

APPEAL AND GRIEVANCE RESOLUTION PROCESSES TECHNICAL REQUIREMENT

I. SUMMARY BACKGROUND

All consumers have the right to a fair and efficient process for resolving complaints regarding their services and supports managed and/or delivered by Prepaid Inpatient Health Plans (PIHPs), their affiliate community mental health services programs (CMHSPs), substance abuse coordinating agencies (CAs) and their provider networks. The Michigan Department of Community Health (MDCH) expects that each CMHSP and CA will maintain a local appeal and grievance resolution process, but the PIHP that manages the Medicaid funds will assure that any affiliates it may have are compliant with this requirement as it relates to the Medicaid beneficiaries they serve. A recipient of, or applicant for, mental health specialty services and supports may access several options to pursue the resolution of a grievance or appeal. These options are defined through the Recipient Rights requirements referenced in the Michigan Mental Health Code (hereafter referred to as the Code) for all recipients of public mental health services, federal law for Medicaid recipients including the Balanced Budget Act (BBA) of 1997 which assures greater beneficiary protections, and the MDCH/PIHP and CMHSP contracts. It is important to note that an individual receiving mental health specialty services and supports may pursue appeals or grievances using multiple options simultaneously. The PIHPs/CMHSPs are reminded that they are expected to comply with the Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency (LEP) when they provide written notices to recipients and engage in oral resolution processes. In addition, PIHPs/CMHSPs are expected to provide reasonable assistance to persons who have illiteracy, hearing-impairments or visual-impairments.

Chapters 7, 7A, 4 and 4a of the Code describe the broad set of rights and protections for recipients of public mental health services, as well as the procedures for the investigation and resolution of recipient rights complaints. For the purposes of this requirement, the focus will be on those appeals related to the actions of denial, reduction, suspension or termination of services and supports; and grievances about any matter other than an action, such as quality of care or relationships. Specifically, the purpose of this document is to provide operational guidance to PIHPs and CMHSPs to meet the requirements of the MDCH/PIHP and CMHSP contracts regarding grievance and appeal systems, contained in Section 6.3.2. Recipient Rights and Grievance/Appeals.

This requirement is based upon the premise that all recipients of, or applicants for, public mental health services will receive notice of their rights and an explanation of the recipient rights complaint, grievance and appeal resolution processes. This requirement in no way requires the exhaustion of local grievance or appeal resolution processes prior to the filing of a recipient rights complaint pursuant to Chapter 7 and 7A

of the Code or prior to filing a request for a Medicaid fair hearing when Medicaid covered services are involved.

II. UNDERLYING VALUES AND PRINCIPLES

Properly structured grievance and appeal resolution processes for consumers should promote the resolution of consumer concerns, as well as support and enhance the overall goal of improving the quality of care. The grievance and appeal resolution processes should be:

- Timely
- Fair to all parties
- Administratively simple
- Objective and credible
- Administratively simple
- Objective and credible
- Accessible and understandable to consumers
- Cost and resource efficient
- Subject to quality review

In addition, the process should:

- Not interfere with communication between consumers and their PIHP service providers.
- Assure that service providers who participate in a grievance, appeal or dispute resolution on behalf of consumers should be free from discrimination or retaliation.
- Assure that consumers who file a grievance should be free from discrimination or retaliation.

(Adapted from the Consumer Bill of Rights and Responsibilities, A report to the President of the United States, prepared by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, November 1997)

III. DEFINITIONS

- A. Action: A determination impacting a Medicaid beneficiary's claim for services through:
1. Denial or limited authorization of a requested Medicaid or non-Medicaid service, including the type or level of service.
 2. Reduction, suspension, or termination of a previously authorized Medicaid or previously provided non-Medicaid covered service.
 3. Denial, in whole or in part, of payment for a Medicaid or non-Medicaid covered service.
 4. Failure to make an authorization decision and provide notice about the decision in within 14 calendar days from the date of the receipt of a standard request for service.

