MCCMH MCO Policy 4-004

Chapter: **CUSTOMER RELATIONS / MEMBER SERVICES**
Title: **MEDICAID DUE PROCESS SYSTEM**

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A. ABSTRACT

This policy establishes the standards of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, regarding MCCMH's adherence to and compliance with applicable due process rights afforded to its Medicaid persons served.

B. APPLICATION

This policy shall apply to the administrative offices and the directly-operated and contract network providers of MCCMH.

C. POLICY

It is the policy of MCCMH that a due process system is established, maintained, and in compliance with federal, state, and other external regulations to ensure all persons served the right to a fair and efficient process for resolving disagreements regarding their services and supports. An MCCMH person served or applicant for public mental health services may access several options to pursue the resolution of disagreements. This system includes both mental health and substance use disorder services and treatments.

This policy in no way requires persons served to utilize due process prior to the filing of a

Recipient Rights complaint pursuant to Chapter 7 and 7a of the Michigan Mental Health Code and affiliate policies relative to the filing of Recipient Rights complaints. This is also true for the Recipients Rights process for substance use disorder services.

D. DEFINITIONS

A. Additional Mental Health Services:
Supports and services available to Medicaid beneficiaries who meet the criteria for specialty services and supports, under the authorization of Healthy Michigan, Habilitation Supports and Waiver and 1115/(i)SPA.

B. Adequate Notice of Adverse Benefit Determination:
Written statement advising the enrollee of a decision to deny or limit authorization of Medicaid services requested and the reasons why. Notice must be provided to the Medicaid enrollee on the same date the Adverse Benefit Determination takes effect and written in an easily understood manner.

C. Advance Notice of Adverse Benefit Determination:
Written statement advising the enrollee of a decision to reduce, suspend, or terminate Medicaid services currently provided. Notice must be provided to the Medicaid enrollee at least thirty (30) calendar days prior to the proposed date the adverse benefit determination takes effect.

D. Adverse Benefit Determination:
A decision that adversely impacts a Medicaid enrollee's claim for services due to:

1. 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. Reduction, suspension, or termination of a previously authorized service;
3. Denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an adverse benefit determination;
4. Failure to make a standard authorization decision and provide notice about the decision within seven (7) calendar days from the date of receipt of a standard request for service;
5. Failure to make an expedited service authorization decision within seventy-two (72) hours from the date of receipt of a request for expedited service authorization;
6. Failure to provide service within the fourteen (14) calendar days of the start date agreed upon during the person-centered planning (PCP) meeting and as authorized by MCCMH;

7. Failure of MCCMH to resolve standard appeals and provide notice of resolution within thirty (30) calendar days from the date the standard appeal request is received by MCCMH;
8. Failure of MCCMH to resolve expedited appeals and provide notice within seventy-two (72) hours from the date the expedited appeal request is received by MCCMH;
9. Failure of MCCMH resolve grievances and provide notice within ninety (90) calendar days of the date the grievance is received by MCCMH; or
10. For residents of a rural area with only one managed care organization (MCO), the denial of an enrollee/enrollee's request to exercise their right under 438.52(b)(2)(ii), and to obtain services outside the network.
11. Denial of the enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial responsibility.

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

F. Community Mental Health Service Program (CMHSP)
A program that contracts with the State to provide comprehensive behavioral health services in specific geographic service areas, regardless of an individual's ability to pay.

G. Enrollee
A Medicaid beneficiary who is currently enrolled in a PIHP, entity managed care program.

H. Due Process:
The process MCCMH implements to handle appeals of adverse benefit determinations and grievances, as well as the processes to collect and track information about them.

I. Expedited Appeal:
The expeditious review of an Adverse Benefit Determination, requested by the enrollee or the enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the enrollee requests the expedited review, MCCMH determines if the request is warranted. If the enrollee's provider makes the request, or supports the enrollee's request, MCCMH must grant the request.

J. Hearing Officer:
Staff person assigned to coordinate the State Fair Hearing process, representing MCCMH.

K. Inquiry
A request from a person served for information that would clarify policy, benefits, procedures, or any aspect of an administrative function but does not express dissatisfaction.

L. Legal Representative:
An adult person's legal guardian, a minor person's parent or legal guardian.

M. Medicaid Appeal:
A local review by MCCMH of an Adverse Benefit Determination, as requested by a Medicaid enrollee or authorized representative.

