For enrollees under the age of eighteen, written consent to file is not required when the individual filing the appeal belongs to the enrollee's assistance group.

4. Enrollees or their representative may file an appeal either verbally by contacting the Customer Service Department or by submitting a request in writing.

5. All written requests are submitted to MCCMH at the following mailing address:

Macomb County Community Mental Health
Hearing Officer
19800 Hall Road
Clinton Township, MI 48038

6. MCCMH will acknowledge receipt of each appeal with a Notice of Appeal Receipt Letter within three (3) calendar days for a standard appeal request and within 24 hours for an expedited appeal request to both the enrollee and provider.

7. If an enrollee or their authorized representative shows good cause in writing, MCCMH may extend the time frame for filing an appeal. The enrollee or their authorized representative must request the appeal in writing and include the reason for good cause. The circumstances considered when making the decision to extend the timeframe to appeal include, but are not limited to:

    a. The enrollee did not personally receive the adverse determination notice from MCCMH or he/she received it late;

    b. The enrollee was seriously ill, which prevented a timely appeal;

    c. There was a death or serious illness in the enrollee's immediate family;

    d. An accident caused important records to be destroyed;

    e. Documentation was difficult to locate within the time limits;

    f. The enrollee had incorrect or incomplete information concerning the reconsideration process; or

    g. The enrollee lacked the capacity to understand the timeframe for filing a request for reconsideration.

8. If MCCMH denies an enrollee's request for a good cause extension, MCCMH will provide written notice that explains the enrollee's right to request an IRE review of the dismissal.

9. An enrollee or their representative may withdraw a request for appeal at any time in writing.

    a. If a withdrawal is filed, MCCMH must receive it before the appeals decision is mailed to the enrollee or the representative.

    b. If the withdrawal is received after MCCMH has forwarded the appeal to an IRE, MCCMH must also forward the withdrawal for IRE processing.

10. The enrollee and his or her representative are provided a reasonable opportunity to present evidence and allegations of fact or law in person and in writing.

11. For expedited cases, MCCMH will inform the enrollee of the limited time available for presenting evidence and allegations of fact or law in person as well as in writing.

12. MCCMH takes all information into account during the appeals process without regard to whether the information was submitted or considered in the case's initial determination.

13. The enrollee and his or her representative are provided opportunities, before and during the appeals process, to examine the enrollee's case file, including medical records and any other documents and records considered during the appeals process.

14. MCCMH will ensure that punitive action is not taken in retaliation against an enrollee or a provider who requests an appeal or a provider who requests an expedited resolution or supports an enrollee's appeal.

15. MCCMH will promptly conduct a full investigation of the reconsideration appeal and log research and documentation of all issues relevant to the reconsideration. The documentation will include, but is not limited to:

    a. Type of appeal (standard or expedited);

    b. The substance of the appeal request, including a short and dated summary of the issues;

    c. Name of the appellant;

    d. Name of the provider or facility (if applicable);

    e. Date of appeal;

    f. Date of decision and the resolution;

    g. The initial adverse action notes and records;

    h. Additional clinical information and documentation submitted by the enrollee, enrollee's representative, and/or enrollee's provider, as applicable; and

    i. All aspects of clinical care involved, including the same specialty reviewer's comments.

16. Clinical appeal considerations are conducted by health professionals who:

    a. Are clinical peers;

    b. Hold an active, unrestricted license to practice in a health profession;

c. Are board-certified, if applicable;

d. Are in the same profession and similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate; and

e. Are not the individual who made the original determination nor a subordinate of such an individual.

17. MCCMH will notify the enrollee/representative if it extends the timeframe for pre-service or expedited appeals by up to fourteen (14) calendar days. The time frame may be extended when the enrollee requests an extension or when MCCMH justifies the need for additional information and documents how a delay is in the best interest of the enrollee.

    a. If MCCMH extends the timeframe, not at the request of the enrollee, it will make reasonable efforts to give the enrollee prompt verbal notice of the delay.

    b. Within two (2) calendar days of the verbal notice, written notice must be provided that explains the reason for the extension and informs the enrollee of their right to file an expedited grievance if they disagree with the decision.

