MCCMH MCO Policy 4-030

Chapter: **CUSTOMER RELATIONS/ENROLLEE SERVICES**
Title: **MEDICARE SERVICES- DECISIONS AND COMPLAINTS (ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS)**

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I. Abstract

It is the practice of Macomb County Community Mental Health (MCCMH) to establish standards and procedures to address and resolve the complaints of an Enrollee receiving Medicare covered services authorized by the MCCMH Managed Care Organization (MCO)/Prepaid Inpatient Health Plan (PIHP) in compliance with federal and state laws, rules, and regulations.

II. Application

This policy shall apply to all directly-operated and contract network service providers of MCCMH serving consumers receiving Medicare Covered services authorized by the PIHP.

III. Policy

MCCMH is committed to ensuring a fair and efficient complaint system, for Enrollees receiving MCCMH authorized Medicare services, that promotes the resolution of Enrollee concerns while supporting and enhancing the overall goal of improving care under standards of best practice.

IV. Definitions

A. Complaint

Any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an Enrollee made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to Enrollees, the claims regarding the right of the Enrollee to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the Enrollee believes he or she is entitled. **A complaint could be either a grievance or an appeal, or a single**

complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

B. Grievance

Any complaint or dispute, other than an organization determination, expressing dissatisfaction with any aspect of MCCMH's operations, activities, or behavior, regardless of whether any remedial action can be taken. An Enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medical health plan, provider, or facility. Grievances may include complaints regarding timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

C. Expedited Grievance

An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration timeframe.

D. Inquiry

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

E. Medicare Covered Services

Medicare Parts A and B services provided to an Enrollee pursuant to the MI Health Link ICO-PIHP managed care contract.

F. Quality of Care Issue

A quality of care complaint may be filed through the Medicare health plan's grievance process and/or a 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.

G. Quality Improvement Organization (QIO)

Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees 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, and ambulatory surgical centers. The QIOs also review continued stay denials for Enrollees receiving care in inpatient hospitals.

H. Reconsideration

An Enrollee's first step in the appeals process after an adverse organization determination; MCCMH or an Independent Review Entity may re-evaluate an adverse Organization Determination or termination of services decision, the evidence and findings upon which it was based, and any other evidence submitted or obtained.

I. Administrative Law Judge (ALJ)

A judge and trier of fact who both presides over trials and adjudicates the claims or disputes (in other words, ALJ-controlled proceedings are bench trials) involving administrative law. Enrollees can request review of the case if the IRE 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.

J. Independent Review Entity (IRE)

An independent review entity contracted by CMS to review Medicare health plans' adverse reconsideration determinations. Reviews the 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. Judicial Review

A constitutional doctrine that gives to 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.

L. 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 monetary threshold.

M. Organization Determination

Any determination made by a Medicare health plan or entity to whom it has delegated decision making processes (hereinafter known as "Medicare health plan") with respect to any of the following:

1. Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;

2. Payment for any other health services furnished by a provider other than the Medicare health plan that the Enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;

3. The Medicare health plan's refusal to provide or pay for services, in whole or in part, including type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan;

4. Reduction, or premature discontinuation of a previously authorized ongoing course of treatment; or

5. Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the Enrollee.

N. Appeal

Any procedure that deals with the review of an adverse organization determination on the health care services the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the Enrollee must pay for a service, as defined under 42 CFR 422.566(b). The types of procedures include reconsideration, an independent review entity, hearings before ALJs, review by the Medicare appeals council (MAC), and judicial review.

O. Post-Service

A post-service appeal is a request to change an adverse determination for care or services that have already been received by the Enrollee.

P. Pre-Service Appeal

A pre-service appeal is a request to change an adverse determination for care or service that the organization must approve, in whole or in part, in advance of the Enrollee obtaining care or services. An Enrollee's request for an appeal of a denial for service if the Enrollee has not received the requested services. In this case, the

Enrollee may not receive coverage for the requested care or service unless the organization approves it.

Q. Representative

An individual appointed by an Enrollee or other party, or authorized under Sate 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 of the rights and responsibilities of an Enrollee or party on obtaining an organization 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.

R. Regulatory Complaint

A complaint that originates from 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).

V. Standards

A. Federal regulation requires that Macomb County Community Mental Health serving as a Medicare organization, establish meaningful complaint procedures, and meet requirements concerning organization determinations and appeals, for Medicare Enrollees, which comply with Subpart M of Part 422 of the Code of Federal Regulations.

1. Electronic Link: The MCCMH main webpage shall have a link to the electronic complaint form on the Medicare.gov internet website.

