Current Status: *Active* **PolicyStat ID:** *5453092*

Origination:	*05/2017*
Effective:	*01/2019*
Last Approved:	*01/2019*
Last Revised:	*01/2019*
Next Review:	*01/2020*
Owner:	*Dorian Johnson*
Policy Area:	*Customer Service*
References:	*NCQA UM 7, NCQA UM 7 ELEMENT C, NCQA UM 8, NCQA UM 8 ELEMENT A, NCQA UM 8 ELEMENT B, RR2 Element B*

Customer Service (CS) Enrollee/Member Appeals Policy

POLICY

It is the policy of Detroit Wayne Mental Health Authority (DWMHA) that enrollees/members receiving and requesting behavioral health services have access to an appeals process consistent with the Michigan Department of Health and Human Services (MDHHS) and Center for Medicare and Medicaid Services (CMS) requirements, contracts, policy guidelines and technical advisories as well as accreditation requirements.

PURPOSE

To provide operational and procedural guidance to DWMHA, the Access Center, Crisis services vendor, and Service Providers for the development and consistent processing of enrollee/member appeals.

APPLICATION

1. The following groups are required to implement and adhere to this policy: DWMHA Staff, Contractual Staff, Access Center, Service Providers, Crisis services vendor
2. This policy serves the following populations: Adults, Children, I/DD, SMI/SEI, SED,SUD, Autism
3. This policy impacts the following contracts/service lines: MI-HEALTH LINK, Medicaid, SUD, Autism

KEYWORDS

1. Adequate Notice of Adverse Benefit Determination
2. Administrative Appeal
3. Advance Notice of Adverse Benefit Determination
4. Adverse Benefit Determination
5. Appeal
6. Behavioral Health Supports and Services
7. Expedited Appeal (Fast)

8. Fair Hearing
9. Grievance
10. Individual Plan of Service (IPOS)
11. Independent Review Entity(IRE)
12. Integrated Care Organization(ICO)
13. Legal Representative
14. Medicaid
15. Medicare
16. Michigan Department of Health and Human Service(MDHHS)
17. Prepaid Inpatient Health Plan (DWMHA)
18. Provider
19. Provider Network
20. Reconsideration
21. Re-determination
22. Similar Specialist
23. State Fair Hearing

STANDARDS

1. DWMHA will:
    a. Ensure that all appeal processes are:
        1. Timely;
        2. Fair to all parties;
            i. Enrollee/member
            ii. Enrollee/member's Authorized or Legal Representative
            iii. Estate Representative of a Deceased Enrollee/Member
            iv. Provider
        3. Administratively simple;
        4. Objective and credible;
        5. Accessible and understandable to enrollees/members and providers;
        6. Subject to quality improvement review;
        7. Developed in a manner to assure that enrollees/members who participate in the appeal process are free from discrimination or retaliation;
        8. Developed in a manner to assure that they do not interfere with communication between member and the receipt of services.
    b. Ensure that DWMHA staff, the Access Center, Mobile Crisis Stabilization Unit and Service Providers are compliant with the appeal requirements as evidenced by:

1. Including all necessary language in contracts and requiring contractor's language is in compliance with state and federal requirements;
2. Structuring the appeal process that promotes the resolution of the enrollee/member's concerns about services;
3. Documenting the substance of the appeal and actions recorded in MH-WIN;
4. Providing technical assistance and training on the appeal processes to promote the resolution of concerns as well as support and enhance services;
5. Engaging providers in consultative meetings to provide information and guidance in implementing appeal policies;
6. Providing standardized documents related to the appeals policy in the form of templates to give providers the ability to customize with their specific identifying information;
7. Ensuring that staff reviewers are licensed practitioners of the healing arts with same or similar clinical expertise in treating the member's condition or disease when the appeal is denied based on medical necessity or involves other clinical issues;
8. Ensuring the staff who reviews the appeal will not be the same person who was involved in making the initial decision that is the subject of the appeal nor be the subordinate of the previous reviewer;
9. Ensuring all forms related to appeal actions (i.e. Appeal bookmarks, Appeal Request forms, Member Handbooks and Request for Hearing forms with envelopes) are available, easily accessible, understandable and linguistically appropriate to enrollees/members and providers via websites, Individual Plan of Service meetings and at provider sites;
10. Incorporating a written process in operational manuals consistent and compliant with this appeal policy;
11. Ensuring that DWMHA, the Access Center, Mobile Crisis Stabilization Unit and the service providers' appeal materials are compliant with all contractual, regulatory and accreditation requirements in regards to reading level (at or below a fourth (4th) grade reading level), font, type size, medium and language. Upon request, DWMHA, the Access Center, Mobile Crisis Stabilization Unit and/or the will provide material in alternative formats to meet the needs of vision and/or hearing impaired enrollee/member upon request. These services are provided at no cost to the enrollee/member.
    i. The availability of vital written information in the prevalent non-English languages in the service area in accordance with the LEP guidelines, Center for Medicare and Medicaid Services (CMS) and/or DWMHA's contract with the Michigan Department of Health and Human Services (MDHHS). Materials will meet the most stringent guideline.
    ii. Upon request, DWMHA will provide materials in alternate formats to meet the needs of vision and/or hearing impaired members, including large font (at least 18-point), Braille, oral interpretation service, ASL, audio and visual formats.
    iii. Translation services will be made available to the member, upon request.
    iv. Interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

c. Provide access to one or more of the following dispute resolution options that may be utilized simultaneously;

1. Grievance
2. Local Appeal
3. Recipient Rights Complaint

d. Provide in writing to the enrollee the appropriate standardized notice in the event of an adverse action. The form(s) shall include:
    1. A statement of what action is being taken in easy, understandable language which does not include:
        i. abbreviations or acronyms that are not defined; and
        ii. is culturally and linguistically sensitive to the enrollees/members' needs; and
        iii. health care procedure codes that are not explained
    2. An explanation of the action including the denial of services in amount, scope and duration if less than what is requested;
    3. The specific jurisdiction that supports or the change in the federal or state law that requires the action including a reference to the benefit provision, guideline, protocol or other similar criterion on which the action is based and the option of the enrollee/member to have a copy of the benefit provision, guidelines or protocol, upon request;
    4. A statement that the enrollee/member has the right to appeal and a description of the expedited and standard appeal process including time frames;
    5. A statement that the enrollee has a right to continue receiving Medicaid covered services if a request is made within ten (10) calendar days from the date of the notice when applicable (per MDHHS and DWMHA contract effective October 1, 2017); and an explanation of the procedures of how to request such services be continued to the end of the currently approved treatment authorization or final decision whichever comes first .
    6. A statement that the enrollee/member may have to pay for the continuation of services if the result of the internal appeal or external State Fair Hearing is to uphold the denial;
    7. A statement that if the decision is found in favor of the enrollee/member made by either the DWMHA or State Fair Hearing and services have been previously discontinued, the DWMHA and/or service provider must reinstate services within 72 hours.
    8. A statement that the enrollee/member, his/her legal guardian or authorized representative has 14 calendar days from the initiation of the appeal request to present evidence, testimony, and allegations of fact or law in person and/or in writing;
    9. A statement that the enrollee/member can request copies of all documents relevant to the appeal, free of charge;
    10. A statement that informs the enrollee/member of their right to designate an authorized representative to act on their behalf as long as the enrollee/member has provided written permission by submitting the request in writing;
    11. Include a list of titles and qualifications, including specialties of the individuals participating in the appeal review.

e. For all pre service, post service and standard local appeals:
    1. DWMHA, Mobile Crisis Stabilization Unit and Service Providers and their staff are prohibited

from taking any punitive or retaliatory actions towards an enrollee/member, authorized representative, legal guardian or provider who requests an appeal.