5. Failure to make an expedited authorization decision within three working days from the date of receipt of a request for expedited service authorization.
 6. Failure to provide 14 calendar days of the start date agreed upon during person-centered planning and authorized by the PIHP.
 7. The failure of the PIHP to act within 45 calendar days from the receipt of a request for a standard appeal.
 8. The failure of the PIHP to act within three working days from the date of the request for an expedited appeal.
 9. Failure of the PIHP to provide disposition and notice of a local grievance/complaint within 60 calendar days of the date of the request.
- B. Additional Medicaid Mental Health Services: Supports and services available to Medicaid beneficiaries who meet the criteria for specialty services and supports, through the authority of Section 1935(b)(3) of the Social Security Act.
- C. Adequate notice – Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid services requested. Notice is provided to the beneficiary at the same time an action takes effect or at the time of the signing of the individual plan of services/supports.
- D. Advance notice – Written statement advising the beneficiary of a decision to reduce, suspend or terminate Medicaid services. Notice is provided/mailed to the beneficiary at least 12 days prior to the proposed date of when the action is to take effect.
- E. Appeal - a request for a review of an action
- F. Authorization of Services: The processing of request by the PIHP for initial and continuing service delivery.
- a. Beneficiary: An individual who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid services through a PIHP.
 - b. Complaint: Oral or written communication by or on behalf of a beneficiary that expresses dissatisfaction with any aspect of the PIHP's or provider's operation.
 - c. Fair Hearing: Impartial state level review of a Medicaid beneficiary's appeal of an action presided over by a MDCH Administrative Law Judge
- G. Grievance - a Medicaid beneficiary's expression of dissatisfaction about any matter relative to a Medicaid or non-Medicaid service, other than an action as defined above, which does not involve a rights complaint as defined below. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the consumer.
- H. Local appeal: A local level review of a Medicaid beneficiary's appeal of an action.
- I. Medicaid covered service - Medicaid State Plan, additional services provided under the authority of Section 1915(b)(3) of the Social Security Act, Children's Waiver or Habilitation Supports Waiver services.
- J. Notice of Disposition – Written statement of the decision of the PIHP provided to the grievances and local appeals process.
- K. Recipient Rights complaint - a written or verbal statement by a recipient or anyone acting on behalf of a recipient alleging a violation of a Code protected

right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

IV. INFORMATION REQUIREMENTS

All beneficiaries must be provided information about grievance, appeal, and fair hearing procedures and time frames. The PHP should use the information developed and produced by the State of Michigan that includes:

- The right to state fair hearing
 - The method for obtaining a hearing
 - The rules that govern representation at the hearing
- The right to file grievances and appeals
 - The requirements and time frames for filing a grievance or appeal
 - The availability of assistance in the filing process
 - The toll-free number that beneficiaries can use to file a grievance or appeal by phone
- The fact that, when requested by the beneficiary, benefits will continue if he/she files an appeal or a request for fair hearing within the time frames specified for filing; and that the beneficiary may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the beneficiary.

V. NOTICE REQUIREMENTS

- A. Notice is given whenever a Medicaid service is denied, reduced, suspended or terminated. The notice must be in writing and must be provided in the language format needed by the individual to understand the content (i.e., the format meets the needs of those with limited English proficiency, and/or limited reading proficiency).

