MCCMH MCO Policy 4-020

(was Administrative Policy 5-06-030)

Chapter: **CUSTOMER RELATIONS / MEMBER SERVICES**

Title: **MEDICAID & NON-MEDICAID NOTICE OF ADVERSE BENEFIT DETERMINATION (ADVANCE & ADEQUATE); NOTICE OF APPEAL RIGHTS**

Also see MCCMH MCO Policies 2-009, "Medicaid Grievances; Non-Medicaid Grievances"; 2-090, "Service Authorizations," 9-170, "Local Dispute Resolution Process (All Consumers)"; 9-171, "Local Appeal Process (Medicaid)"; and 9-180, "Second Opinion Rights."

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Executive Director — Date

I. Abstract

This policy establishes the standards and procedures of the Macomb County Community Mental Health ("MCCMH") Board for providing Consumers with appropriate notice of Adverse Benefit Determination and notice of appeal rights whenever the Macomb County Community Mental Health Service Program / Prepaid Inpatient Health Plan ("CMHSP" / "PIHP") denies, reduces, terminates or suspends services.

II. Application

This policy shall apply to MCCMH administrative staff, directly-operated and contract network providers of the MCCMH Board, as well as to all Consumers of services provided by directly-operated and contract network providers of the MCCMH Board.

III. Policy

It shall be the policy of MCCMH to provide applicants for and consumers of non-Medicaid CMHSP/PIHP services appropriate notice in any event where an existing service or support is suspended, terminated or reduced by an agency or unit performing a utilization review function, or when the action is taken outside of the person-centered planning process when the CMHSP does not have an identifiable UR unit.

In addition, the PIHP will timely provide Medicaid Enrollees with Advance or Adequate Notice of Medicaid Adverse Benefit Determination, as appropriate, as well as a notice of appeal rights, whenever a Medicaid Service or payment for a Medicaid Service is denied, limited, reduced, suspended or terminated, or in the event of a failure to timely authorize or provide services or required notices, or in the event of any other Medicaid Adverse Benefit Determination.

IV. Definitions

A. Adequate Notice of Medicaid Adverse Benefit Determination: Written statement advising the Medicaid Enrollee of a decision to deny or limit authorization of Medicaid Services that were requested and that the Medicaid Enrollee is not currently receiving at the time. Adequate Notice of Medicaid Adverse Benefit Determination will be provided on the same date the Medicaid Adverse Benefit Determination takes effect.

B. Advance Notice of Medicaid Adverse Benefit Determination: Written statement advising the Medicaid Enrollee of a decision to reduce, suspend or terminate Medicaid Services currently provided by the PIHP to the Medicaid Enrollee. Advance Notice of Medicaid Adverse Benefit Determination will be provided at least ten (10) calendar days prior to the proposed effective date, unless one of the limited exceptions described in this policy is present.

C. Advance Notice of Non-Medicaid Adverse Benefit Determination: Written statement advising a non-Medicaid Consumer of a decision to reduce, suspend or terminate CMHSP (Non-Medicaid) services currently provided by MCCMH. With limited exception (as defined in this policy), Advance Notice of Non-Medicaid Adverse Benefit Determination will be provided at least thirty (30) calendar days prior to the effective date of the Non-Medicaid Adverse Benefit Determination.

D. 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.

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

F. Expedited Appeal: The expeditious review of a Medicaid Adverse Benefit Determination, requested by a Medicaid Enrollee or the Medicaid Enrollee's provider, when the time necessary for a standard resolution could seriously jeopardize the Consumer's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

G. Grievance: An expression of dissatisfaction about any matter other than a Medicaid or Non-Medicaid Adverse Benefit Determination. 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. 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."

H. Grievance Process: Impartial local review of a Consumer's Grievance; a subpart of MCCMH's overarching Grievance and Appeal System.

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

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

K. Medicaid Adverse Benefit Determination: Any of the following, ***with respect to Medicaid Enrollees and their Medicaid Services***:

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 seventy-two (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.

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

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

N. Non-Medicaid Adverse Benefit Determination: Also known and referred to as an "Action," may include any of the following: (1) a denial or limited authorization of a requested CMHSP service, including the type or level of service; (2) the reduction, suspension or termination of a previously authorized service; (3) the denial, in whole or in part, of payment for a covered service; (4) the failure to make an authorization decision and provide notice about the decision, within standard time frames; or (5) the failure to provide services within the standard timeframe; (6) the failure of MCCMH to act within the timeframes required for disposition of grievances and appeals.