2. Types of Decisions and Complaints. MCCMH will establish and maintain procedures for the following types of Medicare decisions and complaints:
   a. Standard Organization Determinations (decision)
   b. Expedited Organization Determinations (decision)
   c. Standard Grievances (complaint)
   d. Expedited Grievances (complaint)
   e. Standard Appeals(complaint)
   f. Expedited Appeals (complaint)

3. Enrollee Notification of the Complaint Process
   a. <u>Grievances (Standard and Expedited)</u>
      At initial enrollment, upon involuntary disenrollment initiated by the Medicare health plan, upon denial of an Enrollee's request for expedited review of an organization determination or appeal, upon an Enrollee's request, and annually thereafter;

   b. <u>Appeals (Standard and Expedited)</u>

At initial enrollment, upon notification of an adverse organization determination, upon notification of a service or coverage determination, and annually thereafter;

c. Quality of Care Utilizing the QIO Process
At initial enrollment, and annually thereafter

d. Updates of the Complaint Process
Enrollees and service providers shall be notified of updates to any of the above mentioned complaint processes.

e. Information to File a Complaint
In each instance when the Enrollee is notified of the Complaint Process, the Enrollee shall also be informed of the postal address and toll-free telephone number for filing a complaint.

B. Contractor/Provider Notification of the Enrollee Complaint Process

MCCMH will provide information regarding the Enrollee complaint process to all MCCMH Medicare 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) days of a service authorization.

C. MCCMH Notification of Enrollee Complaint by Contractor/Provider

Upon receipt of an Enrollee complaint, the complaint shall be immediately forwarded by Contractor/Provider to MCCMH.

D. Distinguishing Between Grievances and Appeals

1. If an Enrollee addresses two or more issues in one complaint, then each issue should be processed separately and simultaneously (to the extent possible) under the proper procedure.

2. Upon receipt, the facts surrounding a complaint from an Enrollee or their representative or regulatory agency will determine whether the grievance or appeals process should be initiated. This review ensures routing to the appropriate process and facilitates timely processing.

3. If the complaint is about an action, it will be rerouted to the appeal process and be subject to the appeal policy and procedures.

4. If the complaint is about dissatisfaction with anything other than an action or coverage, it will be processed as a grievance and subject to this policy.

E. Meaningful Resolution of Complaints

The MCCMH complaint system provides Medicare Enrollees:

1. A process for distinguishing between grievances and appeals;

2. A procedure for making timely organization determinations;

3. Appeal procedures that meet requirements for issues that involve organization determinations;

4. A method to ensure that all Enrollees receive written information about the grievance and appeal procedures available to them through MCCMH;

5. MCCMH will comply with the Americans with Disabilities Act (ADA) including providing reasonable accommodations and access as well as 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;

6. A physician with a current and unrestricted license to practice, is employed by MCCMH, and is responsible for ensuring the clinical accuracy of all organization determinations and reconsiderations involving medical necessity; and

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

F. Language Assistance (See also MCCMH MCO Policy 5-002, "Cultural and Linguistic Competency")

Language services will be provided to Enrollees requesting assistance through a bilingual staff or interpreter services face to face or telephonically:

1. To register a complaint;

2. To notify the Enrollee about their complaint; and/or

3. Notify Enrollees of documents available in languages other than English.

G. Enrollee Rights

1. As provided in 42 CFR, Part 422, Subpart M, Enrollees have the following rights:
   a. To have grievances against MCCMH or its providers heard and resolved;
   b. To have a timely determination of a grievance and/or authorization request;
   c. Request an expedited organization determination;
   d. To have a reconsideration of an adverse organization determination, and the right to request an expedited redetermination;
   e. The right to an automatic reconsideration determination made by an initial reconsideration by the Medicare organization is upheld in whole or part;
   f. The right to a hearing before an Administrative Law Judge, if the amount in controversy meets threshold as defined in 42 CFR 422.600;
   g. The right to request a Medicare Appeals Council (MAC) review of the Administrative Law Judge hearing decision;

h. The right to judicial review of the hearing decision if the amount of controversy is met, as provided in 42 CFR 422.612;

2. MCCMH shall not initiate disenrollment because of the Enrollee's attempt to exercise his or her rights under the complaint system.

3. MCCMH will maintain the privacy of all complaint records at all times, including transmittal of the medical record, if applicable.

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

H. Record Keeping

MCCMH will maintain procedures for tracking and maintaining records about the receipt and disposition of a complaint.

1. Complaint information at a minimum will include:
   a. Date received
   b. Enrollee demographic information
   c. Substance of complaint
   d. Date resolved
   e. Date notification of resolution was provided to Enrollee

2. If MCCMH is performing complaints processing as an administrative function delegated by a health plan, it will notify the health plan of complaints received.

I. MCCMH Review of Complaint Process

1. MCCMH shall review its Organization Determination, Grievance, and Appeal procedures at least annually and amend such procedure as necessary.

2. MCCMH shall amend its procedures only upon receiving prior approval from Michigan Department of Community Health.

VI. Procedures

A. Enrollee Grievances

Macomb County Community Mental Health will provide Enrollees receiving MCCMH authorized Medicare services a meaningful process to address dissatisfaction with their provider organization.