Action	Type of Notice	Time frame for Notice
Denial of service request	Adequate	At the time of decision
Person-centered Plan developed	Adequate	At the time of plan development
Increase in benefits	Adequate	At the time of the action
Reduction, suspension or termination of service currently being received	Advance	12 days before action
Standard authorization decision that denies or limits services requested	Adequate	Within 14 days of request*
Expedited authorization decision that denies or limits services requested	Adequate	Within 3 working days of request
Unreasonable delay of start of services	Adequate	At the time of the action

**The timeframe may be extended up to another 14 days at the request of the beneficiary or provider.*

Note: *If a consumer's physician makes a determination that a particular Medicaid service is not medically needed, no adverse action occurred. In these instances, an advance notice of adverse action is not required.*

- B. The written notice of action (as defined above) must contain the following:
1. The action the PIHP/CMHSP or its contactor has taken or intends to take.
 2. The reasons for the action.
 3. The date of the intended action.
 4. If access to services or hospitalization is denied, the right to request a second opinion and an explanation of the process.
 5. The consumer's right to file an appeal, dispute and/or rights complaint (the latter is relative only to the suspension, reduction or termination of a service or the denial of hospitalization) and the timeframes for doing so.
 6. The beneficiary's right to request a MDCH Fair Hearing and the timeframes for doing so.
 8. The procedures for exercising the resolution options.
 9. The circumstances under which expedited resolution is available and how to request it.
 10. The beneficiary's right to have benefits continue pending resolution of the appeal or MDCH Fair Hearing decision, how to request that benefits be continued, and the circumstances under which the consumer may be required to pay the costs of these services. NOTE: Notice must specify that if the consumer requests a MDCH Fair Hearing prior to the date of action (i.e. suspension, reduction, or termination of a Medicaid covered service), in most circumstances the PIHP/CMHSP may not reduce, suspend or terminate the services until a decision is rendered after the hearing.
- C. Time frames for written notice of action: The PIHP/CMHSP must mail/provide the notice to the beneficiary within the following time frames:
1. For termination, suspension or reduction of previously authorized or provided services, at least **12 calendar days** before the date of action. (advance notice)
 2. For authorization or service decisions that deny or limit services within **14 calendar days** of the standard request for services, **or three working days** of the request for expedited authorization. If either of these time frames are extended at the beneficiary's or provider's request (up to an additional 14 calendar days), the PIHP/CMHSP must give the beneficiary written notice of the reason for the extension, and inform the beneficiary of the right to file a grievance if dissatisfied with the decision to extend. (adequate notice)
 3. For authorization decisions that are not made within 14 calendar days (or three days for expedited authorization), and for which an extension has

not been agreed to, a notice must be provided to the beneficiary on the 14th day (or third working day for an expedited authorization).

4. In the case of the written individual plan of service/support (IPOS), at the time the plan is signed by the consumer, his/her guardian or parent of a minor consumer. (adequate notice)
- D. Exceptions to Advance Notice Rule: In addition to B.2. and B.3. above, the PIHP/CMHSP may mail a notice not later than the date of action if:
1. It has factual information confirming the death of the consumer.
 2. The PIHP/CMHSP receives a clear written statement signed by the recipient or his/her legal representative that:
 - a. He/she no longer wishes services; or
 - b. Gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying the information.
 3. The beneficiary has been admitted to an institution where he/she is ineligible under Medicaid for further services.
 4. The individual's whereabouts are unknown and the post office returns. PIHP/CMHSP mail directed to him/her indicating no forwarding address.
 5. It establishes the fact that the beneficiary has been accepted for Medicaid services by another PIHP.
 6. A change in the level of medical care is prescribed by the individual's physician.
 7. The PIHP/CMHSP may shorten the period of advance notice to five days before the date of action if it has facts indicating that the action should be taken because of probable fraud and these facts have been verified, if possible, through secondary sources.
- E. Maintaining Medicaid services and supports
1. If the PIHP/CMHSP mails the advance notice of action impacting Medicaid services as required above and the Medicaid beneficiary or his/her legal representative requests a MDCH Fair Hearing before the date of action in lieu of, or in addition to, filing an appeal, the PIHP/CMHSP may not terminate or reduce services until a decision is rendered after the hearing unless:
 - a. It is determined at the hearing that the sole issue is one of Federal or State law; **AND**
 - b. The PIHP/CMHSP promptly (i.e., in the advance notice) informs the beneficiary that services are to be terminated or reduced pending the MDCH hearing decision.
 2. If the PIHP/CMHSP's action is sustained by the Fair Hearing Decision, the PIHP/CMHSP may seek reimbursement from the beneficiary for the cost of any services provided the consumer during this period of time, up to the individual's ability to pay as determined by the Code.