O. Plan of Service: A formal written plan, accepted by the Consumer or Legal Representative, for the provision of services which describes the issues/problems to be addressed, the desired outcomes of the service, the activities/interventions designed to facilitate achievement of desired outcomes, the individual(s) or program(s) responsible for implementing the activity/intervention, and the dates upon which service reviews will occur. The Plan of Service may include clinical services, supportive services or both. The Plan of Service may be designed to serve an individual or a family

P. 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

Q. State Fair Hearing: Impartial state level review of a Medicaid Enrollee's appeal of a Medicaid Adverse Benefit Determination presided over by a State hearing Officer; also referred to as an "Administrative Hearing." Medicaid Enrollees may request a State Fair Hearing to review a Medicaid Adverse Benefit Determination only after exhausting the Local Appeal Process.

R. 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.

V. Standards

A. Advance Notice of Non-Medicaid Adverse Benefit Determination (Action): In any case where the an agency or unit performing a utilization review function reduces, suspends or terminates a previously authorized service or support (prior authorization is within the current period), written advance notice of the change must be provided to the Consumer according to the following standards:

1. Provided to the Consumer at least thirty (30) days prior to the effective date of the Action.

2. The notice must include: a statement of what Action MCCMH intends to take; the reasons for the intended Action; the specific justification for the intended Action; and an explanation of the Local Dispute Resolution Process (See MCCMH MCO Policy 9-170, "Local Dispute Resolution Process (All Consumers))".

3. NOTE: Actions taken as a result of the person-centered planning process or those ordered by a physician are not considered to be a Non-Medicaid Adverse Benefit Determination.

B. Medicaid Enrollees are entitled to notice of Medicaid Adverse Benefit Determinations that meets additional standards, which the remainder of this policy will describe.

C. Service Authorizations: When a Service Authorization for Medicaid Services is processed (initial request or request for continuation of service delivery) the PIHP will provide the Medicaid Enrollee with a written notice of the service authorization decision according to the timing, notice, and other requirements described in MCCMH MCO 2-090, "Service Authorizations."

D. Notice of Medicaid Adverse Benefit Determination (Generally Applicable Standards):

1. MCCMH will provide Medicaid Enrollees with timely and adequate notice of any Medicaid Adverse Benefit Determination.

2. Content & Format:

a. Format: Notice of Medicaid Adverse Benefit Determination must be in writing and provided in a manner and format that may be easily understood and readily accessible by Medicaid Enrollees and potential Medicaid Enrollees, and must satisfy all other standards detailed in MCCMH MCO 4-010, "Provision and Distribution of Information to

Consumers." (e.g., easily understood language and format, at least 12-point font, etc.).

b. Content: Notice of Medicaid Adverse Benefit Determination must contain the following information:

i. Description of the Medicaid Adverse Benefit Determination;

ii. The reason(s) for the Medicaid Adverse Benefit Determination, and policy/authority relied upon in making the determination;

iii. Notification of the right of the Medicaid Enrollee to be provided free of charge, reasonable access to and copies of all documents, records and other information relevant to the Medicaid Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);

iv. Notification of the Medicaid Enrollee's right to request an Appeal, including information on exhausting the PIHP's single local level appeal process, and the right to request a State Fair Hearing thereafter (See, MCCMH MCO 9-170, "Local Dispute Resolution Process (All Consumers)," and MCCMH MCO 9-171, "Local Appeal Process (Medicaid)";

v. Description of the circumstances under which an Appeal may be expedited, and how to request and Expedited Appeal;

vi. Notification of the right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances under which the Medicaid Enrollee may be required to pay the costs of the continued services (this information is only required when providing "Advance Notice of Medicaid Adverse Benefit Determination") (See MCCMH MCO 9-171, "Local Appeal Process (Medicaid)";

vii. Description of the procedures that the Medicaid Enrollee is required to follow in order to exercise any of these rights, including provision of (i) the MDHHS Hearing Request form, DCH-0092; and (ii) a postage paid, return envelope addressed to the MDHHS Administrative Tribunal.