1. Characteristics of MCCMH Medicare Grievance Process
   a. Enrollees or their representative may express their grievance orally or in writing
   b. Grievances must be filed within 60 days of the event or incident that precipitates the complaint unless the grievance is filed by a MI Health Link

Enrollee. In the case of a MI Health Link Enrollee, a grievance accompanied by a request for remedial action must be filed within 90 days of the event or incident that precipitates the complaint.

c. Grievances may be filed with MCCMH or through 1-800-Medicare. MCCMH will provide to Enrollees the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed.
d. Upon receipt of a complaint, MCCMH will promptly determine and inform the Enrollee/representative, orally or in writing, if requested, whether the complaint is subject to grievance or appeal procedures. 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. Additionally, Enrollees may request that a QIO review their quality of care complaint.
e. Enrollees may request quality of care grievance data related to their quality of care grievance.
f. Complaints will be categorized by:
    i. Quality of Care
    ii. Service Concerns/Availability
    iii. Financial Matters
    iv. Service Environment
    v. Suggestions/Recommendations

2. Non-Grievance Complaints
   Upon receipt of a complaint, MCCMH will promptly assess and notify Enrollee/representative if resolution needs to be referred and determined by another department or entity. Complaints may be referred and handled by the department/organizations listed, but not limited to:
   a. Office of Recipient Rights
   b. Corporate Compliance
   c. Quality/Integrity Program
   d. Utilization Management
   e. MMDHHS
   f. IRE

3. Misclassified Grievances
   When an IRE dismisses an appeal that is a misclassified grievance, the IRE will return the grievance to MCCMH for proper processing. MCCMH will notify the Enrollee that the complaint was misclassified and will be handled through the grievance process.

4. Initiation of Grievance
   a. MCCMH will maintain written records of all Grievance activities.
   b. MCCMH will accept any information or evidence concerning the grievance either orally or in writing up to sixty (60) calendar days after the grievance event.
   c. MCCMH will provide to the Enrollee/Representative a timely acknowledgment of its receipt of the Enrollee grievance.

d. MCCMH will complete a prompt, appropriate investigation of the grievance as expeditiously as the Enrollee's case requires, based on the Enrollee's health status.
e. MCCMH will document all issues relevant to the grievance including any aspect of clinical care involved.
f. If the Grievance is determined to be a quality of care complaint, MCCMH will inform the Enrollee of their right to both Grievance and Appeal processes.
   i. MCCMH will notify enrollees in writing that they may simultaneously file quality of care complaints with MCCMH and the QIO; and
   ii. MCCMH will recognize the authority of the QIO with respect to timely submission of requested information.

5. Grievance Resolution
   a. All clinical complaints or issues will be reviewed and investigated by another clinician not previously involved in the complaint. MCCMH will use health care professionals who have the appropriate clinical expertise, as determined by MMDHHS, when deciding a grievance regarding denial of expedited resolution of an appeal or a grievance that involves clinical issues.
   b. MCCMH will respond, electronically, orally or in writing, to the Enrollee grievance within 30 calendar days after receipt of the grievance. MCCMH will respond in writing to all quality of care grievances.
   c. The Enrollee/Representative and other concerned parties will be notified upon completion of the investigation as expeditiously as the case requires, based on the Enrollee's health status, but no longer than 30 days after the date MCCMH received the complaint unless the grievance is filed by a MI Health Link Enrollee. In the case of a MI Health Link Enrollee, the notifications shall be no longer than 90 days.
   d. MCCMH will notify the Enrollee/Representative if it extends the 30 day timeframe by up to 14 days if the Enrollee requests the extension or if MCCMH justifies the need for additional information and documents an explanation of how the delay is in the best interest of the enrollee.
   e. When MCCMH delays its disposition of a grievance, it will immediately notify the Enrollee/representative about the reason(s) for the delay.
   f. Notification of the resolution will be provided to the Enrollee/representative orally or in writing, as requested by the Enrollee, if received orally, and documented electronically.
   g. Notification of the resolution will be provided in writing if received in writing and documented electronically.
   h. Notification of the resolution of a complaint involving a quality of care issue must be in writing, regardless of how the grievance was filed. Additionally, it must include a description of the Enrollee's right to file a written complaint with the QIO.
   i. If MCCMH cannot provide an immediate resolution to the Grievance, MCCMH will notify Enrollee/Representative that the complaint was received and investigated.
   j. The Enrollee/Representative will be notified of any appeal options, if applicable.

6. Expedited Grievances for Currently Filed Appeals
   a. MCCMH will respond to an Enrollee grievance within 24 hours of receipt of the grievance if it is for one of the following reasons:
      i. MCCMH extends the timeframe to make an Organization Determination or the timeframe is extended for MCCMH to render a decision on an Appeal; or
      ii. MCCMH refuses to grant a request for an expedited Organization Determination or Appeal.

7. Grievance Committee
   The Grievance Committee is responsible for reviewing grievances filed by Enrollees and identifying opportunities for improvement by reviewing grievance management reports.

B. Organization Determinations

1. MCCMH will make timely organization determinations regarding benefits an Enrollee is entitled to receive.
   a. Organization determinations are only made by MCCMH, not by a provider of services because a denial of services by a provider is a treatment decision.
   b. MCCMH will educate Enrollees and practitioners that an Enrollee has the right to request and receive an Organization Determination when the Enrollee disagrees with a practitioner decision.
   c. MCCMH will provide Enrollees with a written denial notice containing appeal rights for each adverse Organization Determination.