N. Medicaid Grievance:
A Medicaid enrollee's expression of dissatisfaction about a service issue at MCCMH, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the enrollee, failure to respect the enrollee's rights regardless of whether remedial action is requested, or an enrollee's dispute regarding an extension of time proposed by MCCMH to make a service authorization decision.

O. Medicaid Services:
Services provided to an enrollee under the authority of the Medicaid State Plan, 1115 Behavioral Health Demonstration Waiver, Healthy Michigan Plan, MI Child, 1915(i) Waiver, 1915(c) Waivers, and/or Section 1915(b)(3) of the Social Security Act (SSA).

P. Mental Health Professional:
A person who is trained and experienced in mental illness or intellectual/developmental disabilities, as identified per MDHHS staff qualification criteria.

Q. Notice of Resolution:
Written statement from MCCMH of the resolution of a grievance or appeal, which must be provided to the enrollee, as described in 42 CFR 438.408.

R. Ombudsman
An MCCMH staff member whose role includes:

1. Helping individuals voice their wishes and concerns so they are heard and understood by MCCMH providers;

2. Facilitating resolution of Medicaid and non-Medicaid grievances;

3. Assisting individuals with accessing the MCCMH Office of Recipient Rights (ORR) to pursue formal processes when a Mental Health Code issue arises; and

4. Maintaining a web-based application documenting a record of Medicaid and non-Medicaid grievances in compliance with the standards and procedures defined herein.

S. Organizational Provider:
Entities under contract with MCCMH that directly employ and/or contract with individuals to provide specialty services and supports.

T. Person Served:
A broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by MCCMH. This includes Medicaid beneficiaries and all other recipients of MCCMH's services.

U. Prepaid Inpatient Health Plan (PIHP):
An organization that manages the Medicaid mental health, developmental disabilities, and substance use services in their geographic area under contract with the State. Each PIHP in Michigan is organized as a Regional Entity or a Community Mental Health Services Program according to the Mental Health Code.

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

W. Second Opinion:
A request for another assessment by an applicant who has been denied mental health services or a recipient who is seeking and has been denied hospitalization.

X. Service Authorization:
The processing of requests for initial and continuing authorization of services by MCCMH's Managed Care Operations Division (MCO), either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested.

Y. State Fair Hearing:
An impartial state level review for a Medicaid enrollee's appeal of an adverse benefit determination, presided over by an MDHHS administrative law judge. Also referred to as "Administrative Hearing." This state fair hearing process is set forth in detail in Subpart E of 42 CFR part 431.

E. STANDARDS

A. General Standards

1. During a person's initial contact with the MCCMH Managed Care Operations Division (MCO), the person shall be provided information on MCCMH's due

process system.

2. MCCMH persons served receiving publicly funded services may access several options to pursue the resolution of complaints, including the right to file a grievance, the right to file a local (internal) appeal, the right to a state fair hearing, the right to file a recipient rights violation complaint, and the right to a second opinion.

3. Persons served who wish to file a complaint may do so independently or with the assistance of MCCMH's Customer Service Division, other available staff, or a person of their choosing. A provider may not refuse to assist a person served who needs help filing a complaint and submitting that complaint for resolution.

4. MCCMH will register oral and written complaints and grievances when received, investigate the issues raised and other relevant issues identified, and communicate the resolution in accordance with this policy.

5. MCCMH shall provide persons served reasonable assistance with completing forms and taking other procedural steps related to a complaint or grievance. Throughout the process, MCCMH shall provide qualified bilingual staff, interpreter services, and auxiliary aids, as appropriate, at no cost to the enrollee. An enrollee may request language assistance when filing a complaint or grievance or by advising the MCCMH staff member handling the matter or the Customer Service Division.

6. Should an individual involved with these processes have limited-English proficiency, MCCMH shall take all necessary and reasonable steps to make accommodations.

7. MCCMH shall provide information about the due process system to all providers and subcontractors at the time they enter into a contract with MCCMH.

B. MCCMH shall maintain a grievance and appeal system available to Medicaid enrollees that includes:

1. A grievance process to seek resolution to any Medicaid grievances which may arise;

2. 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;

3. A local appeal process (one level only) which enables Medicaid enrollees to appeal Medicaid Adverse Benefit Determinations;

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 MCCMH;

5. Information that if MCCMH fails to adhere to notice and timing requirements for a local appeal, the enrollee is deemed to have exhausted MCCMH's appeal process, and the enrollee may initiate a State Fair Hearing.