viii. An explanation that the Medicaid Enrollee may represent him/herself or use legal counsel, a relative, a friend or other spokesman; and

ix. A notice of the rights enjoyed by all Consumers to file Grievances (see MCCMH MCO Policy 2-009, "Medicaid Grievances; Non-

Medicaid Grievances), and/or to file Recipient Rights complaints (see MCCMH MCO Policy 9-510, "Recipient Rights Investigations,") and to request medical second opinions (see MCCMH MCO Policy 9-180, "Second Opinion Rights")

3. Notice of Medicaid Adverse Benefit Determination must be provided to the Medicaid Enrollee in ***writing***. If there is a requesting provider, that provider must be provided notice of any decision by the PIHP to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested; notice to the provider, though, does *not* need to be in writing.

E. Additional Notice Requirements (Advance Notice vs. Adequate Notice):

1. Adequate Notice of Medicaid Adverse Benefit Determination (Medicaid) (Exhibit A).

a. **Denial of payment for services requested (not yet provided)** - notice must be provided to the Medicaid Enrollee at the time of the action affecting the claim.

b. **Service Authorization decision that denies or limits services** - notice must be provided to the Medicaid Enrollee as expeditiously as the Medicaid Enrollee's condition requires, but in no event greater than:

i. 14-days following receipt of the request for service for standard service authorizations;

ii. 72-hours after receipt of a request for an expedited authorization decision when either a provider indicates or MCCMH determines that following the standard timeframe could seriously jeopardize the Medicaid Enrollee's life or health or ability to attain, maintain or regain maximum function.

iii. NOTE: See MCCMH MCO 2-090, "Service Authorizations," for information regarding those limited circumstances where it may be permissible to extend the timeframe for making a Service Authorization, in which cases the Adequate Notice of Medicaid Adverse Benefit Determination would not be required until the extended timeframe expires.

c. **Service Authorization decisions not reached within 14-days for standard requests, or 72-hours for expedited requests, or other properly extended timeframe** (which constitutes a denial and is thus is a Medicaid Adverse Benefit Determination) – notice must be provided to the Medicaid Enrollee on the date that the relevant timeframe expires.

d. **When the person-centered plan is developed and signed by the Consumer** - the finalized Plan of Service must include, or have attached, the adequate notice provisions);

e. **When there is an increase in benefits to the consumer** – notice must be provided to the Medicaid Enrollee at the time of the action affecting the claim; and

f. **When there is an unreasonable delay in the start of services** – notice must be provided to the Medicaid Enrollee upon the expiration of the time period within which services were supposed to have commenced.

2. Advance Notice of Medicaid Adverse Benefit Determination (Medicaid) (Exhibit A):

a. **Termination, suspension, or reduction of previously authorized Medicaid Services,** notice must be sent to Medicaid Enrollee at least ten (10) calendar days prior to the proposed effective date.

b. Limited Exceptions:

i. The PIHP may mail Adequate Notice of Medicaid Adverse Benefit Determination not later than the date of the Medicaid Adverse Benefit Determination, IF:

1. The PIHP has factual information confirming the death of the Medicaid Enrollee;

2. The PIHP receives a clear written statement signed by a Medicaid Enrollee that he/she no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the Medicaid Enrollee understands that this must be the result of supplying that information;

3. The Medicaid Enrollee has been admitted to an institution where he is ineligible under the plan for further services;

4. The Medicaid Enrollee's whereabouts are unknown and the post office returns agency mail directed to him/her indicating "no forwarding address;"

a. NOTE: Discontinued services must be reinstated if his whereabouts become known during the time he is eligible for services.

5. The PIHP establishes that the Medicaid Enrollee has been accepted for Medicaid Services by another local jurisdiction, State, territory, or commonwealth;

6. A change in the level of medical care is prescribed by the Medicaid Enrollee's physician;

7. The notice involves an adverse determination made with regard to the nursing facility preadmission screening requirements of section 1919(e)(7) of the Social Security Act;

8. The Medicaid Adverse Benefit Determination is a transfer or discharge from a Long Term Care Facility, and the date of the action will occur in less than ten (10) calendar days as permitted by 42 CFR 483.15(c)(4)(ii) and (c)(8), which provides exceptions to the 30-days' notice requirements of 483.15(c)(4)(i); or

ii. When the PIHP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the Medicaid Enrollee (in this case, the PIHP may shorten the period of advance notice to five (5) days before the date of action).