2. Denial Notices
   MCCMH will provide Enrollees with a written Notice of its Organization Determination if it denies payment or services, in whole or in part, or discontinues a previously authorized course of treatment.
   a. For pre-service denials or a discontinuation/reduction of a previously authorized course of treatment, MCCMH will use the Notice of Denial of Medicare coverage form.
   b. For payment denials, MCCMH will use the Notice of Denial of Payment form.

3. Adverse Organization Determination Regarding Medical Necessity
   When MCCMH expects to issue a partially or fully adverse medical necessity decision, the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before it is issued.

4. Expedited Organization Determinations
   a. An Enrollee or any physician may request an expedited organization determination if it is believed that waiting for a decision under the standard time frame could place the Enrollee's life, health, or ability to regain maximum function in serious jeopardy.
   b. MCCMH will automatically provide an expedited Organization Determination if it is requested by the physician, either orally or in writing believed that

waiting for a decision under the standard time frame could place the Enrollee's life, health, or ability to regain maximum function in serious jeopardy.

c. An Expedited Organization Determination is not available for situations in which the only issue involves a claim for payment of services that the Enrollee has already received.

C. Enrollee Appeals

Macomb County Community Mental Health will ensure that Enrollees receiving MCCMH authorized Medicare services have a method for addressing any MCCMH Organization Determination with which the Enrollee disagrees.

1. Reconsideration-First Level of Appeal
   a. Enrollees/Representatives may express their complaint appeals orally or in writing.
   b. Upon receipt of a reconsideration appeal, MCCMH will determine if appeal rights are applicable.
   c. If applicable, MCCMH will then promptly determine and inform the Enrollee/Representative, orally or in writing, of appeal procedures.

2. Investigation of a Reconsideration (First Level of Appeal)
   a. Prompt, appropriate action, including a full investigation of the reconsideration appeal will be addressed as expeditiously as the Enrollee's case requires, based on the Enrollee's health status.
   b. MCCMH will research and document all issues relevant to the appeal including any aspect of clinical care involved.

3. Resolution of a Reconsideration (First Level of Appeal)
   a. MCCMH will log research and documentation of all issues relevant to the reconsideration.
   b. All clinical reconsiderations will be reviewed and investigated by a clinician not previously involved in the reconsideration.
   c. The 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 30 days after the date MCCMH received the reconsideration appeal.
   d. MCCMH will notify the Enrollee/Representative if it extends the 30 day timeframe by up to 14 days. The time frame may be extended when the Enrollee requests an extension or MCCMH justifies the need for additional information and documents how a delay is in the best interest of the Enrollee.
   e. When MCCMH delays the resolution, it will notify the Enrollee/Representative immediately with the reason(s) for the delay.
   f. Notification of the resolution will be provided to the Enrollee/Representative orally or in writing, as requested by the Enrollee, if received orally, and documented electronically
   g. Notification of the resolution will be provided in writing if received in writing and documented electronically

h. All appeals, received orally or in writing, will be tracked and maintained by MCCMH
i. Complaint Appeal categories will align with NCQA Quality Management and Improvement complaint and appeal categories

D. Language Assistance (See also MCCMH MCO Policy 5-002, "Cultural and Linguistic Competency")

Language services will be provided to Enrollees requesting assistance through a bilingual staff or interpreter services face to face or telephonically:

1. To register an appeal;

2. To notify the Enrollee of their appeal resolution;

3. Provide notification to Enrollees that documents may be made available in languages other than English.

E. Appeal Types

1. There are five types of Enrollee appeals:
   a. Level 1 – MCCMH Standard Reconsideration Appeal, MCCMH Expedited Reconsideration Appeal
   b. Level 2 – Medicare Independent Review Entity (IRE)
   c. Level 3 – Medicare Administrative Law Judge (ALJ) Hearing
   d. Level 4 – Medicare Appeals Council (MAC) Review
   e. Level 5 – Medicare Judicial Review

2. Upon denial of coverage in whole or in part of an item/service that is covered by Medicare only, the case will be automatically forwarded to the IRE for review and pending that review decision and the dollar amount of the item/service appealed, Enrollees have the right to the following appeal options in successive order; ALJ, MAC and Judicial Review.

F. Enrollee Reconsiderations/Appeals

1. 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 days (60 days) from the date on the *Notice of Action* for items/services. The expiration date to file an appeal is included in the *Notice of Action*.

2. An Enrollee may assign a representative to act on their behalf.
   a. Enrollee assignment of an authorized representative must be in writing and on file with MCCMH.
   b. 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.

3. 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 organization determination notice, 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 capacity to understand the timeframe for filing a request for reconsideration.

4. If MCCMH denies an Enrollee's request for a good cause extension, the Enrollee has a right to file a grievance with MCCMH for the denial of a good cause extension.

5. If MCCMH becomes aware that an Enrollee has received services prior to the completed appeal determination, MCCMH will request a dismissal by forwarding the supporting documentation to the IRE.