2. Appeals for service for which Medicaid and Medicare overlap, the enrollee/member can file an appeal through either the Medicaid or Medicare process or both. Any determination that overturns the denial will be binding.

2. **DWMHA, the Access Center, Mobile Crisis Stabilization Unit and Service Providers will adhere to the Customer Service Appeal Process for Medicaid Standard, Pre-Service or Post Service Appeals which include:**

   a. **Local/Internal Appeals (First Level)**

      1. Identifying and verifying the individual requesting to appeal an Adverse Benefit Determination (Medicaid) or Denial of Medical Coverage (MI Health Link) decision is legally able to do so in order to ensure and protect the enrollee's rights and information.
      2. Sending the enrollee 10 calendar days prior to the effective date of the action the standardized adverse benefit determination (Adequate or Advance) notice or Denial of Medical Coverage notice to inform the enrollee of a denial, reduction, suspension or termination of services.
      3. Providing assistance to the enrollee, legal guardian or authorized representative in completing the needed paperwork to file and submit an internal/local appeal.
      4. The enrollee can request an appeal be resolved in an expedited or standard timeframe. An expedited request requires a 72 hour decision be rendered on the adverse benefit determination as the individual appealing feels a delay in decision making might seriously jeopardize an enrollee's life, health or ability to attain, maintain or regain maximum function. If a decision is made to deny the request for an expedited appeal, .an attempt is made to provide the enrollee/ guardian/authorized representative prompt oral notice of the denial as soon as the decision is rendered. Written correspondence is sent to the enrollee/guardian/authorized representative within two (2) calendar days of the denial. A standard resolution of an appeal acknowledges that a decision on the issue will take place no later than 30 calendar days from the date of the appeal request.
      5. DWMHA may extend the resolution timeframe by no more than 14 calendar days provided that either the enrollee/guardian/authorized representative requests an extension or DWMHA shows to the satisfaction of the State there is a need for additional information and how the delay is in the best interest of the enrollee. If the extension is granted, DWMHA will provide the enrollee written notice within two (2) calendar days of the decision to extend the timeframe as well as inform the enrollee of their right to file a grievance if they disagree with the extension.
      6. Timely processing and distribution of the standardized acknowledgement letters (Notice of Receipt of Appeal) to the enrollee/member, legal guardian or authorized representative to indicate the receipt of the appeal request.
      7. Accurately documenting in MHWIN all contacts with enrollees/members, guardians and authorized representatives.
      8. Providing timely resolution to the appealing party and provide detailed explanation of the appeal decision via the Notice of Appeal Approval or Appeal Denial for Medicaid and Notice of Appeal Decision for MI Health Link enrollees. Resolution and investigation of appeals completed for standard appeals within 30 calendar days and 72 hours for fast/expedited appeals.. The appeal decision letters are mailed within two (2) calendar days of the decision. Included with the Notice

of Appeal Decision and the Notice of Appeal Denial are instructions to pursue next level review options.

b. **Second Level/External Appeal Review for Pre-Service, Standard and Post-Service Appeals:**

1. The enrollee's request for a Medicaid second level/external appeal must be in writing to the Michigan Administrative Hearing Systems in Lansing. There is a form, Request for State Fair Hearing, that is provided to the enrollee with the receipt of the Notice of Appeal Denial **(MI Health Link)** or Notice of Appeal Decision form (Medicaid).
2. The enrollee/member's request for a Medicaid second level external appeal can be standard or expedited. An expedited appeal is a request to review a decision concerning eligibility, screening, admission, continued/concurrent stay or other behavioral healthcare services for an enrollee/member who has received urgent services but has not been discharged from a facility or when a delay in decision-making might seriously jeopardize an enrollee/member's life, health or ability to attain, maintain or regain maximum function. The enrollee/member has 120 calendar days from the date of the Adequate or Advance Notice of Appeal Denial or Notice of Appeal Decision to request a Medicaid second level/external appeal.
3. An Administrative Law Judge (ALJ) from the Michigan Administrative Hearing system will conduct/facilitate the hearing between the appellant (enrollee/member, authorized representative, legal guardian) and the respondent (DWMHA and/or Service Provider) to determine if proper protocol was adhered to while obeying all federal, state and local rules and regulations.
4. The Administrative Law Judge will hear the case and a ruling will be made based upon the information presented by the appellant and the respondent. The ruling is issued to the appellant and/or the appellant's authorized representative and/or legal guardian, respondent and state officials in the form of the Order and Decision notification within 90 days of the hearing.
5. If the decision is in favor of the enrollee and services were not continued during the appeal process, services must be restored within 72 hours of receiving the decision.
6. The enrollee/member, authorized representative and/or legal guardian is then given the opportunity to appeal the decision within 30 days to the Third Judicial Circuit Court. Instructions are provided in the Order and Decision notification that is disseminated to the enrollee/member and/or their representative.

3. **DWMHA, the Access Center, Mobile Crisis Stabilization Unit and Service Providers will adhere to the Customer Service Appeal Process for MI Health Link Pre-Service, Standard and Post-Service:**

a. **First Level/External Appeal Review :**

1. The enrollee/member is given a Notice of Denial of Medical Coverage. Such notice shall be provided at least ten (10) calendar days in advance of the date of notice of Denial of Medical Coverage for ongoing services.
2. The enrollee/member has up to 60 calendar days from the receipt of the Notice of Denial of Medical Coverage to request a first level internal/local appeal for MI Health Link covered services.
3. The enrollee/member's request for first level internal/local appeal for MI Health Link covered services can be verbally or in writing. Unless the request is an expedited request, the appeal request must be followed up in writing.
4. The request for a MI Health Link first level internal/local appeal can be standard or expedited.

An expedited appeal is a request to review a decision concerning eligibility, benefit, screening, admission, continued/concurrent stay or urgent services but has not been discharged from a facility or when a delay in decision-making might seriously jeopardize an enrollee/member's life, health or ability to attain, maintain or regain maximum function.

5. DWMHA shall send a **Notice of Appeal Receipt** within three (3) calendar days of a non-expedited MI Health Link first level appeal request and within 24 hours of an expedited MI Health Link first level appeal request.
6. DWMHA has 72 hours from the receipt of the expedited MI Health Link first level request to review and make a determination and within 30 calendar days from receipt of the non-expedited MI Health Link first level internal/local appeal request to the enrollee.
7. If DWMHA needs to extend the time frame for an appeal, the enrollee must receive prompt oral notice of the delay and in addition provide written notice of the reason for extension. It can be extended up to the 14 calendar days. If the enrollee disagrees with this decision, the Enrollee has the right to file a grievance.
8. A MI Health Link first level internal/local appeal request that results in upholding part or all of the initial denial is communicated verbally to the provider. Written notification using the standardized Notice of Appeal Decision MHL is sent for partial or full denial of services appealed and the Notice of Decision Approval (MHL) letter is sent to the enrollee for fully approved services.
9. The Notice of Appeal Decision must include an explanation that the case is automatically forwarded to Maximus for a second level appeal if the determination is to uphold, all or in part, the non-authorization of eligibility, screening admission, continued/concurrent stay or other behavioral healthcare services.

b. **Second Level Appeal Review for MI Health Link Covered Services:**

1. For services that are Medicare approved, these appeals will be sent directly to Maximus for review. Maximus will respond with a decision within 30 calendar days. For an expedited MI Health link external appeal, the resolution will be made within 72 hours unless a 14 day extension had been granted.
2. For services that are Medicaid covered, the member has the opportunity to file a State Fair Hearing through Michigan Administrative Hearing Systems 120 days from the date on the **Notice of Appeal Decision**. MAHS has up to 72 hours to make a decision on an expedited appeal and up to 90 days to provide a written decision and order on a non-expedited state fair hearing request.
3. For services that are covered by both Medicare and Medicaid, (in which services overlap), enrollees may file an appeal through either or both processes. DWMHA will automatically forward the information to Maximus however, the member can request for a State Fair Hearing. Any determination that is in favor of the Enrollee will be binding and DWMHA is to enforce the decision as expeditiously as possible.

c. **Third Level Medical Necessity Appeal Review for MI Health Link Covered Services:**

1. The third level of appeal is the Administrative Law Judge (ALJ) hearing. This hearing allows the member to present the appeal to a new person who will review the facts independently and listen to testimony before making a new and impartial decision. An ALJ hearing is usually held by phone, video-conference or in some cases, in person. To secure an ALJ hearing, the

minimum amount of the case must be $150. All requests for an ALJ hearing must be written and forwarded to the Office of Medicare Hearing and Appeals (OMHA). The address is documented in MAXIMUS' decision notice.