F. The Advance and Adequate Notice of Medicaid Adverse Benefit Determination Requirements - Quick Grid attached to this policy describes the required notice, the time frame for mailing/providing the notice, and who has the noticing responsibility.

G. All Advance Notice of Medicaid or Non-Medicaid Adverse Benefit Determination and Appeal Rights shall be transmitted to the Consumer by U.S. mail.

H. Adequate Notice of Medicaid Adverse Benefit Determination shall be transmitted to the Consumer by U.S. mail and, whenever possible, conveyed by hand.

VI. Procedures

A. The MCCMH Access Center and other units performing the utilization review function shall process <u>all</u> Service Authorization requests within the time frames described in MCCMH MCO 2-090 for standard and expedited Service Authorization requests. If the authorized service is a Medicaid Service, written notice of the authorization decision shall be provided to the Medicaid Enrollee within the time frames defined in that policy. All authorized services must begin within fourteen (14) calendar days of a non-emergent assessment or the agreed upon start date in the person centered plan.

B. When the Access Center or other unit performing the review function makes a Service Authorization decision regarding a Medicaid Service that constitutes a "Medicaid Adverse Benefit Determination," the unit must:

1. Thoroughly document the bases supporting the Adverse Benefit Determination in the MCO notes, and

2. Provide the appropriate Notice of Medicaid Adverse Benefit Determination to the Medicaid Enrollee.

C. When any Medicaid Consumer or Legal Representative signs the Plan of Service or Service Review, he/she must be given a copy of the Adequate Notice of Medicaid Adverse Benefit Determination (Medicaid). The Plan of Service must be marked to indicate the notice was so provided.

D. The Access Center or other unit performing the review function shall:

1. Mail Notice of Medicaid Adverse Benefit Determination (Exhibit A) to the Medicaid Enrollee under circumstances covered and within the applicable time frames described in Section V(E)(1)-(2) of this policy.

2. Mail Advance Notice of Non-Medicaid Adverse Benefit Determination (Action) to the Consumer under circumstances and within the time frames described in Section V(A) of this policy.

E. All applicable sections of Notice of Medicaid Adverse Benefit Determination and Advance Notice of Non-Medicaid Adverse Benefit Determination forms must be completed in full prior to transmission to the Consumer. These letters have been built into the MCCMH electronic medical record system, FOCUS. For MCCMH network providers who do not use the FOCUS electronic medical record system, sample notice letters are attached to this policy.

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.

F. Advance Notice of Non-Medicaid Adverse Benefit Determination shall include a copy of the Notice of document entitled "Your Right to Request State Level Review (Second Tier Appeal) of the Local Dispute Resolution Results."

G. Procedures specific to the implementation of this policy and the standards listed above shall be contained in Provider Manuals for each service as relevant to that provider's role in the transmission of notices of Medicaid and Non-Medicaid Adverse Benefit Determinations.

VII. REFERENCES / LEGAL AUTHORITY

A. MDHHS/CMHSP Managed Mental Health Supports and Services Contract (the "CMHSP Contract")

B. Attachment 6.3.2.1 to the CMHSP Contract, "CMHSP Local Dispute Resolution Process"

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

D. State of Michigan Executive Budget Bill for FY2018/FY2019, Sec. 8-942

E. 42 CFR Part 431

F. 42 CFR Part 438

G. MCCMH MCO Policy 2-009, "Medicaid Grievances; Non-Medicaid Grievances"

H. MCCMH MCO Policy 2-090, "Service Authorizations"

I. MCCMH MCO Policy 9-170, "Local Dispute Resolution Process (All Consumers)"

J. MCCMH MCO Policy 9-171, "Local Appeal Process (Medicaid)"

K. MCCMH MCO Policy 9-180, "Second Opinion Rights"

VIII. EXHIBITS

A. Notice of Adverse Benefit Determination

B. MDHHS Hearing Request Form DCH-0092

C. MDHHS Hearing Request Withdrawal Form DCH-0093

D. Medicaid – Advance and Adequate Notice of Adverse Benefit Determination Requirements - Quick Grid

E. Instructions for use by MCCMH Provider Agency / Staff for completing Adequate and Advance Adverse Benefit Determination Notice letters