6. 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 was mailed to the Enrollee or the representative.
   b. If the withdrawal is received after MCCMH has forwarded the appeal to an IRE, then MCCMH must also forward the withdrawal to the IRE for processing.

7. Enrollees or their representative may file an appeal either verbally by contacting the Customer Service Department at 1-855-996-2264 or by submitting a request in writing. Unless the Enrollee is requesting an expedited appeal resolution, a verbal appeal request must be followed up by a written, signed appeal.

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

   Macomb County Community Mental Health
   Hearing Officer
   22550 Hall Road
   Clinton Township, MI 48036

9. 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.

10. MCCMH will comply with the Americans with Disabilities Act (ADA) including providing reasonable accommodations including any reasonable assistance in completing appeal forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services, at no cost to the Enrollee, both telephonically and in person.

11. MCCMH will proactively include information and reminders about the availability of the Ombudsman's Office and will refer the Enrollee to the Ombudsman's Office. The referral may include direct outreach to the Ombudsman's office, warm transfer to Ombudsman's office and will include full collaboration with the Ombudsman's office.

12. MCCMH will acknowledge the receipt of all appeals in writing within three (3) business days after receiving an appeal request either orally or in writing.

13. MCCMH will ensure that the individuals who make decision on appeals are individuals who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the MDHHS, in treating the Enrollee's condition or disease:
    a. An appeal or a denial that is based on lack of medical necessity;
    b. An appeal that involves clinical issues.

14. 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 in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate; and
    e. Are neither the individual who made the original non-certification, nor the subordinate of such an individual.

15. Oral inquiries seeking to appeal are treated as appeals (to establish the earliest possible provider requests expedited resolution).

16. The Enrollee and his or her representative are provided a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing.
    a. 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, in the case of expedited resolution.
    b. MCCMH takes all information into account during the appeals process without regard to whether the information was submitted or considered in the initial consideration of the case; and implements the decision of appeal if it overturns the initial denial.

17. The Enrollee and his or her representative are provided with an opportunity, 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.

18. The appeals process will include, as parties to the appeal, the Enrollee and his or her representative or the legal representative of a deceased Enrollee's estate.

19. MCCMH will resolve each appeal and make reasonable effort to provide oral notice and will provide written notice of the appeal resolution, as expeditiously as the Enrollee's health condition requires but will not exceed thirty (30) calendar days from the date the appeal is received for pre-service and post-service appeals.

20. For expedited appeal requests, MCCMH notifies the party filing the appeal, as soon as possible, but in no event more than twenty-four (24) hours after the submission of the appeal, of all information that the plan requires to evaluate the appeal. MCCMH will render a decision on the appeal within seventy-two (72) hours.
    a. For notice of an expedited resolution, MCCMH will make reasonable effort to provide oral notice as expeditiously as the Enrollee's health requires.
    b. MCCMH will provide written notice to all parties to the appeal, the Enrollee, the practitioner and the representative if designated, as expeditiously as the Enrollee's health requires but no later than within 2 business days of the decision.

21. MCCMH may extend the timeframe for standard or expedited resolution of the appeal by up to fourteen (14) calendar days if:
    a. The Enrollee requests the extension;
    b. MCCMH demonstrates (to the satisfaction of the MDHHS, upon its request) that there is need for additional information and how the delay is in the Enrollee's interest.
    c. MCCMH will provide the Enrollee written notice of the reason for the delay.

22. An expedited review process for appeals will be utilized if it is determined by MCCMH, or if the provider indicates (in making the request on the Enrollee's behalf or in support of the Enrollee's request) that taking the time for standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain or regain maximum function.

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

24. If an Enrollee's request for expedited resolution is denied, the appeal will be transferred to the timeframe for standard resolution and MCCMH will make reasonable efforts to give the Enrollee prompt verbal notice of the denial within

one (1) business day and follow up within two (2) calendar days with a written notice.

25. MCCMH will continue the Enrollee's benefits if:
    a. The Enrollee or the provider files the appeal timely;
    b. As used in here, "timely" filing means filing on or before the later of the following:
        i. Within twelve (12) calendar days of the health plan mailing the notice of action.
        ii. The intended effective date of the health plan's proposed action.
    c. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
    d. The services were ordered by an authorized provider; and
    e. The original period covered by the original authorization has not expired.

26. If the time required for an appeal process could seriously jeopardize an Enrollee's life, health, or ability to attain, maintain, or regain maximum function, the Enrollee, or the Enrollee's representative with the written consent of the Enrollee, may request an expedited resolution. 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.

27. If MCCMH, the commissioner for independent review, the State Fair Hearing Officer, the IRE, ALJ, MAC or Judicial review reverses the decision to deny, limit or delay services that were not furnished while the appeal was pending, MCCMH will authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires.

28. If MCCMH, the IRE, ALJ, MAC or Judicial review reverses the decision to deny authorization of services and the Enrollee received disputed services while the appeal was pending, MCCMH will pay for those services.

29. MCCMH will maintain the privacy of all appeals records at all times, including the transmittal of medical records, if applicable.