2. In most cases, the ALJ will review a case, make a decision and notify DWMHA, the provider and the enrollee/member within ninety (90) days of the request.
3. If the ALJ upholds part or all of the second level decision by MAXIMUS, they provide written notification of their decision to DWMHA and the enrollee/member. The Notice also includes an explanation of the next (fourth) level appeal process.
4. If the ALJ overturns part or all of the second level decision by MAXIMUS, DWMHA will inform the servicing provider to reinstate the services and submit the services for payment no later than thirty (30) calendar days from the ALJ's decision.

d. **Fourth Level Appeal Review for MI Health Link Covered Services** :

1. The fourth level of appeals is with the Medicare Appeals Council (MAC). The request for a review by MAC must be submitted in writing, must be within 60 calendar days of the ALJ decision and must specify the issues and finding that are being contested.
2. In most cases, MAC will review a case, make a decision and notify DWMHA and the enrollee/ member within 90 days of receipt of the request. However, that time frame may be extended for various reasons including but not limited to the case being escalated from an ALJ hearing. If MAC does not issue a decision within the applicable time frame, the enrollee/member can ask MAC to escalate the case to the next (fifth) level review, the Judicial Review.
3. If MAC overturns part or all of the third level decision by the ALJ, DWMHA will inform the servicing provider to reinstate services and submit the claim no later than 30 calendar days from MAC's decision.

e. **Fifth Level Medical Necessity Appeal Review for MI Health Link Covered Services** :

1. If at least $1,460 or more is still in controversy following the MAC decision, a judicial review before a U.S. District Court judge can be requested. This is the fifth and final level of appeal. The request must be submitted in writing and must be within 60 calendar days of MAC's decision.
2. There is no statutory time frame for the Federal Court decision.
3. If the Federal Court upholds part or all of MAC's decision, they provide written notification of their decision to DWMHA and the enrollee/member. The Notice also includes an explanation that this is the final level for appeal.
4. If the Federal Court overturns part or all of MAC's decision, DWMHA will notify the servicing provider to re-instate services and submit claims for payment no later than thirty (30) calendar days from the Federal Court decision.

4. **DWMHA, the Access Center, Mobile Crisis Stabilization Unit and Service Providers will adhere to the Customer Service Appeal Process for Services provided to the Uninsured/Underinsured population (Pre Service, Post Service and/or Standard):**

a. **First Level Appeal Review for Uninsured/Underinsured Services:**

1. The enrollee/member, authorized representative or legal guardian has up to 30 calendar days (per the MDHHS CMHSP contract effective October 1, 2017) from the date of the Adequate or AdvanceNotice of Adverse Benefit Determination to request a first level internal/ local dispute

resolution review. DWMHA and/or the service provider must provide written notification 30 calendar days in advance of any changes to services that are currently being provided.

2. The enrollee's request for a first level internal/ local dispute resolution review can be verbal or in writing to DWMHA.
3. The enrollee/member's request for a first level internal local dispute resolution can be standard or expedited. An expedited appeal is a request to review a decision concerning eligibility, benefit coverage, screening, admission, continued/concurrent stay, or other behavioral healthcare services for an enrollee/member who has received urgent services but has not been discharged from a facility or when a delay in decision-making might seriously jeopardize an enrollee/member's life, health or ability to attain, maintain or regain maximum function. The enrollee/member can request an expedited first level local dispute resolution based on the information from the Adequate orAdvance Notice of Adverse Benefit Determination.
4. DWMHA shall send a standardized Notice of Local Dispute Resolution Review Request within 24 hours of an expedited first level local dispute resolution request and within five (5) calendar days of a non-expedited internal first level/ local dispute resolution review request to the enrollee.
5. DWMHA has 72 hours from the receipt of the expedited internal first level/ local dispute resolution request to review and make a determination and 30 calendar days from receipt of the non-expedited internal, first level/ local dispute resolution request to review and make a determination.
6. An internal, first level/ local dispute resolution request that results in upholding part or all of the initial denial is communicated verbally to the enrollee and/or their representative. If it is an expedited local dispute resolution request, the Notice of Local Dispute Resolution Denial will be sent within 72 hours. If the first level local dispute resolution request is found in favor of the enrollee/member, Notice of Local Dispute Resolution Approval is sent. If it is a non-expedited appeal request and the request is partially or fully denied, the standardized Notice of Local Dispute Resolution Denial will be sent. For approved appeals, the Notice of Local Dispute Resolution Approval is sent. The resolution letters are sent within 2 calendar days of the decision.
7. The Notice of Local Dispute Resolution Denial must include an explanation of how to file a second level external/alternate dispute resolution..

b. **Second Level Review for Uninsured/Underinsured Services**

1. After the exhaustion of the local dispute resolution process, the enrollee/member, guardian or authorized representative may request an alternate dispute resolution within ten (10) days from the date on the Notice of Adequate Benefit Determination or Notice of Advance Adverse Benefit Determination. This request must be in writing and submitted to: Department of Health and Human Services, Division of Program Development, Consultation and Contracts, Bureau of Community Mental Health Services. Attn: Request for MDHHS Level Dispute Resolution, Lewis Cass Building-5th Floor, Lansing, MI 48913
2. MDHHS shall review all requests within two (2) business days of receipt.
3. If MDHHS determines that the denial, suspension, termination or reduction of services/supports will pose an immediate or adverse impact upon the consumer's health and safety, the issue is referred within one (1) business day to the Community Services Division within Mental Health and Substance Abuse Services for contractual action consistent with Section 8.0 of the MDHHS

/CMHSP contract.

5. **Independent Review Organization (IRO)**
    a. DWMHA, The Access Center, Mobile Crisis Stabilization Unit and service providers will advise enrollees and providers at least annually of the availability and right to an external appeal of the final internal determination for Medicare and Medicaid covered services by an independent review organization (IRO) including their contact information. Under federal and state law, the DWMHA, Mobile Crisis Stabilization Unit and/or the service provider is responsible to forward to the IRO all relevant medical records and any supporting documentation that was used in the adverse action determination such:
        1. A summary of applicable issues;
        2. The final decision;
        3. Relevant portions of the criteria used to make the decision;
        4. For medical necessity decisions, the clinical reasons for the decision;
        5. Communications from the provider and enrollee/member to DWMHA, the Access Center, Mobile Crisis Stabilization Unit and/or service provider; and
        6. Any new information related to the case that became available after the final internal appeal decision.
    b. The DWMHA, Mobile Crisis Stabilization Unit and/or Service Provider do not influence the IRO review process and must adhere to and implement the IRO's decision within the time frame specified by the IRO. The IRO decision is final and binding.
    c. Written notification of the IRO decision will be given to the enrollee/member and provider by the DWMHA and in the event that the IRO overturns any part of the denial decision, the written notification includes the time and procedure for claim payment or approval of services. The DWMHA will maintain data and track all IRO requests and review findings on each appeal case and forward the information to the ICOs for the MI Health Link population. The DWMHA will also use this information in evaluating and revising its medical necessity decision-making process.

