LAPEER COUNTY COMMUNITY MENTAL HEALTH **Date Issued** 06/13/2001
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CHAPTER Recipient Rights	**CHAPTER** 04	**SECTION** 001	**SUBJECT** 10
SECTION Recipient Rights	**DESCRIPTION** Grievance and Appeals and Second Opinion Process		
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APPLICATION:

☒CMH Staff	☒Board Members	☒Provider Network	☒Employment Services Providers
☐Employment Services Provider Agency	☒Independent Contractors	☒Students	☒Interns
☒Volunteers	☒ Persons Served		

POLICY:

Lapeer County Community Mental Health (LCCMH) follows all state and federal regulations ensuring a fair and efficient process for resolving complaints regarding services and supports.

STANDARDS:

A. For persons served with Medicaid, LCCMH follows the Region 10 Prepaid Inpatient Health Plan (PIHP) Grievance and Appeals Policy to assure the right to a fair and efficient process for resolving disagreements, in compliance with state and federal regulations. See Grievance and Appeal System Policy #07.02.01 at www.region10pihp.org

B. For persons served without Medicaid, this policy outlines the local grievance and appeals processes.

C. Persons served in publicly funded services may access several options to pursue the resolution of complaints. These options include filing a local appeal, filing a grievance, filing a Recipient Rights Violation Complaint, or requesting a second opinion.

1. Persons with Medicaid may also request a State Fair Hearing. Standards and procedures for State Fair Hearings are covered in the Region 10 PIHP Grievance and Appeals Policy #07.02.01.

D. The Region 10 PIHP has delegated certain functions of the grievance and appeal process to LCCMH and Substance Use Disorder (SUD) providers, as defined in the PIHP/Provider Contractual Agreement. These functions are outlined in the Region 10 Grievance and Appeals Policy #07.02.01 and are formally monitored by the PIHP on an ongoing and annual basis.

E. Persons served are not required to utilize the grievance or appeal process prior to filing a Recipient Rights Complaint pursuant to Chapter 7 and 7a of the Michigan Mental Health Code and affiliate policies relative to the filing of Recipient Rights Complaints. This is also true for the Recipient Rights process for SUD services.

F. During the initial contact with Access, applicants are provided with information for the Grievance and Appeal System.

G. Persons served/applicants may file complaints independently or with the assistance of the Customer Services Representative, other available staff, or a person of their choosing. LCCMH and providers may not refuse to assist the person who needs help filing a complaint and submitting the complaint for resolution.

H. LCCMH and the provider network take necessary steps to make accommodations for persons served/applicants with limited English proficiency.

I. LCCMH provides information about the Grievance and Appeal System to all providers and subcontractors at the time they enter into a contract.

NOTICE OF ADVERSE BENEFIT DETERMINATION

A. LCCMH utilizes the Notice of Adverse Benefit Determination (ABD) for any determinations adversely impacting persons served or applicants' services or supports.

   1. Adequate Notice of ABD is used for the denial of payment for services (in part or whole) requested but not currently provided. Adequate Notice is

provided to the person served, applicant, or their guardian/representative on the effective date.

2. Advance Notice of ABD is used for reductions, suspensions, or terminations of previously authorized/currently provided services prior to the end of the current authorization. Advance Notice is provided a minimum of 10 calendar days prior to the effective date of the action.

B. Notices must meet the language format needs of the person served, as specified in 42 CFR 438.10. Person served or applicant notice must be in writing and must include:

1. A description of the ABD taken or proposed.

2. The reason for the ABD, including the policy/authority relied upon for the decision.

3. The effective date of the action.

4. The right to file an Internal Review/Local Level Appeal through the Customer Services Representative and instructions for doing so.

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

6. An explanation of how the person served or applicant may represent their self or use legal counsel, a relative, a friend, or other spokesperson.

7. The right for the person served or applicant to be provided reasonable access to and copies of all documents, records, and other information relevant to the person served or applicant’s ABD including medical necessity criteria, and processes, strategies, or evidentiary standards used in setting coverage limits, upon request and free of charge.

8. Advance Notice of ABD entitles persons served the right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstance under which the enrollee may be required to pay the costs of the continued services.

9. 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.