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

G. Request for Continued Benefits During Appeals Process

An Enrollee may continue to receive services during the appeals process under the following circumstances:

1. As used in this section, "timely" filing means filing in writing on or before the later of the following:
    a. Within twelve (12) calendar days of the mailing of the notice of action.
    b. The intended effective date of the proposed action.

2. The Enrollee's benefits will be continued if the Enrollee or the provider files the appeal timely; the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the Enrollee requests extension of the benefits.
   a. For items/services that are covered by Medicare only, benefits will continue through the health plan appeal process as long as the appeal is filed timely within twelve (12) calendar days from Notice of Action.
   b. For items/services that are covered by Medicaid only and by both Medicaid and Medicare, benefits will continue through the State Fair Hearing process if each subsequent appeal is filed within twelve (12) calendar days of the prior adverse decision letter.

3. If the Enrollee requests benefits to 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. Twelve (12) calendar days pass after MCCMH mails the notice, providing the resolution of the appeal against the Enrollee, unless the Enrollee, within the twelve (12) calendar day timeframe, has requested an External Review or State Fair Hearing with continuation of benefits until a decision is reached.
   c. An External Reviewer or the State Fair Hearing Officer issues a hearing decision adverse to the Enrollee.

4. The time period or service limits of a previously authorized service has been met.

5. If the Enrollee requests benefits to be continued while the appeal is pending, the benefits will continue until one of the following occurs:
   a. The Enrollee withdraws the appeal.
   b. Twelve (12) calendar days pass after MCCMH mails the notice, providing the resolution of the appeal against the Enrollee, unless the Enrollee, within the twelve (12) calendar day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached.
   c. A State Fair Hearing Officer issues a hearing decision adverse to the Enrollee.
   d. The time period or service limits of a previously authorized service has been met.

6. If the final resolution of the appeal is adverse to the Enrollee, that is, upholds MCCMH's action, the services will be terminated upon the intended effective date of the action or if that date has passed, services will be terminated within 10 business days of the decision.

H. Pre-Service/Post–Service Appeals Process

1. Upon receipt, MCCMH logs and tracks all complaint types Grievance and Appeals Database. The content will be available to the MDHHS or CMS in electronic format upon request.

2. The Hearing Officer will send an acknowledgment letter to the Enrollee or authorized Enrollee representative and/or the Enrollee's provider as applicable.
    a. The letter will provide information about their appeal rights.
    b. It will include a request for any additional clinical documentation that could support the services requested.

3. The Enrollee and/or the Enrollee's representative may present supporting documentation or evidence in person or in writing on or before the date of the appeal meeting date.

4. The Enrollee and/or their representative may request to review the Enrollee's file or clinical records that will be presented to the appropriate person, persons or department before and or during the appeals process by contacting the Customer Service Specialist.

5. An investigation of the appeal will take place and will be documented. 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, 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
    i. All aspects of clinical care involved
    j. Same specialty reviewer's (same specialty reviewer not involved in the initial determination and not a subordinate of any person involved in the initial determination) comments.

6. The appeal request and all supporting documentation are presented to the appropriate person/persons or department.

7. The case is then reviewed by a person/persons or department who was not involved in the initial determination and not a subordinate of any person involved in the initial determination.

8. All appeals that are clinical in nature are reviewed by an appropriately licensed practitioner who was not involved in the initial review and denial and is not the subordinate of any person involved in the initial determination. This practitioner must be board eligible or certified as required, have clinical expertise in the same or a similar specialty, and typically treat the medical condition or perform the procedure.

9. The appeal will be reviewed and a decision reached by the Appeals Committee. It is then approved and signed by the authorized MCCMH decision maker

including, but not limited to the Medical Director, physician designee, Clinical Strategies and Improvement Director, Executive Director or designee, or other clinical peer. Reasonable efforts are made to provide oral notice of the decision and a written notice of resolution is sent to the Enrollee and practitioner as expeditiously as the Enrollee's health requires but not to exceed 2 business days from receipt of a pre-service and post-service appeal decision; if the decision is upheld, the Appeal Decision Letter explains the next level of appeal.

a. For items/services covered by Medicare only, the denial will be forwarded for IRE review.
b. The Hearing Officer maintains hard copy and/or electronic images of the complete appeal records in accordance with applicable record retention policies. Full documentation of the appeal will include all components of the investigation as well as any actions taken.

10. MCCMH reports appeals to the MDHHS and ICO in the format and frequency specified by the MDHHS and CMS.

11. MCCMH will promptly forward any adverse decisions to MDHHS and/or ICO for further review/action upon request by MDHHS, ICO or the MCCMH Enrollee.

12. 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.

I. Non-Participating Provider Post Service Appeals
   a. Payment Denial
      Upon denial of payment on a claim for an item/service that is covered by Medicare only or by Medicare and Medicaid, non-participating providers have the right to request a non-Participating Provider Claim Appeal in writing with a completed Waiver of Liability (WOL) form within sixty (60) days of the remittance advice.
   b. Payment Dispute
      i. 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, or
      ii. Request IRE review in writing upon completion of the non-Participating Provider Payment dispute process and within one hundred eighty (180) calendar days of the remittance advice.