6. **The Access Center, Crisis Vendors and Direct Contract Providers are expected to develop their policies in alignment with DWMHA directives**.

QUALITY ASSURANCE/IMPROVEMENT

DWMHA shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the Quality Assurance Performance Improvement Program (QAPIP) Goals and Objectives.

The quality improvement programs of contracted service providers must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWMHA staff and contractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. Federal Regulation 42 CFR: Sections 431.200 et seq., 435.911-920, 438.400 et seq;
2. Michigan Department of Community Health (Administrative Hearings, Policies and Procedures)
3. Michigan Mental Health Code, PA 258 of 1974, as amended;
4. Contract between United States Department of Health and Human Services, Center for Medicare and Medicaid Services in Partnership with the State of Michigan and the Integrated Care Organizations, current or as amended(The Three Way Contract)
5. Agreement between Michigan Department of Health and Human Services and DWMHA for the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Programs, Healthy Michigan Programs, and Substance Use Disorder Community Grant Programs, Attachment 6.3.1.1

RELATED POLICIES

1. Member Grievance
2. SUD Recipient Rights
3. Utilization Management (UM) Provider Appeals

RELATED DEPARTMENTS

1. Clinical Practice Improvement
2. Compliance
3. Customer Service
4. Information Technology
5. Integrated Health Care
6. Managed Care Operations
7. Quality Improvement
8. Recipient Rights
9. Substance Use Disorders
10. Utilization Management

CLINICAL POLICY

NO

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:

Adequate Notice of Adverse Benefit Determination Medicaid
Adequate Notice of Adverse Benefit Determination Uninsured_Underinsured
Advance Notice of Adverse Benefit

Determination Medicaid
Advance Notice of Adverse Benefit Determination Uninsured_Underinsured
Appointment of Representative Form.pdf
Enrollee Agreement for Request for Additional Information Medicaid
Enrollee Agreement for Request for Additional Information MHL
Enrollee Request for Additional Information Uninsured_Underinsured
Grievance and Appeals TA FY 18.pdf
Hearing Summary.doc
Local Appeal Procedures for Enrollee_Members with Medicaid.pdf
Local Appeal Request Form (Medicaid SMI, IDD, SUD) 112018.doc
Local Appeal Request Form (MHL) 112018.doc
Local Dispute Resolution Procedures
MAHS Form Requisition.doc
Maximus Case Submission Cover Sheet-Instruction Guide.docx
Medicare/Redetermination/Local Appeals Procedures for Enrollees/Members
Michigan Department of Health and Human Services Medicaid State Fair Hearings Procedures for Enrollees/Members
Notice of Appeal Approval Form Medicaid
Notice of Appeal Approval MHL
Notice of Appeal Decision Form MHL.pdf
Notice of Appeal Denial Medicaid.doc
Notice of Denial of Medical Coverage .docx
Notice of Denial of Medical Coverage Form (MHL).docx
Notice of Dismissal of Appeal Request Form.pdf
Notice of Dismissal of Medicare Appeal Request Form.pdf
Notice of Local Dispute Resolution Approval Uninsured_Underinsured
Notice of Local Dispute Resolution Denial Uninsured_Underinsured
Notice of Our Failure to Make a Coverage Decision Form.pdf
Notice of Receipt of Appeal Form (Medicaid SMI, IDD, SUD).docx
Notice of Receipt of Appeal Form (MHL) (10).docx
Notice of Receipt of Local Dispute Resolution

Review Form
Process Flowchart_Enrollee-Member Medicare Appeals.docx
Request for Additional Information Medicaid
Request for Additional Information MHL
Request for Additional Information Uninsured_Underinsured
Request for Hearing Form

Approval Signatures

Approver	Date
Dana Lasenby: Chief Clinical Officer	01/2019

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB
No. 0938-0950

Appointment of Representative

Name of Party	Medicare or National Provider Identifier Number

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):
I appoint this individual, _____ to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security Act (the "Act") and related provisions of title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 2: Acceptance of Appointment

To be completed by the representative:
I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)
I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)
I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Charging of Fees for Representing Beneficiaries Before the Secretary of the Department of Health and Human Services

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of the Department of Health and Human Services (DHHS) (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council review, or a proceeding before an ALJ or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR §405.910(f).
The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for Medicare Appeals Council review.
Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation

Authorization of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent): (1) your appeal if you are filing an appeal, (2) grievance if you are filing a grievance, or (3) initial determination or decision if you are requesting an initial determination or decision.

If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227).

GRIEVANCE AND APPEAL TECHNICAL REQUIREMENT
PIHP GRIEVANCE AND APPEAL SYSTEM FOR MEDICAID BENEFICIARIES

OCT. 2017

TABLE OF CONTENTS

I. PURPOSE AND BACKGROUND

This Technical Advisory is intended to facilitate Prepaid Inpatient Health Plan (PIHP) compliance with the Medicaid Enrollee Grievance and Appeal System requirements contained in Part 11, 6.3.1 of the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services (MDHHS). These requirements are applicable to all PIHPs, Community Mental Health Services Programs (CMHSPs) and their provider networks.

Although this technical advisory specifically addresses the federal Grievance and Appeal System processes required for Medicaid Enrollees, other dispute resolution processes available to all Mental Health consumers are identified and referenced.

Under the Due Process Clause of the U.S. Constitution, Medicaid Enrollees are entitled to "due process" whenever their Medicaid benefits are denied, reduced or terminated. Due process requires that Enrollees receive: (1) prior written notice of the adverse action; (2) a fair hearing before an impartial decision maker; (3) continued benefits pending a final decision; and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements. The Medicaid Enrollee Grievance and Appeal System provides a process to help protect Medicaid Enrollee due process rights.

Consumers of mental health services who are Medicaid Enrollees eligible for Specialty Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid beneficiaries who participate in managed care:

- State fair hearings through authority of 42 CFR 431.200 et seq.
- PIHP appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid Enrollees, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, Chapters 7,7A, 4 and 4A, including:

- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.).
- Medical Second Opinion through authority of the Mental Health Code (MCL 330.1705).

II. DEFINITIONS

The following terms and definitions are utilized in this Technical Requirement.

Adverse Benefit Determination: A decision that adversely impacts a Medicaid

Enrollee's claim for services due to: *(42 CFR 438.400)*

- 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. *42 CFR 438.400 (b)(1).*
- Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2).*
- Denial, in whole or in part, of payment for a service. *42 CFR 438.400(b)(3).*
- Failure to make a standard Service Authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service. *42 CFR 438.210(d)(1*).
- Failure to make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization. *42 CFR 438.210(d)(2).*
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP. *42 CFR 438.400(b)(4).*
- Failure of the PIHP to resolve standard appeals and provide notice within **30 calendar days** from the date of a request for a standard appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).*
- Failure of the PIHP to resolve expedited appeals and provide notice within **72 hours** from the date of a request for an expedited appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).*
- Failure of the PIHP to resolve grievances and provide notice within **90 calendar days** of the date of the request. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*
- For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under *§ 438.52(b)(2)(ii),* to obtain services outside the network. *42 CFR 438.400(b)(6).*
- Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. *42 CFR 438.400(b)(7).*

Adequate Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to deny or limit authorization of Medicaid services requested, which notice must be provided to the Medicaid Enrollee on the same date the Adverse Benefit Determination takes effect. *42 CFR 438.404(c)(2).*

Advance Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to reduce, suspend or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid Enrollee at least **10 calendar days prior** to the proposed date the Adverse Benefit Determination is to take effect. *42 CFR 438.404(c)(1); 42 CFR 431.211*.