C. A service authorization decision must be made within 14 calendar days for a standard request or 72 hours for an expedited request for services.

1. Failure to meet these timeframes results in an ABD Notice.

2. The timeframes can be extended up to 14 additional calendar days if either the person served, or applicant requests the extension or if LCCMH can show there is need for additional information and the extension is in the enrollee or applicant's best interest. If LCCMH extends the timeframe not at the request of the enrollee or applicant, LCCMH must:

   a. Make reasonable efforts to give the person served or applicant prompt oral notice of the delay

   b. Within two calendar days, provide the person served or applicant written notice of the reason for the decision to extend the timeframe and inform the person served or applicant of the right to file a Grievance if they disagree with the decision

   c. Issue and carry out its determination as quickly as the person served or applicant's health condition requires and no later than the date the extension expires.

LOCAL GRIEVANCE

A. A grievance may be filed at any time.

B. A grievance may be filed by the person served, guardian, parent or legal representative of a minor child, or provider with written permission from the enrollee indicating the wish to file a grievance.

C. The provider may file a grievance or request a State Fair Hearing (for persons with Medicaid) on behalf of the person served since the State permits the provider to act as the enrollee's authorized representative in doing so.

D. Grievance may be filed orally or in writing.

E. Grievances are forwarded to the Customer Services Representative, who determines if the complaint is a Recipient Rights complaint or an appeal and refers to the appropriate office of jurisdiction for processing. The Customer Services Representative is trained and possesses current working knowledge of populations served, eligibility, services and other topics as required in the Customer Service Standards of the LCCMH Service Contract.

F. All grievances must be documented in the “Grievance Module” in the Electronic Health Record (EHR).

G. The Customer Services Representative acknowledges the grievance in writing within five business days.

H. LCCMH completes an investigation by taking the steps necessary to gather information to create the best resolution.

   1. Customer Services Representative ensures the complaint is reviewed by a health care professional, with appropriate clinical expertise, if grievance involves clinical issues or involves the denial of an expedited appeal.

   2. The Customer Services Representative can:

      a. Not be involved with the original complaint

      b. Not be involved in any previous denial of an expedited review

      c. Possess the appropriate authority to require corrective action if needed

      d. Acknowledge and log each grievance received

      e. Ensure individual(s) who make decisions of grievances:

         i. Were not involved in any previous level of review or decision making including a denial of an expedited appeal.

         ii. Are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee or applicant’s condition or disease.

iii. Have the authority to require corrective action if necessary.

3. Take into account all comments, documents, records, and other information submitted by the enrollee, applicant, or their representative without regard to whether such information was submitted or considered in the initial ABD.

I. The Customer Services Representative provides a written Notice of Resolution to the person served, applicant, or their representative.

1. The Notice of Resolution meets the requirements of 42 CFR 438.10 and is presented in an interpretable format to meet the needs of those with limited English proficiency and/or limited reading proficiency.
2. Resolution of Notice contains:
    a. The results of Grievance process.
    b. The date of the Grievance process was concluded.
    c. Notice of the person served or applicant's right to request a State Fair Hearing if the notice of resolution is more than 90 calendar days from the date of the grievances.
    d. Instructions on how to access the State Fair Hearing process, if applicable.

J. Grievance records are maintained in the EHR module for review.

LOCAL APPEAL

A. Persons served or applicants may pursue the option to dispute any ABD.

B. A local appeal is the first step of the appeal process and must be completed.

C. Persons served or applicants are given 60 calendar days after the date of the Notice of ABD to request the Appeal.

D. The person served or applicant may request an Appeal orally or in writing. LCCMH ensures oral inquiries seeking to appeal an ABD are treated as requests for filing to establish the earliest possible filing date for the appeal.

E. A network provider may file an appeal on behalf of the person served or applicant, as long as they have written permission from the person served or applicant.

    1. LCCMH does not take punitive action against a provider who requests an expedited resolution or supports person served or applicant's appeal.

    2. The provider may not request service continuation on behalf of the person served or applicant.

F. Upon request, persons served, or applicants are given assistance from staff in the filing process, including explanation of process and/or completing forms. This also includes, but is not limited to interpreter services, auxiliary aids and services upon request, and toll-free numbers with interpreter capabilities.