- F. Reinstatement of Medicaid covered services
1. The PIHP/CMHSP must reinstate Medicaid services if a beneficiary or his/her legal representative requests a MDCH Fair Hearing not more than 12 calendar days after the date of action.
 2. The reinstated Medicaid services must continue until the hearing decision unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.
 3. The PIHP/CMHSP must reinstate and continue Medicaid services until a hearing decision, if:
 - a. Action was taken without the required advance notice; AND
 - b. The beneficiary or his/her legal representative requests a hearing within 12 calendar days of the mailing of the notice of action; AND
 - c. The PIHP/CMHSP determines that the action resulted from factors other than the application of Federal or State law or policy.
 4. If a beneficiary's whereabouts are unknown as indicated by return of non-forwardable mail from the PIHP/CMHSP, any discontinued Medicaid services must be reinstated if his/her whereabouts become known during the time he/she is eligible for services.

VI. APPEALS AND GRIEVANCE RESOLUTION PROCESSES

Action	Local Processes ²	State Level Processes
Denial of request for hospitalization	Step 1. Request 2 nd Opinion, then Step 2. Complaint to Office of Recipient Rights (see limitations under A.2.) Step 1.or 2. Appeal to Local Dispute Resolution Process	Step 1.or 2. Request for Fair Hearing (for Medicaid beneficiaries) Last Step: MDCH Alternative Dispute Resolution Process (for consumers without Medicaid)
Denial of access to PHP/CMHSP services	Step 1. Request 2 nd Opinion Step 1.or 2. Appeal to Local Dispute Resolution Process	Step 1.or 2. Request for Fair Hearing (for Medicaid beneficiaries) Last Step: MDCH Alternative Dispute Resolution Process (for consumers without Medicaid)
Denial, reduction, suspension, termination, or unreasonable delay of Medicaid services. ¹	Step 1.or 2. Appeal to Local Dispute Resolution Process and/or, Step 1.or 2. Complaint to Office of Recipient Rights (treatment suited to condition)	Step 1.or 2. Request for Fair Hearing (for Medicaid beneficiaries)
Dissatisfaction with program, provider, other	Step 1. Grievance with Local Dispute Resolution Process and/or, Step 1. Office of Recipient Rights (if complaint is violation of Mental Health code protected right)	
Denial of Family Support Subsidy	Step 1. Appeal to CMHSP	Step 2. MDCH Alternative Dispute Resolution Process

¹ Action taken at time of Person-centered planning, or as an outcome of the service authorization process or management decision

² Medicaid beneficiaries are not required to exhaust local dispute processes before they request a Medicaid Fair Hearing

Note about the steps: the Local Dispute Resolution Process may be engaged concurrently with appeal to ORR, and/or request for state Fair Hearing, unless otherwise noted.

PHPs are encouraged to offer mediation services as an alternative to formal dispute resolution processes. The beneficiary, however, is still entitled to the formal processes if he/she chooses.