Appeal: A review at the local level by a PIHP of an Adverse Benefit Determination, as defined above. *42 CFR 438.400*.

Authorization of Services: The processing of requests for initial and continuing service delivery. *42 CFR 438.210(b).*

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

Enrollee: A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program**.** *42 CFR 438.2*.

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by an 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, the PIHP determines if the request is warranted. If the Enrollee's provider makes the request, or supports the Enrollee's request, the PIHP must grant the request. *42 CFR 438.410(a).*

Grievance: Enrollee's expression of dissatisfaction about PIHP/CMHSP service issues, 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 the PIHP to make a service authorized decision. *42 CFR 438.400*.

Grievance Process: Impartial local level review of an Enrollee's Grievance**.**

Grievance and Appeal System: The processes the PIHP implements to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them. *42 CFR 438.400*.

Medicaid Services: Services provided to an Enrollee under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

Notice of Resolution: Written statement of the PIHP of the resolution of a Grievance or Appeal, which must be provided to the Enrollee as described in *42 CFR 438.408*.

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

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, including but not limited to *42 CFR 438.210.*

State Fair Hearing: Impartial state level review of a Medicaid Enrollee's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

III. GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS

Federal regulation *(42 CFR 438.228)* requires the State to ensure through its contracts with PIHPs, that each PIHP has a grievance and appeal system in place for Enrollee's that complies with Subpart F of Part 438.

The Grievance and Appeal System must provide Enrollees:

- An Appeal process (one level, only) which enables Enrollees to challenge Adverse Benefit Determinations made by the PIHP or its agents.
- A Grievance Process.
- The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints.
- Access to the State Fair Hearing process to further appeal an Adverse Benefit Determination, after receiving notice that the Adverse Benefit Determination has been upheld by the PIHP level Appeal.
- Information that if the PIHP fails to adhere to notice and timing requirements as outlined in PHIP Appeal Process, the Enrollee is deemed to have exhausted the PIHP's appeals process. The Enrollee may initiate a State fair hearing.
- The right to request, and have, Medicaid covered benefits continued while a local PIHP Appeal and/or State Fair Hearing is pending.
- With the written consent from the Enrollee, the right to have a provider or other authorized representative, acting on the Enrollee's behalf, file an Appeal or Grievance to the PIHP, or request a State Fair Hearing. The provider may file a grievance or request a state fair hearing on behalf of the Enrollee since the State permits the provider to act as the Enrollee's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so.

IV. NOTICE OF ADVERSE BENEFIT DETERMINATION

A PIHP is required to provide timely and "adequate" notice of any Adverse Benefit Determination. *42 CFR 438.404(a)*.

A. Content & Format: The notice of Adverse Benefit Determination must meet the following requirements: *(42 CFR 438.404(a)-(b))*

1. Enrollee notice must be in writing, and must meet the requirements of 42 CFR 438.10 (i.e., "…manner and format that may be easily understood and

is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency);

2. Notification that *42 CFR 440.230(d)* provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures;

3. Description of Adverse Benefit Determination;

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

5. Notification of the right of 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, any processes, strategies, or evidentiary standards used in setting coverage limits);

6. Notification of the Enrollee's right to request an Appeal, including information on exhausting the PIHP's single local appeal process, and the right to request a State Fair Hearing thereafter;

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

8. Notification of the Enrollee's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the Enrollee may be required to pay the costs of the continued services (only required when providing "Advance Notice of Adverse Benefit Determination";

9. Description of the procedures that the Enrollee is required to follow in order to exercise any of these rights; and

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

B. Timing of Notice: *(42 CFR 438.404(c))*

1. Adequate Notice of Adverse Benefit Determination:

   a. For a 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. *42 CFR 438.404(c)(2).*

b. For a Service Authorization decision that denies or limits services notice must be provided to the Enrollee within 14-days following receipt of the request for service for standard authorization decisions, or within 72-hours after receipt of a request for an expedited authorization decision. *42 CFR 438.210(d)(1)-(2); 42 CFR 438.404(c)(3)&(6).*

c. For Service Authorization decisions not reached within 14-days for standard request, or 72-hours for an expedited request, (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire. *42 CFR 438.404(c)(5).*
   - NOTE, however, that the PIHP may be able to extend the standard Service Authorization timeframe in certain circumstances *(42 CFR 438.210(d)(1)(ii)).* If so, the PIHP must: (i) provide 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 he or she disagrees with that decision; and (ii) issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. *42 CFR 438.404(c)(4).*

2. Advance Notice of Adverse Benefit Determination:

a. Required for reductions, suspensions or terminations of previously authorized/ currently provided Medicaid Services.

b. Must be provided to the Enrollee at least ten (10) calendar days prior to the proposed effective date**.** *42 CFR 438.404(c)(1); 42 CFR 431.211.*

c. Limited Exceptions: The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, IF *(42 CFR 431.213; 42 CFR 431.214)*

   i. The PIHP has factual information confirming the death of an Enrollee;

   ii. The PIHP receives a clear written statement signed by an Enrollee that he no longer wishes services, or that gives information that requires 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 is ineligible under the plan for further services;

iv. The Enrollee's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address;

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

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(e)(7) of the Act;

viii. The date of action will occur in less than 10 calendar days.

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

C. Required Recipients of Notice of Adverse Benefit Determination:

1. The Enrollee must be provided written notice. *42 CFR 438.404(a); 42 CFR 438.210(c).*

2. The requesting 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 does NOT need to be in writing. *42 CFR 438.210(c).*

3. If the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an adverse benefit determination, and requires a written notice of action.

V. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

A. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the PIHP MUST continue the Enrollee's benefits if all of the following occur: *42 CFR 438.420*

1. The Enrollee files the request for Appeal timely (within 60 calendar days

from the date on the Adverse Benefit Determination Notice); *42 CFR 438.402(c)(2)(ii);*

2. The Enrollee files the request for continuation of benefits timely (on or before the latter of (i) 10 calendar days from the date of the notice of Adverse Benefit Determination, or (ii) the intended effective date of the proposed Adverse Benefit Determination). *42 CFR 438.420(a)*; and

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

B. Duration of Continued or Reinstated B**e**nefits *(42 CFR 438.420(c))***.** If the PIHP continues or reinstates the Enrollee's benefits, at the Enrollee's request, while the Appeal or State Fair Hearing is pending, the PIHP must continue the benefits until one of following occurs:

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

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

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

C. If the final resolution of the Appeal or State Fair Hearing upholds the PIHP's Adverse Benefit Determination, the PIHP may, consistent with the state's usual policy on recoveries and as specified in the PIHP's contract, recover the cost of services furnished to the Enrollee while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements. *42 CFR 438.420(d)*.

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

E. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations. *42 CFR 438.424(b)*

F. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a).*

VI. PIHP APPEAL PROCESS

A. Upon receipt of an adverse benefit determination notification, federal regulations

42 CFR 400 et seq., provide Enrollees the right to appeal the determination through an internal review by the PIHP. Each PIHP may only have one level of appeal. Enrollees may request an internal review by the PIHP, which is the first of two appeal levels, under the following conditions:

1. The Enrollee has **60 calendar days** from the date of the notice of Adverse Benefit Determination to request an Appeal. *42 CFR 438.402(c)(2)(ii).*

2. The Enrollee may request an Appeal either orally or in writing. Unless the Enrollee requests and expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal. *42 CFR 438.402(c)(3)(ii).*

   NOTE: Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal). *42 CFR 438.406(b)(3).*

3. In the circumstances described above under the Section entitled "Continuation of Benefits," the PIHP will be required to continue/reinstate Medicaid Services until one of the events described in that section occurs.