G. Person served, applicant, or their representative may file an appeal by calling or writing to the LCCMH Customer Services Representative, within 60 calendar days of the date of the ABD Notice.

H. The Customer Services Representative forwards Medicaid Appeals to the PIHP.

I. Local appeals for non-Medicaid persons served are processed by the LCCMH Customer Services Representative. An Acknowledgement Letter is mailed to person served or applicant.

J. Persons served or applicants may request an expedited appeal. Documentation in the request must show taking the time for a standard resolution could seriously jeopardize the person served or applicant's life, health, or ability to attain, maintain or regain maximum functioning.

    1. If there is a denial of a request for the expedited appeal, LCCMH ensures the following:

        a. Transfer the appeal to the timeframe for standard resolution.

        b. Makes reasonable efforts to give the person served or applicant prompt oral notice or the denial and follow up within two calendar days with a written notification.

c. Provide the person served or applicant the option to file a grievance about the denial of the expedited appeal request.

d. Resolve the appeal as quickly as the person served or applicant’s health condition requires but not to exceed 30 calendar days.

2. If the request is granted, LCCMH resolves the Appeal and provides Notice of Resolution with 72 hours after receiving the request.

K. LCCMH may extend the timeframe of resolution of appeal, if evidence can prove the need for additional information benefits the enrollee or applicant. All of the following must be met:

1. Make reasonable efforts to give the enrollee or applicant prompt oral notice of the delay.

2. Within two calendar days, give the enrollee or applicant written notice of the reason for the decision to extend the timeframe and inform the enrollee or applicant of the right to file a Grievance if they disagree with the decision.

3. Resolve the Appeal as expeditiously as the enrollee or applicant’s health condition requires and not later than the date the extension expires.

L. Persons served or applicants must be provided a reasonable opportunity to present evidence, testimony, and allegations of fact or law, in person as well as in writing. In the case of an expedited request, the person served or applicant must be notified of the limited time available.

M. Persons served or applicants and/or their representative must be allowed the opportunity, before and during the appeal process, to examine the person served or applicant’s case file, including medical records and any other documents and records relied upon during the appeal process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for the appeal.

N. LCCMH ensures the individual making the decision on appeals:

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

2. Is a healthcare professional who has the appropriate clinical expertise, as determined by MDHHS, in treating the person served or applicant's condition or disease, if deciding on either of the following:

    a. An appeal of denial based on lack of medical necessity,

    OR

    b. An appeal involving clinical issues.

3. Takes into account all comments, documents, records, and other information submitted by the person served or applicant or their representative without regard to whether such information was submitted or considered in the initial ABD.

O. A Notice of Resolution, in writing from LCCMH upon completion of the LCCMH Appeal, is given to the person served or applicant no later than 30 calendar days from the date of receipt of request for a standard appeal and no later than 72 hours for expedited appeal. The Notice of Resolution contains:

1. A general description of the reason for appeal.

2. The date received.

3. The date the review process.

4. The results of the appeal process.

5. The date of resolution.

CONTINUATION OF BENEFITS PENDING APPEAL

A. Persons served or applicants may request services to continue while waiting for appeal if all the following criteria are met:

1. The person served, applicant, or their representative files the appeal in a timely manner, within 10 calendar days of the date of the notice, before or on the effective date indicated on the notice.

2. The appeal involves an ABD of termination, reduction, or suspension of a previously authorized service.

3. The services were ordered by an authorized provider.

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

5. The person served, applicant, or their representative has asked for the continuation of services.

B. If all conditions above are met, benefits must continue until one of the following occurs:

1. The person served, applicant, or their representative withdraws the appeal.

2. The person served, applicant, or their representative fails to request continuation of benefits within 10 days after LCCMH sends the person served the Notice of Resolution, upon completion of the appeal.

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

C. If the services of the person served were reduced, terminated, or suspended without an Adverse Benefit Advance Notice, LCCMH must reinstate services to the level before the action.

RECORD KEEPING

A. LCCMH maintains records of person served and applicant Grievances and Appeals in accordance with 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for no less than 10 years.

B. LCCMH is required to keep record of processed Medicaid Mental Health Grievances. The PIHP reviews LCCMH grievances to ensure compliance with requirements, and as part of state quality strategy.