18. An enrollee may continue to receive services during the appeals process under the following circumstances:

    a. For items/services that are covered by Medicare only, benefits will continue through the health plan appeal process if the appeal is filed within ten (10) calendar days of receipt of the notice.

    b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

    c. The services were ordered by an authorized provider;

    d. The original period covered by the original authorization has not expired; and/or

    e. The enrollee files an appeal or a request for a Medicaid State Fair Hearing within specified timeframes of no more than one hundred and twenty (120) calendar days from the notice of appeal decision.

19. If the enrollee requests benefits be continued or reinstated while the appeal is pending, the benefits will continue until one of the following occurs:

    a. The enrollee withdraws the appeal;

    b. An external reviewer or the State Fair Hearing Officer issues a hearing decision adverse to the enrollee;

    c. The time period or service limit of a previously authorized service has been met;

    d. The final resolution of the appeal is adverse to the enrollee and upholds MCCMH's action. Services will then be terminated upon the intended effective

date of the action or if that date has passed, within ten (10) business days of the decision.

20. The appeal process is executed with utmost regard given to protecting the confidentiality of any protected health information gathered through the process. The appeals process follows MCCMH's Privacy Policies, which comply with HIPAA requirements.

21. Misclassification of Appeals

    a. All coverage determinations are subject to appeal procedures. Sometimes complaints do not appear to involve coverage determinations and are misclassified as grievances exclusively.

    b. Upon discovery of such an error, MCCMH shall notify the enrollee in writing that the case was misclassified and will be handled through the appeals process. The timeframe for processing the appeal begins on the date the appeal is received by MCCMH; as opposed to the date the plan discovers its error.

22. The enrollee/representative will be notified in writing of the appeal resolution as expeditiously as the case requires based on the enrollee's health status, but no longer than thirty (30) calendar days after the date MCCMH received the standard pre-service reconsideration appeal, sixty (60) calendar days for a post-service standard appeal, and within seventy-two (72) hours for an expedited appeal.

23. Written Appeal Decision Letter – Pre-Service Standard and Expedited

    a. Enrollees will receive a written notice of appeal decision that is specific to the item or service being appealed.

    b. The written notice of the appeal resolution will include:

        i. A description of the item/service being appealed;

        ii. The results of the resolution process and the date it was completed;

        iii. For items/services covered by Medicare that were not resolved wholly in the favor of the enrollee, the information that the case has been forwarded to the IRE for review;

        iv. That oral interpretation is available in any language;

        v. That written translation is available in prevalent languages, as applicable;

        vi. That written alternative forms may be available, as needed;

        vii. How to access interpretation and translation services as well as alterative formats;

viii. The right to seek assistance from the Ombudsman's Office at any time throughout the appeal process and how to do so;

ix. Reasons for the determination and in cases where the determination has a clinical basis, the clinical rationale for the determination;

x. A reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based;

xi. Notification that the enrollee can obtain, upon request, a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based;

xii. Notification that the enrollee is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents or records relied upon and documents and records submitted while making the appeal decision at no cost to the enrollee;

xiii. A list of the titles and qualifications of each individual participating in the appeal review, including specialty, as appropriate. Participant names need not be included in the written notification to the enrollees, but must be provided to enrollees upon request; and

xiv. A carbon copy of notification to the provider, if applicable.

24. All appeals, received orally or in writing, shall be tracked and maintained by MCCMH.

25. MCCMH shall maintain the privacy of appeal records, including the transmittal of medical records, as applicable.

26. MCCMH shall retain all appeal files in a secure, designated area for a period of at least ten (10) years following the final decision.