.

B. PIHP Responsibilities when Enrollee Requests an Appeal:

1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a).*

2. Acknowledge receipt of each Appeal. *42 CFR 438.406(b)(1).*

3. Maintain a record of appeals for review by the State as part of its quality strategy. *42 CFR 438.416.*

4. Ensure that the individual(s) who make the decisions on Appeals: *42* CFR 438.406(b)(2).

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

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

   c. Take into account 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.

5. Provide the Enrollee a reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing, and inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals; *42 CFR 438.406(b)(4).*

6. Provide the Enrollee and his/her 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 the PIHP in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. *42 CFR 438.406(b)(5).*

7. Provide opportunity to include as parties to the appeal the Enrollee and his or her representative, or the legal representative of a deceased Enrollee's estate; *42 CFR 438.406(b)(6*).

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

C. Appeal Resolution Timing and Notice Requirements:

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

2. Expedited Appeal Resolution (timing):

a. Available where the PIHP determines (for a request from the Enrollee) or the provider indicates (in making a request on the Enrollee's behalf or supporting the Enrollee's request) that 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. *42 CFR 438.410(a).*

b. The PIHP may not take punitive action against a provider who requests an expedited resolution or supports an Enrollee's appeal. *42 CFR 438.410(b).*

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

i. Transfer the appeal to the timeframe for standard resolution. 42 CFR 438.410(c)(1).

ii. Make reasonable efforts to give the Enrollee prompt oral notice of the denial. *42 CFR 438.408(c)(2), 438.410(c)(2)*.

iii. Within 2-calendar days, give 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**.** *42 CFR 438.408(c)(2), 438.410(c)(2).*

iv. Resolve the Appeal as expeditiously as the Enrollee's health condition requires but not to exceed 30 calendar days.

d. If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than **72-hours** after the PIHP receives the request for expedited resolution of the Appeal. *42 CFR 438.408.*

3. Extension of Timeframes: The PIHP may extend the resolution and notice timeframe by up to **14 calendar days** if the Enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the Enrollee's interest. *42 CFR 438.408(c).*

a. If the PIHP extends resolution/notice timeframes, it must complete all of the following: *42 CFR 438.408(c)(2)*

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

ii. Within 2-calendar days, give 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.

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

4. Appeal Resolution Notice Format:

a. The PIHP must provide Enrollees with written notice of the resolution of their Appeal, and must also make reasonable efforts to provide oral notice in the case of an expedited resolution. *42 CFR 438.408(d)(2).*

b. Attached to this agreement are recommended notice templates for grievance and appeals. They are titled, Exhibit A "Notice of Adverse

Benefit Determination", Exhibit B "Notice of Receipt of Appeal/Grievance", Exhibit C Notice of Appeal Approval", and Exhibit D "Notice of Appeal Denial". These templates incorporate the information needed to meet the requirement of grievance and appeal recordkeeping in 42 CFR 438.416. Specifically, 42 CFR 438.416 indicates the State must require the PIHP maintain records with (at minimum) the following information:

(1) A general description of the reason for the appeal or grievance.
(2) The date received.
(3) The date of each review or, if applicable, review meeting.
(4) Resolution at each level of the appeal or grievance if applicable.
(5) Date of resolution at each level, if applicable.
(6) Name of the covered person for whom the appeal or grievance was filed.

Further this recordkeeping must be "accurately maintained in a manner accessible to the state and available upon request to CMS."

IF the PIHP chooses not to use the recommended notice templates the alternatives used by the PIHP must include the required information under 42 CFR 438.416 as noted above.

c. Enrollee notice must meet the requirements of *42 CFR 438.10* (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

5. Appeal Resolution Notice Content: *42 CFR 438.408(e)*

a. The notice of resolution must include the results of the resolution and the date it was completed.

b. When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's:
   i. Right to request a state fair hearing, and how to do so;
   ii. Right to request to receive benefits while the state fair hearing is pending, and how to make the request; and
   iii. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination

VII. GRIEVANCE PROCESS

A. Federal regulations provide Enrollees the right to a grievance process to seek resolution to issues that are not Adverse Benefit Determinations. *(42 CFR 438.228)*

B. Generally:

1. Enrollees must file Grievances with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances.

2. Grievances may be filed at any time by the Enrollee, guardian, or parent of a minor child or his/her legal representative. *42 CFR 438.402(c)(2)(i).*

3. Enrollee's access to the State Fair Hearing process respecting Grievances is only available when the PIHP fails to resolve the grievance and provide resolution within **90 calendar days** of the date of the request. This constitutes an "Adverse Benefit Determination", and can be appealed to the MDHHS Administrative Tribunal using the State Fair Hearing process. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*

C. PIHP Responsibility when Enrollee Files a Grievance:

1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a).*

2. Acknowledge receipt of the Grievance. *42 CFR 438.406(b)(1).*

3. Maintain a record of grievances for review by the State as part of its quality strategy.

4. Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination. *42 CFR 434.32*

5. Ensure that the individual(s) who make the decisions on the Grievance:

   a. Were not involved in any previous level review or decision-making, nor a subordinate of any such individual. *42 CFR 438.406(b)(2)(i).*

   b. When the Grievance involves either (i) clinical issues, or (ii) denial of expedited resolution of an Appeal, are individual(s) who have appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.

   c. Take into account 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

D. Grievance Resolution Timing and Notice Requirements

1. Timing of Grievance Resolution: Provide the Enrollee a written notice of resolution not to exceed **90 calendar days** from the day the PIHP received the Grievance.

2. Format and Content of Notice of Grievance Resolution:

a. Enrollee notice of Grievance resolution must meet the requirements of 42 CFR 438.10 (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

b. The notice of Grievance resolution must include:
   i. The results of the Grievance process;
   ii. The date the Grievance process was concluded;
   iii. Notice of the Enrollee's right to request a State Fair Hearing, if the notice of resolution is more than **90-days** from the date of the Grievance; and
   iv. Instructions on how to access the State Fair Hearing process, if applicable .

VIII. STATE FAIR HEARING APPEAL PROCESS

A. Federal regulations provide an Enrollee the right to an impartial review by a state level administrative law judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances:

1. After receiving notice that the PIHP is, after Appeal, upholding an Adverse Benefit Determination. *42 CFR 438.408(f)(1);*

2. When the PIHP fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals, as described in *42 CFR 438.408. 42 CFR 438.408(f)(1)(i).*

B. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the Enrollee, free to Enrollee, independent of State and PIHP, and not extend any timeframes or disrupt continuation of benefits). *42 CFR 438.408(f)(1)(ii).*

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

D. Enrollees are given **120 calendar days** from the date of the applicable notice of resolution to file a request for a State Fair Hearing. *42 CFR 438.408(f)(2).*

E. The PIHP is required to continue benefits, if the conditions described in Section V, MEDICAID SERVICES CONTINUATION OR REINSTATEMENT are satisfied, and for the durations described therein.

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

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

H. Expedited hearings are available.

Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at:

www.Michigan.gov/mdhhs>>Assistance Programs>>Medicaid>>Medicaid Fair Hearings http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html
OR

Department of Licensing and Regulatory Affairs
Michigan Administrative Hearing System Fair Hearing
http://www.michigan.gov/lara/0,4601,7-154-10576_61718_77732---,00.html

IX. RECORDKEEPING REQUIREMENTS

The PIHP is required to maintain records of Enrollee Appeals and Grievances, which will be reviewed by the PIHP as part of its ongoing monitoring procedures, as well as by State staff as part of the State's quality strategy.