C. Records must contain the minimum:

1. A general description of the reason for the Grievance or Appeal.

2. The date received.

3. The date of review.

4. The resolution at each level of the Appeal or Grievance, if applicable.

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

6. Name of the covered person for whom the Grievance or Appeal was filed.

D. LCCMH maintains such records accurately and in a manner accessible to the State and available upon request to Centers for Medicare and Medicaid Services.

DEFINITIONS:

Access: The initial point of contact for applicants to request mental health and substance use disorder services and supports.

Adverse Benefit Determination (ABD): A decision in which it adversely impacts an enrollee or applicant's claim for services due to:

- Denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- Reduction, suspension, or termination of previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service authorization.
- Failure to make an expedited authorization decision within 72 hours from the date of receipt of a request for expedited service authorization.
- Failure to provide service within 14 calendar days of the start date agreed upon during the person-centered planning and as authorized by the PIHP.
- 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.
- Failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal.
- Failure of the PIHP/CMH to provide disposition and notice of a grievance/complaint within 90 calendar days of the date of the request.

- For residents of a rural area with only one provider, the denial of an enrollee or applicant's request to exercise their right to obtain services outside the network.
- Denial of an enrollee or applicant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee or applicant financial responsibilities.

Adequate Adverse Benefit Determination Notice: Written statement advising the enrollee or applicant of a decision to deny or limit the authorization of Medicaid services requested. Notice is provided to the Medicaid enrollee or applicant on the same date the action takes effect.

Advance Adverse Benefit Determination Notice: Written statement advising the enrollee or applicant of a decision to reduce, terminate, or suspend Medicaid services currently provided. Notice is provided to the enrollee or applicant at least 10 calendar days prior to the proposed date the action is to take effect.

Appeal: A review at the local/regional level by a PIHP of an Adverse Benefit Determination.

Applicant: A person, or their legal representative, who makes a request for mental health or substance use disorder services.

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

Customer Service Representative: Staff person who interacts with customers on behalf of a company. Responsibilities include handling customer inquiries, helping resolve complaints, providing information, and fostering a positive relationship between the customer and the company.

Enrollee: An individual who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid services through a PIHP/CMHSP.

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by an Enrollee or the Enrollee's provider, when the time necessary for the normal appeal review process could seriously jeopardize the Enrollee's life or 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.

Grievance: Medicaid Enrollee's expression of dissatisfaction about PIHP/CMHSP service issues, other than an Adverse Benefit Determination, as defined above. 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 the right to dispute an extension of time proposed by the PIHP to make an authorized decision.

Grievance Process: Impartial review of a Medicaid enrollee or applicant's grievance (expression of dissatisfaction) about PIHP/CMHSP service issues.

Grievance and Appeal System: The process the PIHP implements to handle appeals of Adverse Benefit Determinations and grievances, as well as the processes to collect and track information about them.

Hearing Officer: Staff person assigned to represent the PIHP at a State Fair Hearing.

Medicaid Services: Services provided to an enrollee under the authority of the Medicaid State Plan, 1915 (c) Habilitation Supports Waiver, and/or Section 1915 (b0(3) of the Social Security Act.

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

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 42CFR 438.408.

Organizational Provider: Entities under contract with the PIHP who directly employ and/or contract with individuals to provide specialty services and supports. Examples of organizational providers include, but are not limited to CMHSPs, hospitals, psychiatric hospitals, partial hospitalization programs, substance use disorder providers, case management programs, assertive community treatment programs, and skill building programs.

Prepaid Inpatient Health Plan (PIHP): An organization who manages the Medicaid mental health, intellectual/developmental disabilities, and substance use services in their geographic area under contract with the State.

Recipient Rights Complaint: Written or verbal statement by a person receiving services, or anyone acting on behalf of the person receiving services alleging a violation

of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved though processes established in Chapter 7a.

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

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 requested under the applicable law.

State Fair Hearing: Impartial state level review for a Medicaid enrollee or applicant's appeal of an Adverse Benefit Determination, presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing."

REFERENCES:

Region 10 PIHP Grievance and Appeals Policy #07.02.01

LR

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This policy supersedes
#06/01023 dated 06/13/2001.
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