J. Participating Service Provider Service Appeals
   a. Participating, network service providers shall use the appeals process found in MCCMH Policy 2-006.

K. Expedited Appeals

1. May be submitted orally and do not require written confirmation or the Enrollee's written consent to have the provider act on the Enrollee's behalf.

2. Enrollee or provider must file a request for an appeal within 10 days of the adverse action determination.

3. Enrollees will be informed of the limited time available to the Enrollee to present evidence and allegations of fact or law in person or in writing.

4. Decisions are communicated orally, followed by written notification within 2 business days of the decision.

5. An Enrollee or an Enrollee's representative may request an expedited appeal if they feel the timeframe required for a standard appeal could seriously jeopardize life or health, or the ability to attain, maintain or regain maximum function.

6. The clinically appropriate member of the MCCMH appeals committee reviews the expedited appeal request, together with any support documentation submitted, as expeditiously as the Enrollee's health requires upon receipt of the request to determine if the case meets expedited urgency or need.

7. In cases where MCCMH determines an Enrollee's request meets expedited urgency or a practitioner supports the Enrollee's request, MCCMH's Medical Director renders a decision as expeditiously as the Enrollee's health requires, but no later than seventy-two (72) hours from the receipt of the request.

8. If an Enrollee or Enrollee's representative requests an expedited appeal and MCCMH denies the request because it does not meet the expedited urgency or need, the appeal will be processed and resolved in accordance to a non-expedited standard appeals process.

9. The Customer Service Specialist will give the Enrollee/representative and/or practitioner prompt oral notice within one (1) business day of the receipt of the request and follow up within two (2) calendar days with a written notice that the appeal will be handled through the non-expedited standard process.

L. Regulatory Complaints Process

1. Regulatory complaints may be received from the State primarily through the Ombudsman's office or forwarded by a managed care organization or health plan contracted with CMS from the Complaint Tracking Module (CTM) of the Health Plan Management System (HPMS).

2. MCCMH will process complaints forwarded by a managed care organization or health plan according to the CMS assigned issue level:
   a. "Immediate" within two (2) calendar days

b. "Urgent" within seven (7) calendar days
c. "Non-Urgent" within thirty (30) calendar days

3. Processing of all other regulatory complaints will follow the grievance or appeal process timeframes depending on complaint classification unless the regulatory body stipulates a different timeframe for the complaint.

4. Within one (1) calendar day of receipt by MCCMH of a regulatory complaint, the facts surrounding the complaint will be reviewed to determine whether the grievance, coverage determination or appeals process should be initiated.

5. MCCMH will ensure that all regulatory agencies are aware of any regulatory complaints filed as necessary.

6. All regulatory complaints will be identified as a regulatory complaint, processed and tracked in the appeal and grievance database to allow for comprehensive trending of all received complaints regardless of origination. As specified in CMS Part C Reporting and Technical Specifications, regulatory complaints will not be included in regulatory reporting.

M. Same Specialty Review Process

1. All appeals that are clinical in nature are reviewed by an appropriately licensed practitioner who:
   a. Was not involved in the initial review and denial,
   b. Is not the subordinate of any person involved in the initial determination, and
   c. Is Board eligible or certified as required and has clinical expertise in the same or similar specialty and typically treats the medical condition, performs the procedure or provides the treatment.
   d. Has an active unrestricted license to practice.

2. All same specialty review recommendations are presented to the appropriate person, persons or department as part of the appeal investigation.

N. Misclassification of Appeals

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

2. Upon discovery of such an error, MCCMH must 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.

O. Timeframe for Resolving Pre-Service/Post-Service and Expedited Appeals

1. Standard pre-service and post-service appeals are processed within thirty (30) calendar days of receipt of the appeal unless an extension is granted, then the appeal will be processed within forty-four (44) calendar days from receipt of the appeal.

2. Expedited pre-service appeals are processed within seventy-two (72) hours of receipt of the appeal unless an extension is granted, then the expedited appeal will be processed within seventeen (17) calendar days to the hour of the appeal receipt.

3. Post-service appeals are not eligible for expedited processing.

4. After the appeal has been reviewed and processed, the appeal decision is communicated to the Enrollee or authorized representative of the Enrollee and provider in writing as expeditiously as the Enrollee's health requires but not to exceed two (2) business days of the receipt of the pre-service and post-service appeal decision.

5. An extension may be granted at the Enrollee's request, or if the MDHHS allows the organization to request additional information from the Enrollee. MCCMH will resolve the appeal no later than the date on which the extension expires.

6. MCCMH may extend the timeframe for standard or expedited resolution of the appeal by up to fourteen (14) calendar days, if:
   a. The Enrollee requests the extension.
   b. MCCMH demonstrates (to the satisfaction of the MDHHS, upon its request) that there is need for additional information and how the delay is in the Enrollee's interest.
   c. MCCMH will provide the Enrollee written notice of the reason for the delay.