A PIHP's record of each Grievance or Appeal must contain, at a minimum:

A. A general description of the reason for the Grievance or Appeal;
B. The date received;
C. The date of each 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. Name of the covered person for whom the Grievance or Appeal was filed.

PIHPs must maintain such records accurately and in a manner accessible to the State and available upon request to CMS.

HEARING SUMMARY

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

INSTRUCTIONS:

Complete this form and mail it at least **seven (□) calendar days** prior to the scheduled hearing to:

- **MICHIGAN ADMINISTRATIVE HEARING SYSTEM**
  FOR THE DEPARTMENT OF
  HEALTH AND HUMAN SERVICES
  PO BOX □□□□□
  LANSING MI □□□□□

- **AND TO THE CLIENT/BENEFICIARY**

If you have questions, you may call toll free
□ **(**□□□**)** □□□**-**□□□□

SECTION □ □ Client Information:

Client Name	Client Number	Co.	Dist.	Sect.	Unit	Wkr.

SECTION □ □ Hearing Summary:

1. Effective Date of Action	2. Date Client was Notified of Department Action	3. Date Hearing Requested

4. Were Medicaid services continued pending outcome of the hearing□	5. Was Conference Held Prior to Hearing□
☐ **NO** ☐ **YES**	☐ **NO** ☒ **YES**

6. Explanation of Action(s) Taken:

7. Facts and Fact Sources Used in Taking This Action(s):
I

8. Law(s), Regulation(s) and Policy Manual Item(s) Used in Taking This Action(s):

SECTION □ □ Signature:

9. Prepared By: (Signature)	10. Date Signed	11. Phone Number

The Michigan Department of Health and Human Services does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

COMPLETION: Is Voluntary

FORMS REQUISITION

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH

INSTRUCTIONS:

- Order only the forms listed below on this requisition.
- All other items will be deleted.
- Indicate the quantity **NEEDED** (distributed by each)
- Make a PHOTOCOPY for your records.
- Allow □ **weeks** for processing and delivery.
- You may also fax your order to: **(**□□□**)** □□□**-**□□□□
- **This form and all forms listed below are available at:**
  www.michigan.gov/mdhhs □□ Assistance Programs □□ Medicaid □□ Medicaid Fair Hearings

Complete this form and mail it to:
MICHIGAN ADMNISTRATIVE HEARING SYSTEM
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PO BOX □□□□□
LANSING MI □□□□□

REQUESTER INFORMATION:

Requesting Business or Office Name Detroit Wayne Mental Health Authority		Date of Request 07/07/20166	Phone Number **( )313344-9099 Ext 3207 -**
To The Attention of Pamjela J. Oehmke, LMSW, LMFT, CAADC		Approval Signature(s) (as needed)	
Delivery Address (Number and Street) 707 W. Milwaukee - Customer Service			
City Detroit	State MI	□IP Code 48202	

□□ COMMODITY NUMBER	□□ QUANTITY NEEDED BY EACH	□□ FORM or ENVELOPE NUMBER	□□ FORM or ENVELOPE TITLE
4829-0092		DCH-0092	Request For An Administrative Hearing
4829-0093		DCH-0093	Hearing Request Withdrawal
4829-0367		DCH-0367	Hearing Summary
4829-0700		DCH-0700	Medicaid Fair Hearings Rights & Responsibilities Brochure
4829-0368	150	AHS-0368	Business Reply Envelope

Authority:	None	The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.
Completion:	Is Voluntary, but this information is required to obtain supply of the above printed materials.	

For Office Use Only

Administrative Services Approval	Date Processed	DMB - Processed by

Make a photocopy for your records

Maximus Case Submission Cover

MAXIMUS Federal Services

MEDICARE MANAGED CARE RECONSIDERATION BACKGROUND DATA FORM

1. CASE PRIORITY:

☐ Expedited
☐ Standard Service (Pre-authorization)
☐ Standard Claim (Reimbursement**)**

2-a. AMOUNT IN CONTROVERSY: $ _____

2-b. DATE(S) OF SERVICE IN QUESTION: _____

2-c. DOES THIS CASE INVOLVE A COST SHARING ISSUE?

☐ **Yes** ☐ **No**

3. DISMISSAL REASON *(Complete if sending for dismissal)*

☐ Untimely Filing
☐ Waiver of Liability missing
☐ Not an Authorized Rep
☐ Not a Valid Rep of Estate
☐ Other _____

Preservice

4-a. ENROLLEE DATA

Enrollee Name:_____ **HIC:**_____

Enrollee Street:_____ **Enrollee Phone:** _____

Enrollee City:_____ **State:**_____ **Zip:**_____

Is the Enrollee Deceased? ☐ **No** ☐ **Yes-** Date of Death____/___/_____

Is the Enrollee in Hospice? ☐ **No** ☐ **Yes-** Date of Election___/___/_____ (election form must be provided)

Does the Enrollee require the final Determination Notice in a language other than English?

☐ No ☐ Yes_____ (specify language)

4-b. APPEAL REQUESTOR DATA (check one)

☐ **Enrollee is Requestor**

☐ Enrollee's treating physician (no AOR required for Expedited or Standard Service cases)

☐ Enrollee's Estate	Is Estate Documentation in File?	☐ Yes	☐ No
☐ Non-Contract Provider (payment cases only)	Is a Waiver of Liability in File?	☐ Yes	☐ No
☐ Representative	Is an AOR or Power of Attorney in File?	☐ Yes	☐ No
☐ Surrogate acting in accordance with State Law		☐ Yes	☐ No

Name of Requestor:_____ Phone:_____

Company Name:_____

Street:_____

City:_____ State:_____ Zip:_____

5. MEDICARE HEALTH PLAN (MHP) DATA

CMS Contract # (REQUIRED):_____

Plan Name:_____

Plan Type: ☐HMO ☐ MSA ☐HCPP ☐Cost ☐PSO ☐Local PPO ☐Regional PPO ☐Demo ☐PFFS ☐SNP ☐PACE ☐ MMP

Address for Appeal Correspondence:

Street: _____

City:_____

State:_____ Zip:_____

6. MHP CONTACT PERSON FOR THIS RECONSIDERATION

Contact Person Name:_____ **Email:**_____

Phone:_____

RI Fax Number:_____ **Decision Letter Fax Number:**_____

Alternate Contact Person or Supervisor Name:_____ **Phone:**_____

7. MHP ORGANIZATION DETERMINATION (Complete for all cases, including cases sent for dismissal.)

a.	**Date of Initial Authorization request or claim submission**	____/____/____
b.	**Date of Plan's initial Denial (Organization Determination)**	____/____/____
c.	**Was an Expedited request made?**	☐ Yes ☐ No
d.	**Was the expedited request granted?**	☐ Yes ☐ No
e.	**Did the plan take an extension? (If so, please provide notice in file)**	☐ Yes ☐ No

8. MHP RECONSIDERATION (Complete for all cases, including cases sent for dismissal.)

a.	**Date of Reconsideration Request**	____/____/____
b.	**Date of Plan's Reconsideration Determination (or date plan forwards dismissal to IRE)**	____/____/____
c.	**Was an Expedited request made? (n/a for dismissals)**	☐ Yes ☐ No
d.	**Was the expedited request granted? (n/a for dismissals)**	☐ Yes ☐ No
e.	**Did the plan take an extension? (If so, please provide notice in file)(n/a for dismissals)**	☐ Yes ☐ No