6. The right to request and receive continued Medicaid services pending resolution of the Appeal or State Fair Hearing.

7. 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 grievance to MCCMH or request a State Fair Hearing, given the State permits the provider to act as an enrollee's authorized representative. Punitive action may not be taken by MCCMH against a provider who acts on the Medicaid enrollee's behalf with the Medicaid enrollee's written consent.

8. Notices of Medicaid Adverse Benefit Determinations will instruct Medicaid enrollees to contact the MCCMH Ombudsman for assistance with 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.

C. Medicaid Grievances

1. A grievance may be filed orally or in writing at any time by the enrollee, guardian, parent of minor child, the person's authorized representative, or provider, with written permission from the enrollee indicating the wish to file a grievance.

2. MCCMH shall acknowledge receipt of the grievance within five (5) business days.

3. MCCMH shall ensure grievances are all logged, documented, recorded, and maintained in a secure location.

4. The grievance record shall include:
    - the enrollee's reason for the complaint or grievance; relevant prior complaint or grievance history;
    - all actions taken; information and evidence reviewed; findings for each issue raised or otherwise identified as relevant;
    - the basis for the resolution; and
    - follow-up activities, including communications and actions taken in response to the findings.

5. MCCMH shall designate at least one (1) staff person to be responsible for facilitating the resolution of grievances. The designee shall:

a. Timely acknowledge and log each grievance received;

b. Ensure the individual(s) who make decisions of grievances are individuals:

i. Who were neither involved in any previous level of review or decision making nor subordinate of any such individual;

ii. Are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the person's condition or disease; for a grievance regarding denial of expedited resolution of an appeal and/or grievance that involves clinical issues;

iii. Consider all comments, documents, records, and other information submitted by the person/representative without regard to whether such information was submitted or considered in the initial complaint.

6. MCCMH shall investigate each issue raised by the enrollee and each additional issue identified during the investigation that is relevant to the complaint or grievance. The investigative record shall identify the evidence reviewed, findings for each issue, and the basis for the resolution.

7. A complaint or grievance involving quality of clinical care, clinical decision-making, patient safety, or potential harm shall be reviewed by a qualified practitioner with appropriate clinical expertise who was not involved in the matter. MCCMH procedures shall specify when practitioner review is required and how the matter is escalated.

8. At intake, MCCMH shall assess whether a complaint or grievance indicates a risk to the enrollee's health, safety, or access to necessary care or services. MCCMH shall prioritize such matters and resolve them as expeditiously as the circumstances require no longer than 72 hours. The record shall document the urgency assessment, response steps, and related notifications.

9. All grievances shall be resolved within ninety (90) calendar days from the date of receipt. A State Fair Hearing is only allowed if the grievance is resolved past the 90-calendar day timeframe requirement.

10. MCCMH may extend the grievance resolution and notice timeframe by up to fourteen (14) calendar days if the enrollee requests an extension, or if MCCMH shows to the satisfaction of the State that there is a need for additional information and how the delay is in the enrollee's interest.

a. If MCCMH extends the resolution/notice timeframes not at the request of the enrollee, it must:

i. Make reasonable efforts to give the enrollee prompt oral notice of

the delay.

ii. Within two (2) calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe and inform them of their right to file a grievance if they disagree with the decision.

11. MCCMH shall acknowledge, investigate, and provide resolution for substance use disorder (SUD) service-related grievances.

12. A Resolution Notice shall contain:

a. The results of the grievance process;

b. The date the grievance process was concluded;

c. Notice of the enrollee's right to request a state fair hearing if the notice of resolution is more than ninety (90) calendar days from the date of the grievance; and

d. Instructions on how to access the state fair hearing process, if applicable.

D. Noncoverage Appeals

1. MCCMH shall register oral and written noncoverage appeals upon receipt and record the original receipt date. MCCMH shall acknowledge receipt within 5 calendar days and resolve the appeal and provide written notification within 30 calendar days from receipt. At intake, MCCMH shall assess whether standard processing could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. Appeals meeting these urgency criteria shall be resolved, and notification provided, as expeditiously as the enrollee's condition requires, but no later than72 hours from receipt. The urgency assessment and all applicable deadlines shall be documented.

2. Of note, bilingual staff or interpreter services are available throughout the noncoverage appeal process, including investigation, communications, and explanation of the decision.