P. Record Keeping

1. MCCMH logs and tracks all appeals in the Appeals and Grievance Database and maintains for all appeal types:
   a. The date of receipt of the appeal;
   b. Copy of the appeal, if written;
   c. A copy of the Enrollee's acknowledgment letter;
   d. All requests for expedited processing and the determination if the request meets the requirements for expedited processing;
   e. Necessary documentation to support any extensions; and
   f. The determination made, including the date of the determination, titles, and in the case of a clinical determination, the credentials of the plan's personnel who reviewed the appeal.
   g. The date the Enrollee was notified of the determination.

2. The content of the Appeals and Grievance Database will be available to the Department in electronic format upon request. MCCMH will retain a copy of the database for ten (10) years.

Q. Written Appeal Decision Letter – Pre-Service and Expedited

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

2. The written notice of the appeal resolution will include:
   a. A description of the item/service being appealed;
   b. The results of the resolution process and the date it was completed;
   c. 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
   d. That oral interpretation is available in any language;
   e. That written translation is available in prevalent languages as applicable;
   f. That written alternative forms may be available as needed; and
   g. How to access interpretation and translation services as well as alterative formats.
   h. The right to seek assistance from the Ombudsman's Office at any time throughout the appeal process and how to do so.
   i. Reasons for the determination and in cases where the determination has a clinical basis, the clinical rationale for the determination.
   j. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
   k. 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.
   l. 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 record relied upon and document and records submitted in the course of making the appeal decision at no cost to the Enrollee.
   m. 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;
   n. Carbon copy of notification to the provider if applicable.

R. Independent Review Entity (IRE)

1. For items/services that are covered by Medicare only or by Medicare and Medicaid, if MCCMH upholds the coverage decision in whole or in part, it will complete and submit a written case summary to the Independent Review Entity (IRE) according to the IRE defined timeframes and processes.
   a. Standard requests will be processed no later than seven (7) calendar days.
   b. Expedited requests within twenty-four (24) hours for expedited requests.

c. And no later than ten (10) days for requests for payment.

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

3. The IRE will conduct the review as expeditiously as the Enrollee's health condition requires.

4. The IRE will notify all parties of the determination.

5. The notice will include the right to an ALJ hearing and the procedure to request one if the total dollar amount of the items/services being appealed meets or exceeds the AIS threshold.

S. Adjudicated Law Judge (ALJ) Hearing

1. In order for a case to be reviewed at an ALJ Hearing, it must meet the AIC threshold.

2. 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.

3. 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.

T. Medicare Appeal Council (MAC) Review

Enrollees or their authorized representative must request a MAC review in writing through a letter to the MAC within 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

U. Judicial Review

Any party 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 AIC threshold.

1. The party may combine claims to meet the amount in controversy requirement. To meet the requirement:
   a. All claims must belong to the same Enrollee;
   b. The MAC must have acted on all the claims;
   c. The Enrollee must meet the 60 day filing limit for all claims, and;
   d. The request must identify all claims.

2. To file a Judicial Review, any party must file a civil action in the District Court of the United States in accordance with procedures outlines in 42 CFR 422.612 and 405.1136 except that escalation does not apply.
   a. The action should be initiated in the Judicial District in which the Enrollee lives or where MCCMH has its principal office.

V. Final Decisions by All Other Review Entities

If the organization determination is reversed in whole or in part by the IRE, ALJ, the Medicare Appeals Council (MAC) or Judicial Review;

1. MCCMH must pay for, authorize, or provide the service under dispute as expeditiously as the Enrollee's health condition requires, but no later than 60 calendar days from the date it receives notice reversing the initial organization determination.

2. However, if MCCMH requests MAC review of an ALJ decision, the plan may await the outcome of the review before paying for, authorizing or providing the service under dispute.

3. 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.

4. Whenever MCCMH imposes a decision, it must inform the IRE.

W. Second Opinions

1. Enrollees have the right to a Second Opinion review under the authority of the State of Michigan Mental Health Code and the Balanced Budget Act. The Second Opinion review process may be requested for denial of inpatient hospitalization and for denial of initial services under Section 409 and 705 of the Michigan Mental Health Code.

2. For each denial of inpatient care or eligibility for services, at the time of the denial, MCCMH is required to provide the Enrollee with written Adequate Notice of Action and a Notice of the Rights to a Second Opinion Process. The Notice shall contain all information as identified in this policy. In addition, the Notice must also indicate that the beneficiary is entitled to request a Second Opinion and the process for doing so.

3. Second Opinions are made available at no cost to beneficiaries, for a qualified health professional within the network or outside the network if a qualified health professional is not available within the network under Section 438.206(b) of the Balanced Budget Act.

X. Voicemail Procedures

1. Where voicemail is used outside of normal business hours provided, the voicemail message must contain the following information:
   a. Indicates that the mailbox is secure;
   b. Lists the information that must be provided so the case can be worked [e.g., provider identification, Enrollee identification, type of request (coverage determination or appeal), physician support for an exception request, and whether the Enrollee is making an expedited or standard request];
   c. For coverage determination call (including exceptions request), articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests.

VII. References / Legal Authority

Medicare Managed Care Manual Chapter 13, Federal Code of Regulations Title 42, part 422 Subpart M

VIII. Attachments

None