9. If the plan is requesting a dismissal in this case, did the plan take an extension to try to get an Appointment of Representation? ☐ Yes ☐ No

10. PROVIDER IDENTIFICATION DATA- Please List All Providers applicable to this appeal, including referring providers

Provider Name(s)	**Specialty**	**Records Requested?**	**Records Provided?**	**Contract Provider?**
1. _____	_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. _____	_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. _____	_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. _____	_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Services received/requested outside of the MHP's geographic service area?	☐ **Yes**	☐ **No**	
Services received/requested outside of MHP's network of providers?	☐ **Yes**	☐ **No**	
Services received/requested outside of Enrollee's medical group?	☐ **Yes**	☐ **No**	☐ **N/A**

11. DEFINITION OF DENIED SERVICES OR CLAIMS

Item/service in dispute _____

Enrollee's ICD-9/10 diagnosis code(s) applicable to the issues in this case: _____

_____

_____

HCPCS/CPT codes representing the items/services in dispute _____

(Please do not substitute revenue codes for outpatient hospital services) _____

CASE NARRATIVE OUTLINE (Attach to file as a document separate from the Background Data Form)

Please note, if the reason for coverage denial is that covered services must be given by **a contracted provider who is associated with a specific PCP group/network** it is important that you **include that information in the case file narrative**.

1. **CASE SUMMARY** (Please make sure to include the following: Enrollee name, age, sex, specific plan (i.e., Value plan vs. Deluxe Plan) and information about any supplemental riders that the enrollee may have, in addition to a description of the item/service in dispute)

2. **CHRONOLOGY OF CARE** (This should be a brief overview of the timeline of events in this case. Please refer to claim numbers for dates of service as appropriate)

3. **APPELLANT'S ARGUMENTS FOR COVERAGE**

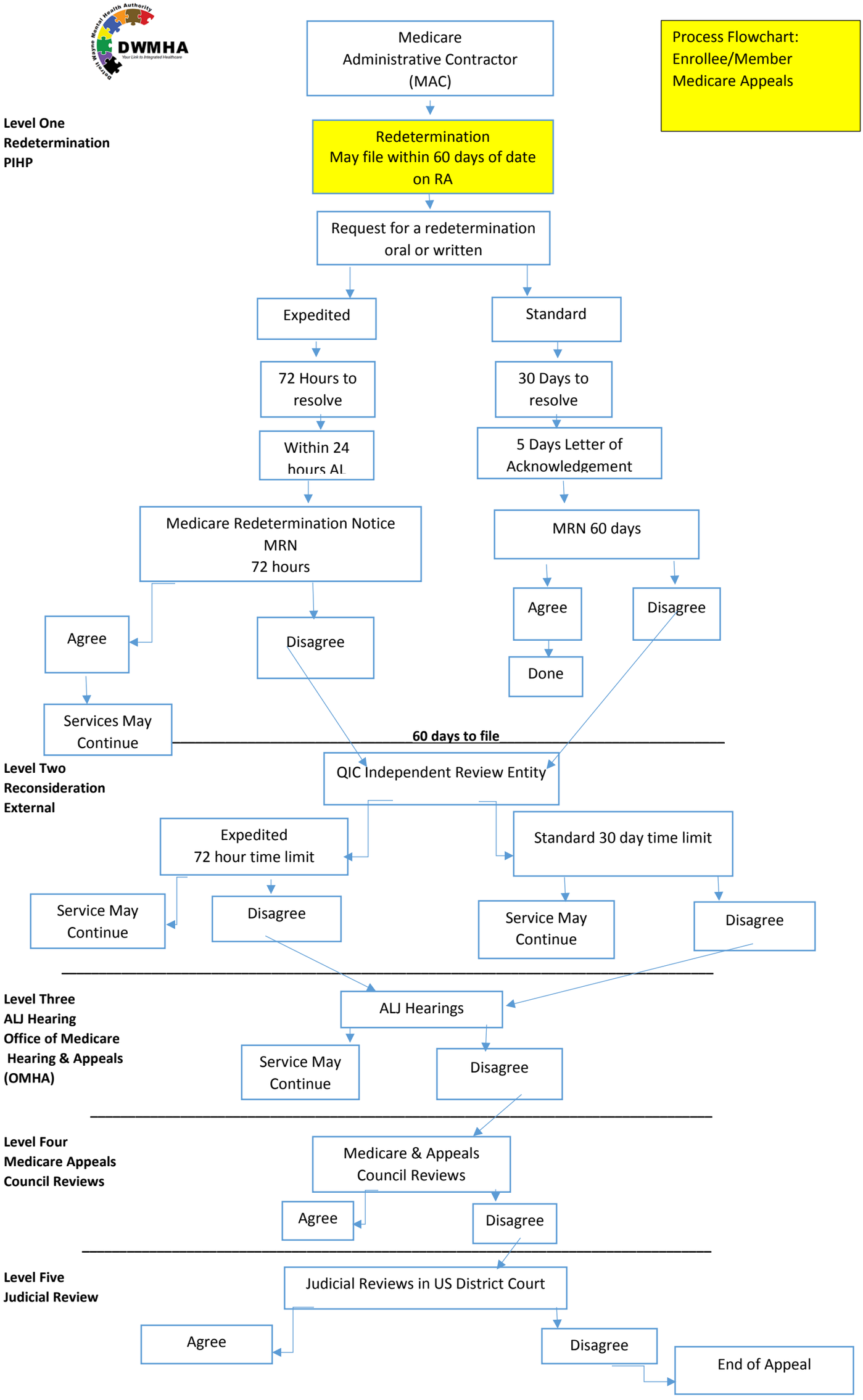
4. **MHP RATIONALE FOR DENIAL**

5. **JUSTIFICATION(i.e. citations to rules upon which plan denied coverage)**

6. **Please indicate if the Following Documents are included in the file**

a.	**Organization Determination Notice <u>with appeal rights</u>**	☐ **Yes**	☐ **No**
b.	**Notice of Appeal Status/Closure letter**	☐ **Yes**	☐ **No**
c.	**Appeal Letter (or phone records if expedited request was made)**	☐ **Yes**	☐ **No**
d.	***Evidence of Coverage**	☐ **Yes**	☐ **No**
e.	**Criteria used to reach decision**	☐ **Yes**	☐ **No**
f.	**Medical Records (legible)**	☐ **Yes**	☐ **No**
g.	**Original X-rays, Digital X-ray prints, Photographs**	☐ **Yes**	☐ **No**

***Please note: we encourage MHPs to submit these types of files in an electronic format on a CD. Please note: .PDF format is preferable.**


Process Flowchart:
Enrollee/Member
Medicare Appeals
Medicare
Administrative Contractor
(MAC)
Level One
Redetermination
PIHP
Redetermination
May file within 60 days of date
on RA
Request for a redetermination
oral or written
Expedited
Standard
72 Hours to
resolve
30 Days to
resolve
Within 24
hours AL
5 Days Letter of
Acknowledgement
Medicare Redetermination Notice
MRN
72 hours
MRN 60 days
Agree
Disagree
Agree
Disagree
Done
Services May
Continue
60 days to file
Level Two
Reconsideration
External
QIC Independent Review Entity
Expedited
72 hour time limit
Standard 30 day time limit
Service May
Continue
Disagree
Service May
Continue
Disagree
Level Three
ALJ Hearing
Office of Medicare
Hearing & Appeals
(OMHA)
ALJ Hearings
Service May
Continue
Disagree
Level Four
Medicare Appeals
Council Reviews
Medicare & Appeals
Council Reviews
Agree
Disagree
Level Five
Judicial Review
Judicial Reviews in US District Court
Agree
Disagree
End of Appeal