E. <u>MCCMH Voicemail</u>

1. Where voicemail is used outside of the normal business hours provided, the voicemail message shall contain the following information:

   a. Indication that the mailbox is secure;

   b. Information that must be provided so the case can be worked; and

   c. For coverage determination calls, articulates a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests.

F. <u>External Appeals</u>

1. If the first level/internal appeal review is not fully favorable or the decision is not made within the required timeframes and the decision is for services where Medicare and Medicaid overlap, enrollees may file an appeal through either the Medicaid or Medicare appeals processes or both. An enrollee may go through both the Medicaid and Medicare appeal processes at the same time.

2. CMS Independent Review Entity (IRE)

   a. Upon MCCMH's appeal denial of coverage in whole or in part of an item/service that is covered by Medicare or where Medicare and Medicaid overlap, the case will automatically be forwarded to the IRE for review. The enrollee must request all other levels of external review.

   b. MCCMH will notify the enrollee that it has forwarded the case to the IRE for review. The notice will include contact information for the IRE and depict the enrollee's right to submit additional evidence that may be relevant to the case directly to the IRE.

   c. The IRE will send the enrollee and MCCMH a written decision within:

      i. Thirty (30) calendar days for standard external appeals;

      ii. Sixty (60) calendar days for payment requests;

      iii. Seventy-two (72) hours for expedited external appeals; or

      iv. At the end of an up to fourteen (14) calendar day extension.

   d. The decision notice will include the right to an Administrative Law Judge (ALJ) Hearing and the procedure to request one if the total dollar amount of the items/services being appealed meets or exceeds the amount in controversy (AIC) threshold.

   e. If the IRE decides in the enrollee's favor and reverses MCCMH's decision, MCCMH must authorize the service under dispute as expeditiously as the enrollee's health requires, but no later than seventy-two (72) hours from the date MCCMH receives notice of the decision being reversed.

   f. If MCCMH or the enrollee disagrees with the IRE's decision, further levels of appeal may be available.

3. The Medicaid State Fair Hearing Process

   a. Upon MCCMH's appeal denial of coverage in whole or in part of an item/service that is covered by Medicaid, providers or enrollees can appeal in writing to the Michigan Administrative Hearing System (MAHS).

   b. Written appeal requests must be filed within one hundred and twenty (120) calendar days from the Notice of Appeal Decision.

c. Once the Request for Hearing is received, the Michigan Administrative Office of Hearings and Rules will process and schedule a hearing date and time.

d. External appeals to the Medicaid State Fair Hearing process that qualify as expedited appeals shall be resolved within seventy-two (72) hours or as expeditiously as the enrollee's condition requires.

e. External appeals to the Medicaid State Fair Hearing process that do not qualify as expedited shall be resolved within ninety (90) calendar days of the date of filing.

f. If the enrollee disagrees with the Medicaid State Fair Hearing's decision, they can file a request for reconsideration or re-hearing thirty (30) days from the date of the decision.

g. If the appeal is not fully approved regarding the denial of a claim, the enrollee has the right to file an external review request with the Department of Insurance and Financial Services through the Michigan Department of Health and Human Services (MDHHS). The enrollee has 127 days to file this request in writing.

4. Adjudicated Law Judge (ALJ) Hearing - Medicare Covered Services

a. The enrollee or their authorized representative must file a request for an ALJ hearing in writing within sixty (60) days of the IRE notice of determination with the entity specified in the IRE's reconsideration notice.

b. For a case to be reviewed at an ALJ Hearing, it must meet the amount in controversy (AIC) threshold.

c. If MCCMH receives a written request for an ALJ hearing from the enrollee, MCCMH must immediately forward the enrollee's request to the IRE. The IRE is responsible for compiling the reconsideration file and forwarding it to the appropriate ALJ hearing office.