E. Notice of Adverse Benefit Determination

1. MCCMH shall utilize the Notice of Adverse Benefit Determination, as identified by MDHHS, for any decisions that adversely impact an enrollee's services or supports.

2. The Notice shall meet the language format needs of the enrollee, as specified in 42 CFR 438.10.

3. The Notice shall be in writing to the enrollee or the guardian on record.

4. The requesting provider must be provided with notice of any decision by MCCMH

to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. Notice to the provider does not need to be in writing.

5. The Notice shall include:

    a. A description of the adverse determination in understandable language which does not include abbreviations or acronyms that are not defined or health care procedure codes that are not explained;

    b. Language that is culturally and linguistically sensitive to the enrollee's needs;

    c. The reason(s) for the determination;

    d. The policy/authority relied upon for making the determination;

    e. The effective date of the determination;

    f. The enrollee's right to file an appeal of MCCMH's adverse benefit determination, including information on exhausting MCCMH's one level of appeal and the right to request a State Fair Hearing thereafter and instructions on how to do so;

    g. The right to a State Fair Hearing should MCCMH fail to provide timely notice, or fail to provide notice of resolution within the required timeframes;

    h. The circumstances under which an expedited appeal can be requested and instructions for doing so;

    i. An explanation of representation options;

    j. The right for the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination (including medical necessity criteria, processes, strategies, or evidentiary standards used in setting coverage limits);

    k. The enrollee's right to have benefits continue pending resolution of the appeal, instructions on how to request benefit continuation, and a description of the circumstances under which the enrollee may be required to pay the costs of the continued services (Advance Notice Only); and

    l. That 42 CFR 440.230(d) provides the basic legal authority for MCCMH to place appropriate limits on a service based on such criteria as medical

necessity or on utilization control procedures.

6. Timing of Notices:

Adequate Notice of Adverse Benefit Determination:

a. Adequate notice is given/mailed to the enrollee/guardian on the effective date. Adequate notice is used in the following determinations:

   i. Denial of payment for services requested (not currently provided), notice must be provided to the enrollee at the time of the action affecting the claim;

   ii. Denial of access into mental health services;

   iii. Denial of access into substance use disorder programs;

   iv. Denial or limited denial of requested services, amount, or duration of services.

b. Adequate notice must be provided in writing to the enrollee/guardian/parent of minor child within:

   i. Seven (7) calendar days following receipt of the request for service for a standard authorization decisions; or

   ii. Seventy-two (72) hours after receipt of a request for an expedited authorization decision.

c. Adequate notice must be provided verbally or in writing to the requesting provider.

d. A standard service authorization decision not reached within seven (7) calendar days, or seventy-two (72) hours for an expedited request, constitutes a denial and is considered an adverse benefit determination. Notice must be sent to the enrollee on the date the resolution timeframe expires.

e. MCCMH may be able to extend the standard or expedited service authorization timeframes for up to an additional fourteen (14) calendar days if either the enrollee requests the extension, or if MCCMH can show that there is a need for additional information and the extension is in the enrollee's best interest. If MCCMH extends the timeframe not at the request of the enrollee, MCCMH must:

   i. Make reasonable efforts to give the enrollee prompt oral notice of

the delay.

ii. Within two (2) calendar days, provide the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of their right to file a grievance if they disagree with that decision;

iii. Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

Advance Notice of Adverse Benefit Determination:

a. Advance Notice is required for reductions, suspensions, or terminations of previously authorized/currently provided Medicaid services.

b. Advance Notice must be provided to the enrollee/guardian a minimum of thirty (30) calendar days prior to the proposed effective date of the determination.

c. The Advance Notice must contain language specifying that upon request, services and supports may remain in place and must be provided prior to a reduction, termination, suspension, or denial of services. Of note, bilingual staff or interpreter services are available throughout the noncoverage appeal process, including investigation, communications, and explanation of the decision.

d. Services will continue if a request is made within ten (10) days of the Advance Notice. Services will not be terminated if the authorization period has ended.

e. Advance Notice is required even if the authorization has expired.

f. Exceptions to the advance notice, where MCCMH may mail an adequate notice of action not later than the date of action to terminate, suspend, or reduce previously authorized services may occur in the following situations:

i. There is factual information confirming the death of the enrollee.

ii. MCCMH receives a clear written statement signed by the enrollee that he/she no longer wishes services, or that gives information that requires the termination or reduction of services and indicates that the enrollee understands that this must be the result of supplying that information.

iii. The enrollee has been admitted to an institution where he/she is ineligible under Medicaid for further services. (For example, jail, prison, state hospital, extended care facility).

iv. There is an established fact that the enrollee has been accepted for Medicaid covered services by another local jurisdiction, state, territory, or commonwealth.

v. The enrollee's whereabouts are unknown, and the United States Post office returns agency mail directed to him/her indicating no forwarding address.