- A. Denial of hospitalization – Any or all of the following processes may be utilized:
1. Request for second opinion
 - a. If a pre-admission screening unit or children’s diagnostic and treatment service of the PIHP/CMHSP denies hospitalization, the individual, his/her guardian or his/her parent in the case of a minor child, may request a second opinion from the executive director of the PIHP/CMHSP.
 - b. The request for the second opinion shall be processed in compliance with Sections 409(4), 498e(4) and 498h(5) of the Code. If the conclusion of the second opinion is different from the conclusion of the children’s diagnostic and treatment service or the pre-admission screening unit, the executive director, in conjunction with the medical director, shall make a decision based upon all clinical information available within **one business day**.
 2. Recipient Rights complaint
 - a. If the request for a second opinion itself is denied, the individual or someone on his/her behalf may file a rights complaint with the PIHP/CMHSP Office of Recipient Rights for processing under Chapter 7A.
 - b. If the initial request for inpatient admission is denied, **and** the individual is a current recipient of other PIHP/CMHSP services, the individual or someone on his/her behalf may file a rights complaint alleging a violation of his/her right to treatment suited to condition.
 - c. If the second opinion determines the individual is not clinically suitable for hospitalization **and** the individual is a current recipient of other PIHP/CMHSP services, **and** a recipient rights complaint has not been filed previously on behalf of the individual, the individual or someone on his/her behalf may file a complaint with the PIHP/CMHSP Rights Office for processing under Chapter 7A.
 3. Appeal - See Exhibit 1: Local Appeals Resolution Requirements and Process
 4. MDCH level:
 - a. Medicaid Fair Hearing (see page 8): for Medicaid beneficiary appeals on actions that impact Medicaid ~~covered~~ services.
 - b. MDCH Alternative Dispute Resolution (see page 9): for appeals on actions that impact non-Medicaid ~~covered~~ services.

- B. Denial of access to any services for individuals not receiving any PIHP/CMHSP services – Any or all of the following processes may be utilized:
1. Request for second opinion
If an initial applicant for public mental health services is denied such services, the applicant or his/her guardian, or the applicant's parent in the case of a minor must be informed of their right to request a second opinion of the executive director. The request shall be processed in compliance with Section 705 of the Code and must be resolved within **five business days**.
 2. Recipient Rights complaint
The applicant or his/her guardian may not file a recipient rights complaint for denial of services suited to condition as he/she does not have standing as a recipient of mental health services. The applicant or his/her guardian may, however, file a rights complaint if the request for a second opinion is denied.
 3. Appeal - See Exhibit 1: Local Appeals Resolution Requirements And Process
 4. MDCH Level:
 - a. Medicaid Fair Hearing (see page 8): for Medicaid beneficiary appeals on actions that impact Medicaid services.
 - c. MDCH Alternative Dispute Resolution (see page 9): for appeals on actions that impact non-Medicaid covered services.
- C. Denial through the service authorization process of the request for Medicaid service, or denial of the requested amount, scope or duration of a service that was identified and agreed upon by the beneficiary during person-centered planning
1. Rights complaint
 2. Appeal - See Exhibit 1: Local Appeals Resolution Requirements And Process
 3. MDCH level:
 - a. Medicaid Fair Hearing (see page 8): for Medicaid beneficiary appeals on actions that impact Medicaid services.
 - b. MDCH Alternative Dispute Resolution (see page 9): for appeals on actions that impact non-Medicaid covered services.
- D. Unreasonable delay of a Medicaid service beyond the start date agreed upon during person-centered planning and as authorized by the PIHP. Unreasonable delay is defined as **14 or more calendar days**.
1. Recipient Rights complaint
 2. Appeal - See Exhibit 1: Local Appeals Resolution Requirements And Process
 3. MDCH level:
 - a. Medicaid Fair Hearing (see page 8): for Medicaid beneficiary appeals on actions that impact Medicaid covered services.

- b. MDCH Alternative Dispute Resolution (see page 9): for appeals on actions that impact non-Medicaid covered services.
- E. Suspension, reduction or termination of a current Medicaid service - Any or all of the following processes may be utilized:
 - 1. Recipient Rights complaint
 - 2. Appeal - See Exhibit 1: Local Appeals Resolution Requirements And Process
 - 3. MDCH level:
 - a. Medicaid Fair Hearing (see page 8): for Medicaid beneficiary appeals on actions that impact Medicaid covered services.
 - b. MDCH Alternative Dispute Resolution (see page 9): for appeals on actions that impact non-Medicaid covered services.
- F. Dissatisfaction about any matter relative to a Medicaid service other than an action as described above.
 - 1. Grievance – See Exhibit 2: Grievance Process
Possible subjects include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a provider and the consumer.
 - 2. Recipient Rights complaint
Statements or allegations, verbal or written, by the consumer or anyone acting on his/her behalf that allege a violation of a Code protected right cited in Chapter 7 will be resolved through processes established in Chapter 7A.