5. Medicare Appeal Council (MAC) Review - Medicare Covered Services

Enrollees or their authorized representative must request a MAC review in writing through a letter to the MAC within sixty (60) days of the ALJ decision. The request should be submitted directly to the MAC at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, DC 20201

6. Judicial Review – Medicare Covered Services

a. An enrollee may not obtain judicial review unless the MAC has acted on the case either in response to a request for review or on its own motion and the cost of the items/services meets or exceeds the amount in controversy (AIC) threshold.

b. The enrollee may combine claims to meet the AIC requirement. To meet the requirement:

i. All claims must belong to the same enrollee;

ii. The MAC must have acted on all claims;

iii. The enrollee must meet the 60-day filing limit for all claims; and

iv. The request must identify all claims.

c. To file for a Judicial Review a party must file a civil action in the District Court of the United States in accordance with procedures outlined in 42 CFR 422.612 and 405.1136 except that escalation does not apply. The action should be initiated in the judicial district where the enrollee lives or MCCMH has its principal office.

7. Final Decisions by External Review Entities

a. If the MCCMH determination is reversed in whole or in part by the IRE, ALJ, MAC, Judicial Review or State Fair Hearing, MCCMH must pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health condition requires or in the time frames below:

i. For Medicare covered expedited/pre-service services, MCCMH must authorize services within 72 hours.

ii. For Medicare payment appeals, MCCMH must pay within sixty (60) calendar days.

iii. For MAHS decisions, MCCMH must authorize services under dispute within 72 hours.

iv. If the enrollee received the disputed services, MCCMH must pay for those services in accordance with State rules and policy.

b. If MCCMH requests MAC review an ALJ decision, the plan may await the outcome of the review before paying for, authorizing, or providing the services under dispute. If MCCMH files an appeal with the MAC, it must concurrently send a copy of the appeal request and any accompanying documents to the enrollee and must notify the IRE that it has requested a MAC review.

G. <u>Non-Contracted Provider Post-Service Appeal</u>

1. If MCCMH denies a request for payment from a non-contract provider for an item/service that is covered by Medicare only or by Medicare and Medicaid, MCCMH must notify the non-contract provider of the specific reason for the denial and provide a description of the appeal process.

2. MCCMH must deliver either a remittance advice/notice or other similar notification that states the non-contract provider:

a. Has the right to request a reconsideration of MCCMH's denial of payment;

b. Must submit a Waiver of Liability (WOL) form holding the enrollee harmless regardless of the outcome of the appeal;

c. Has sixty (60) calendar days from the remittance notification to request a reconsideration;

d. Should include documentation, such as a copy of the original claim or remittance notification showing the denial, and must include any clinical records and other documentation that supports the provider's argument for reimbursement; and

e. Return the request for reconsideration to MCCMH following the instructions provided by MCCMH on where to send the request.

3. If MCCMH receives a non-contract provider appeal that is missing a properly executed WOL, MCCMH must make multiple attempts to obtain the missing documents. At least one attempt must be in writing.

4. If the WOL is not received sixty (60) calendar days from the date of the standardized notice form, MCCMH must use a Notice of Dismissal form to dismiss the appeal and notify the provider of the right to file a request with the IRE.

5. Upon disagreement with a payment on a submitted claim for an item/service that is covered by Medicare only or by Medicare and Medicaid, the non-participating provider may dispute in writing with supporting documentation that they should receive a different payment under original Medicare within sixty (60) days of the remittance advice. If MCCMH upholds the coverage decision in whole or part, it will complete and submit a written case summary to MAXIMUS according to the defined timeframes and processes.

VII. REFERENCES / LEGAL AUTHORITY

A. 42 CFR: Sections 431.200 et seq., 435.911-920, 438.400 et seq., 422(m)

B. Contract between United States Department of Health and Human Services, Center for Medicare and Medicaid Services in Partnership with the State of Michigan and the Integrated Care Organizations, (The Three-Way Contract), (in effect, and as amended)

C. Michigan Mental Health Code, PA 258 of 1974, as amended

VIII. EXHIBITS

None.