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

vii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919€(7) of the SSA.

viii. The date of action will occur in less than thirty (30) calendar days.

ix. MCCMH has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the enrollee. In such cases, MCCMH may shorten the period of advance notice to five (5) calendar days before the date of action.

F. Medicaid Appeal

1. Upon receipt of an adverse benefit determination notification, Medicaid enrollees may appeal the determination through an internal review by MCCMH.

    a. Enrollees have sixty (60) calendar days from the date of the Notice of Adverse Benefit Determination to request an appeal.

    b. Enrollees may request an appeal orally or in writing. Oral inquiries seeking to appeal an adverse benefit determination are treated as appeals to establish the earliest possible filing date for the appeal.

2. An appeal is the first step of dispute and must be completed prior to the State Fair Hearing.

3. Enrollees are informed of their right to submit a written request to MCCMH designating an authorized representative (including an organizational provider) to act on their behalf.

a. For urgent care decisions, MCCMH allows a health care practitioner with knowledge of the member's medical condition (e.g., a treating practitioner to act as the authorized representative.)

b. For nonurgent care decisions, MCCMH determines if an individual is authorized to act on behalf of a member.

c. MCCMH must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

d. The provider may not request service continuation on behalf of the enrollee.

4. The MCCMH Customer Service Division is the contact point when requesting a Local Appeal.

5. MCCMH shall provide enrollees assistance from staff in the appeal filing process, including explanation of the process and/or assistance completing forms. This also includes but is not limited to providing interpretive services, auxiliary aids and services upon request, and a toll-free number with interpreter capabilities.

6. MCCMH shall acknowledge in writing receipt of an expedited appeal request within seventy-two (72) hours of receipt and within five (5) business days for a standard appeal.

7. Documentation for an expedited appeal must show that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum functioning. Expedited reviews are granted for all requests concerning admissions, continued stay, or other health care services for a member who has received emergency services but has not been discharged from a facility.

    a. If there is a denial of a request for the expedited appeal, MCCMH shall:

        i. Transfer the appeal to the timeframe for standard resolution;

        ii. Make reasonable efforts to give the enrollee prompt oral notice of the denial if MCCMH extends the timeframes not at the request of the enrollee;

        iii. Within two (2) calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of their right to file a grievance if they disagree with the decision; and

iv. Resolve the appeal as expeditiously as the enrollee's health condition requires, but not to exceed thirty (30) calendar days from the day MCCMH received the appeal.

b. If the request is granted, MCCMH shall resolve the expedited appeal and provide notice of resolution to the affected parties no longer than seventy-two (72) hours after MCCMH receives the request for expedited resolution of the appeal.

8. MCCMH may extend the timeframe of resolution of an appeal up to fourteen (14) additional calendar days if the enrollee or provider requests an extension, or MCCMH shows (to the satisfaction of the State, upon its request) that the need for additional information will benefit the enrollee. If MCCMH initiates the need for an extension not at the request of the enrollee, all the following must be met:

    a. Documentation of actions taken shall include the enrollee's previous appeal history, if any, relevant prior denial history, and all follow-up activities associated with the current appeal. Follow-up activities include, as applicable, requests for additional information, communications with the enrollee, authorized representative, or provider, additional reviews, and actions taken to implement the appeal resolution. The appeal record shall identify the dates of these activities and their outcomes.

       MCCMH makes reasonable efforts to give the person prompt oral notice of the delay;

    b. Within two (2) calendar days, MCCMH gives the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if they disagree with the decision; and

    c. MCCMH resolves the appeal as expeditiously as the enrollee's health condition requires and not later than the date the extension expires.