VII. APPEAL OF DENIAL OF FAMILY SUPPORT SUBSIDY

Demand for CMHSP hearing and appeal

- 1. Pursuant to Section 159(3) of the Code, if an application for a family support subsidy is denied or a family support subsidy is terminated by a community mental health services program, the parent or legal guardian of the affected eligible minor may demand, in writing, a hearing by the community mental health services program. The hearing shall be conducted in the same manner as provided for contested case hearings under Chapter 4 of the Administrative Procedures Act of 1969, Act No. 306 of the Public Acts of 1969, being Sections 24.271 to 24.287 of the Michigan Compiled Laws."
- 2. Pursuant to the Administrative Rules: Copies of blank application forms, parent report forms, the forms for changed family circumstances, and appeal forms shall be available from the community mental health services program. (R330.1616 Availability of forms) (Note: It is acceptable to ask families to write a letter to the CMHSP requesting an appeals hearing, in lieu of a standardized form.)
- 3. A CMHSP shall review an application and promptly approve or deny the application and shall provide written notice to the applicant of its action

and of the opportunity to administratively appeal the decision if the decision is to deny the application. If the denial is due to the insufficiency of the information on the application form or the required attachments, the PIHP shall identify the insufficiency. (Rule R330.1641 Application review)

4. If an application is denied or the subsidy terminated, a parent or legal guardian may file an appeal. The appeal shall be in writing and be presented to the community mental health service program within two months of the notice of denial or termination. (R330.1643 Appeal)

VIII. MEDICAID FAIR HEARING REQUIREMENTS

For beneficiaries receiving Medicaid State Plan or Waiver services, the PIHP must comply with applicable sections of Federal Law 42 CFR 431.200-250 regarding fair hearings, as defined through the MDCH policy communications listed as references at the end of this document.

A. Background

Under a fee-for-service payment structure, Medicaid recipients received services from their physicians or other treating professionals who then submitted their bills for payment. Disputes generally involved payment, not treatment, and the recipients had their medical records and the expertise of their physicians or treating professionals to support the appropriateness of treatment.

Under a prepaid managed Medicaid system, the incentive for the managed care organization (i.e., PIHP) is to keep costs within the amount of pre-payment they receive from the state. The methodology to achieve this is utilization review. Disputes under this system are more likely to involve services denied, reduced or terminated as a result of actions taken by the managed care organization. Therefore, federal law and state Medicaid policy establish the requirements for adverse notice to Medicaid recipients whenever the managed care organization denies, suspends, reduces, or terminates Medicaid State Plan services or supports as a result of a utilization review function.

B. The key aspects of the Medicaid policy and federal law are as follows:

Whenever Medicaid State Plan or Waiver services are denied, suspended, reduced, or terminated as a result of a utilization review or authorization function by the PIHP or their contracting agencies, the agency must issue a written advance notice of adverse action to the affected beneficiary. In addition, adequate notice must be provided at the time the individual plan of service, developed through a person-centered planning process, is finalized with the consumer. For PIHPs where the utilization review function is not part of an identified organization program or unit (e.g., access centers, prior authorization and continued stay units, etc.), any denial, suspension, reduction, or termination of service that occurs outside of the person-centered planning process is considered an adverse action, requiring notification.

The beneficiary who has received notice of an action has the right to request a fair hearing with a MDCH administrative law judge. Beneficiaries are given **90 calendar days** from the date on the notice to file a request for fair hearing. They may concurrently file an appeal for local resolution. If the beneficiary files a request for fair hearing prior to the PIHP taking an adverse action, the PIHP must continue the service and not take the action until a fair hearing decision has been made.