9. MCCMH shall document the substance of every appeal and all actions taken, regardless of whether an extension of the appeal timeframe is requested or granted. The appeal record shall include:

    a. The enrollee's reason for appealing the previous decision and any additional clinical or other information submitted with the appeal.
    b. The enrollee's previous appeal history, if any, and relevant prior denial history.
    c. All actions taken and follow-up activities associated with the current appeal, including, as applicable, requests for additional information; communications with the enrollee, authorized representative, or provider; additional reviews; and actions taken to implement the appeal resolution.
    d. The dates and outcomes of these actions and follow-up activities.

e. The substance of the appeal includes but is not limited to the member's reason for appealing the previous decision and additional clinical or other information provided with the appeal request.

f. Documentation of actions taken includes but is not limited to previous denial or appeal history and follow-up activities associated with the denial and conducted before the current appeal, if applicable.

10. MCCMH shall provide enrollees a reasonable opportunity to present evidence, testimony and allegations of fact or law, in person as well as in writing. MCCMH informs the enrollee of the limited time available for this in advance of the resolution timeframe for appeals and documents when members fail to submit relevant information by the specified deadline.

11. MCCMH shall provide the enrollee and their representative the enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of MCCMH, in connection with the Appeal of the Adverse Benefit Determination. This must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

12. MCCMH shall provide the opportunity to include as parties to the appeal the enrollee and the enrollee's representative or legal representative of a deceased person's estate.

13. MCCMH shall provide the enrollee with information regarding the right to request a State Fair Hearing and the process to request one. The enrollee can only request a State Fair Hearing after receiving notice that MCCMH has upheld the Adverse Benefit Determination.

14. If MCCMH fails to adhere to the notice and timing requirements of thirty (30) calendar days, the enrollee is deemed to have exhausted MCCMH's appeals process and may initiate a State Fair Hearing.

15. MCCMH will ensure that the individual making the decision on an appeal:

    a. Was not involved in the previous level of review or decision-making, nor a subordinate of that individual.

    b. Is an appropriate professional, as defined by the National Committee of Quality Assurance (NCQA).

    c. If deciding on an appeal that involved clinical issues, a healthcare professional who has the same or similar specialty/clinical expertise, as

determined and defined by MDHHS and NCQA, in treating the enrollee's condition or disease.

d. Considers all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

16. MCCMH shall investigate the substance of each appeal, including all issues raised by the enrollee or authorized representative and any additional issues identified during the investigation that are relevant to the appeal, including any aspects of clinical care involved. The appeal record shall document the information and evidence reviewed, the findings for each relevant issue, and the basis for the appeal decision. MCCMH's appeal review does not give deference to the previous decision. MCCMH shall issue a written Notice of Resolution upon completion of an appeal investigation to the enrollee and make reasonable efforts to provide oral notice in the case of an expedited resolution.

17. Notice of Resolution for a standard preservice or post service appeal shall be issued no later than thirty (30) calendar days from the date of receipt of request and seventy-two (72) hours from the date of receipt of request for an expedited appeal.

    a. A Notice of Resolution shall contain:

        i. A general description of the reason for appeal;

        ii. The date received;

        iii. The date of the review process;

        iv. The results of the appeal process; and

        v. The date of resolution.

    b. The Notice shall provide all required information in a manner and format that is based on enrollees' cultural and linguistic needs, may be easily understood, is readily accessible by enrollees, and meets the needs of those with limited English proficiency and/or limited reading proficiency.

    c. The Notice shall reference the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision is based.

    d. The Notice shall include a list of titles and qualifications, including specialties of the individuals participating in the appeal review, including the same-or-similar specialist reviewer, when applicable.

        i. For a benefit appeal, a reviewer's title will be included.

ii. For a medical necessity appeal, a reviewer's title, qualifications, and specialty will be included.

e. If the resolution is not resolved wholly in favor of the enrollee, the Notice shall also include:

i. The right to a State Fair Hearing and instructions on how to file;

ii. The timeframe of no more than 120 calendar days from the date of the applicable Notice of Resolution to file a request for a State Fair Hearing;

iii. The right to request to receive benefits while the State Fair Hearing is pending, and instructions on how to make the request;

iv. Potential liability for the cost of those benefits if the hearing decision upholds MCCMH's Adverse Benefit Determination.

18. MCCMH shall document the substance of the appeal and any actions taken in accordance with the record-keeping standards described herein.

G. Medicaid State Fair Hearing

1. Medicaid enrollees have the right to an impartial review by a state level administrative law judge (State Fair Hearing), after receiving MCCMH's Notice of Resolution of the Appeal upholding an Adverse Benefit Determination.

2. A State Fair Hearing is allowed if MCCMH fails to adhere to the notice and timing requirements for the resolution of appeals.

3. MCCMH shall not limit or interfere with an enrollee's freedom to make a request for a State Fair Hearing.

4. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if the review is:
   a. Optional to the Medicaid enrollee and not required before or used as a deterrent to proceed to the State Fair Hearing;
   b. Independent of both the State and MCCMH;
   c. Offered at no cost to the Medicaid enrollee;
   d. The review must not extend any of the timeframes specified above and must not disrupt the continuation of benefits.

5. Enrollees are given no more than 120 calendar days from the date of the Notice of Resolution from the internal appeal process to file a request for a State Fair Hearing.

6. Enrollees may request service continuation if the conditions described in Section

G. of this policy are met.

7. If the enrollee's services were reduced, terminated, or suspended without advance notice, MCCMH must reinstate services to the level before the Adverse Benefit Determination.

8. The parties to the State Fair Hearing include the enrollee and his/her representative, or the representative of a deceased person's estate, and MCCMH.

9. The Recipient Rights Officer shall not be appointed as the Hearings Officer due to the inherent conflict of roles and responsibilities.

10. Expedited State Fair Hearings are available.

11. If the final resolution of the appeal or State Fair Hearing upholds MCCMH's Adverse Benefit Determination, MCCMH may, consistent with the State's policy on recoveries and as specified in the PIHP contract, recover the cost of services furnished to the enrollee while the appeal and State Fair Hearing were pending, to the extent that they were furnished solely because of these requirements.

12. If MCCMH or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, MCCMH or the State must pay for those services in accordance with State policy and regulations.

13. If MCCMH or the State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, MCCMH must authorize or provide the disputed services as promptly and as expeditiously as the Medicaid enrollee's health condition requires, but no later than seventy-two (72) hours from the date it receives notice reversing the determination.

H. Medicaid Continuation of Benefits Pending Appeal

1. MCCMH shall continue the enrollee's benefits if all the following occur:

   a. The enrollee files the request for an appeal in a timely manner, within sixty (60) calendar days from the date on the Adverse Benefit Determination Notice;

   b. The enrollee files for continuation of benefits timely (on or before the latter of within ten (10) calendar days of MCCMH sending the notice of Adverse Benefit Determination or the intended effective date of the proposed Adverse Benefit Determination);

   c. The appeal involves the termination, reduction, or suspension of a previously authorized service;

d. The services were ordered by an authorized provider; and

e. The period covered by the original authorization request has not expired.

2. Benefits must continue (if all above conditions are met) until one of the following occurs:

a. The enrollee withdraws the appeal or request for State Fair Hearing;

b. The enrollee fails to request a State Fair Hearing and continuation of benefits within ten (10) calendar days after MCCMH sends the enrollee the Notice of Resolution, upon completion of the appeal;

c. The State Fair Hearing Office issues a hearing decision adverse to the person served;

d. The duration of the previously authorized service has ended.

3. If the enrollee's services were reduced, terminated, or suspended without an advance notice, MCCMH must reinstate services to the level before the action.

I. Record Keeping

1. MCCMH maintains records of person's served grievances and appeals, which are reviewed by MCCMH as part of its ongoing monitoring procedures.

2. These records will be maintained in the Electronic Medical Records.

a. These records consist of instances for staff to make demographic or administrative updates and instances for staff to review information without making changes.

b. The Due Process Coordinator and Grievance/Appeal Consultant will be the only staff who can alter the records.

c. The grievance and appeal modules will not include the information required to document updates for staff reviews.

d. Staff reviews flagged in the system are not included in the audit process.

3. Records shall contain the following:

a. A general description of the reason for the grievance or appeal;

b. The date received;

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

d. The resolution at each level of the appeal or grievance, if applicable;

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

f. The name of the covered person for whom the grievance or appeal was filed.

4. MCCMH shall maintain records accurately and in a manner accessible to the State and available upon request to CMS.

F. REFERENCES / LEGAL AUTHORITY

A. Michigan Department of Health and Human Services Medicaid Provider Manual

B. 42 CFR: Sections 422.504, 431.200, 438 et. seq.

C. MDHHS/PIHP Contract Attachment 6.3.1.1

D. MDHHS/CMHSP Contract Attachment 6.3.2.1

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

F. MDHHS Administrative Rules

G. EXHIBITS

None.