Please refer to MDCH's Administrative Hearings Policy for detailed information and instructions about the Medicaid Fair Hearings process online at:

www.michigan.gov/documents/Manual_9658_7.pdf

[Note: Failure to make an authorization decision and provide written notice within **14 calendar days** of receipt of a non-emergent request for a service constitutes a service denial or adverse action. Failure to make authorization decisions within **three working days** after the receipt of an urgent (i.e., following a standard time frame for authorization could seriously jeopardize the beneficiary's health condition) request for service constitutes a service denial or adverse action. The PIHP may extend either time frame up to 14 additional calendar days if the beneficiary or provider requests an extension.]

IX. MDCH ALTERNATIVE DISPUTE RESOLUTION PROCESS

- A. Within **five business days** of receipt of the decision on the local dispute (appeal or grievance), the consumer, his/her guardian or parent of a minor recipient, may file a request for a MDCH level dispute resolution to:

Department of Community Health
Division of Program Development, Consultation and Contracts
Bureau of Community Mental Health Services
ATTN: Request for DCH Level Dispute Resolution
Lewis Cass Building – 6th Floor
Lansing, MI 48913

- B. If the DCH representative, using a “reasonable person” standard, believes that the denial, suspension, termination or reduction of the services and/or supports will pose an immediate and adverse impact upon the consumer's health and safety, the issue is to be referred within **one business day** to the Bureau of Community Mental Health Services for contractual action consistent with applicable provisions of the MDCH/CMHSP contract.

In all other cases, DCH shall complete its review of the dispute within **15 business days** of receipt. Written notice of the resolution shall be submitted to the consumer, his/her guardian or parent of a minor recipient.

X. RECORDKEEPING AND REPORTING REQUIREMENTS

The PIHP and CMHSP must maintain a record of appeals and grievances and their disposition that is available for review by State staff. The records should also contain sufficient information to accurately reflect:

- The process in place to track requests for Medicaid services denied by the PIHP or any of its providers.
- The volume of denied claims for services in the most recent fiscal year.

XI. REFERENCES

PA 516 of 1996

PA 258 of 1974, as amended

S.353-Health Insurance Bill of Rights of 1997

42 CFR Chapter IV, Subpart E, Sections 431.200 et seq

42 CFR Chapter IV, Subpart F, Sections 438.402 to 424

MDCH-MSA Policy Bulletin: Medicaid Eligibility Manual - Beneficiary Hearings

MDCH-MSA Policy Bulletin: Hourly Home Care - Criteria for Determining Number of Hours (Children's Waiver)

EXHIBIT 1

LOCAL APPEALS RESOLUTION REQUIREMENTS and PROCESS

- A. **Special requirements for appeals** - The process for appeals must:
1. Provide that oral requests for appeal of an action are treated as appeals (to establish the earliest possible filing date for the appeal), but must be confirmed in writing, unless the beneficiary requests expedited resolution.
 2. Give the beneficiary reasonable assistance in completing forms and taking other steps to complete the appeals process. This assistance includes, but is not limited to, interpreter services, and toll-free numbers that have TTY/TTD and interpreter capability.
 3. Provide the beneficiary a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The PIHP must inform the beneficiary of the limited time available for this in the case of expedited resolution.)
 4. Provide the beneficiary and his/her representative opportunity, before and after the appeals process, to examine the consumer's case file, including medical records, and any other documents considered during the appeal process.
 5. Include, as parties to the appeal:
 - a. The beneficiary and his/her representative; or
 - b. The legal representative of a deceased consumer's estate.
- B. **Appeal process**
1. Within **45 calendar days** of receipt of the action notice, the consumer or his/her legal representative, or the provider on his/her behalf, may file an appeal with the PIHP Customer Services or Recipient Rights Office (whichever is approved and administratively responsible for facilitating appeals), which shall then:
 - a. Log receipt of the appeal for reporting to the PIHP Quality Improvement Program.
 - b. Acknowledge receipt of the appeal; and for a Medicaid beneficiary disputing an action that impacts a Medicaid covered service, advise the individual, guardian, or in the case of a minor, the parent, that he/she may file a request for a MDCH Fair Hearing in lieu of, or in addition to, the appeal. Information shall include the process for filing the request for a hearing, an offer of assistance in filing the request and an explanation of time frames and circumstances under which Medicaid services will be continued pending the hearing decision.
 - c. Submit the appeal for review by appropriate staff, including a health care professional who has the appropriate clinical expertise in treating the beneficiary's condition, and a PIHP administrator with the authority to require corrective action, all of whom were not involved in the initial determination to deny, suspend, terminate or

- reduce the Medicaid covered service.
- d. Facilitate review of the appeal within **10 calendar days** from receipt of the appeal.
 - e. Assure an expedited review of an appeal involving an emergent situation where the standard 10-day time frame would seriously jeopardize the health or life of the individual. Such a review shall be completed within **three working days** of receipt of the appeal.
 - f. Assure the content of the resolution notice and timeframe for submission to the consumer and his/her legal representative complies with subsection 2. below.

2. **Resolution notice**

- a. Content of resolution notice: Written notice of the appeal resolution must include:
 - (1) The results of the resolution process and the date it was completed.
 - (2) For appeals not resolved wholly in favor of the Medicaid beneficiary disputing action taken that impacts Medicaid covered services:
 - The right to request a MDCH Fair Hearing, and how to do so, including an offer of assistance;
 - The right to request to receive services while the hearing is pending, how to make the request, including an offer of assistance; and
 - The consumer may be held liable for the cost of those services if the hearing decision upholds the PIHP's action.
 - (3) For appeals not resolved wholly in favor of the consumer who is disputing action taken that impacts non-Medicaid covered services:
 - The right to seek MDCH alternative dispute resolution, how to do so, and an offer of assistance.
 - (4) For appeals resolved to the satisfaction of the beneficiary or his/her legal representative, an explanation of, and an offer of assistance in the process for withdrawing any request filed for a MDCH Fair Hearing.
- b. Timing of resolution notice:
 - (1) Written notice of the appeal resolution must be submitted to the consumer and his/her legal representative within **10 calendar days** following receipt of the appeal.
 - (2) For notice of an expedited appeal, the PIHP must make reasonable efforts to provide oral notice as soon as possible followed by written notice within **two calendar days** following the receipt of the appeal.

EXHIBIT 2

GRIEVANCE PROCESS

1. The consumer, guardian, or parent of a minor child or his/her legal representative may file a grievance at any time regarding dissatisfaction with any aspect of service provision other than an adverse action as defined in this requirement or an allegation of a recipient rights violation. The beneficiary must be given reasonable assistance in completing forms for filing a grievance. The grievance shall be filed with the PIHP/CMHSP Customer Services or Recipient Rights Office, whichever is approved and administratively responsible for facilitating resolution of the grievance.

2. Customer Services or the Recipient Rights Office shall then:
 - a. Log receipt of the verbal or written grievance for reporting to the PIHP/CMHSP Quality Improvement Program.
 - b. Determine whether the grievance is more appropriately a recipient rights complaint, and if so, refer the grievance, with beneficiary's permission, to the Office of Recipient Rights
 - c. Acknowledge to the beneficiary the receipt of the grievance
 - d. Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of whom shall have been involved in the initial determination.
 - e. Facilitate resolution of the grievance within **30 calendar days** of receipt of the grievance.
 - f. Within **five calendar days** of a decision by the PIHP/CMHSP regarding the grievance, notification of the outcome of the process is provided to the consumer, guardian, or parent of a minor child.

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