POLICY AND PROCEDURE MANUAL	BCCMHA	PAGE 1 OF 23
CATEGORY – CUSTOMER SERVICE	CHAPTER 10	SUBJECT F
APPEAL AND GRIEVANCE/FAIR HEARING/SECOND OPINION POLICY *(Replaces Fair Hearing Policy 10 G)*	**REVISED** 02/01/01 01/07/10 03/15/02 06/01/10 04/04/03 11/03/10 03/28/06 05/24/11 02/15/07 08/11/11 01/14/08 04/20/12 09/30/08 10/03/12 05/11/09 07/20/13 07/24/14 06/25/15 08/09/16 01/26/17 12/12/17	**EFFECTIVE** 10/13/99

I PURPOSE

To assure that the appeal and/or grievance process for clients complies with federal and state laws including, but not limited to, Office of Recipient Rights, Social Security Act, Michigan Mental Health Code, the Balanced Budget Act of 1997, and Due Process Clause of the US Constitution.

To set forth steps to ensure due process when services are reduced, suspended, terminated, and/or denied.

To set forth expedited steps for addressing emergency appeals/grievances.

To provide for a process of tracking and analyzing client appeals and grievances.

II APPLICATION

All service programs of Barry County Community Mental Health Authority (BCCMHA).

III POLICY

All service clients have the right to a fair and efficient process for resolving complaints regarding the services and/or supports managed and/or delivered by BCCMHA and/or Southwest Michigan Behavioral Health (SWMBH), the Prepaid Inpatient Health Plan (PIHP). As such, all clients of, or applicants for, public behavioral health will receive notice of their rights and an explanation of the grievance and appeal resolution process.

GRIEVANCE AND APPEAL

The appeal and grievance process for clients will promote the resolution of the client's concerns as well as support and enhance the overall goal of improving the quality of care. The goals of the appeal and grievance process are the assurance of covered services appropriate to the client's condition and the protection of rights guaranteed by law.

Appeal and grievance processes implemented by BCCMHA (directly or through SWMBH) will be timely, fair to all parties, administratively simple, objective and credible, accessible and understandable to all clients, cost and resource-efficient, and subject to review by the Quality Improvement System, Customer Service and governing body.

Procedures will also assure clients, or their legally appointed representative, are provided with information and assistance as needed throughout the appeal and grievance process.

Appeal and grievance processes will not interfere with communication between the client and the service provider(s). There will be no discrimination or retaliation toward a client or a service provider for initiating or participating in the grievance and/or appeal process.

The Michigan Mental Health Code states, "An individual shall not be denied services because of the inability of the responsible parties to pay for services" (330.1810). This is supported by BCCMHA.

Denial, reduction, suspension or termination of service may occur due to client lack of eligibility, unavailability of the service as a covered benefit, the level of medical or clinical necessity presented by the client, failure to justify the use of a covered service, and so on. The appeal and grievance mechanism allows clients the ability to challenge these service decisions. BCCMHA will provide the client, or their representative, with a reasonable opportunity to present evidence of fact or law in person as well as in writing. The client, or their representative, will be provided with an opportunity before, during and after the appeals process to examine the client's medical record and any other documents or records considered during appeals and/or grievance processes. Please see the Confidentiality Policy.

BCCMHA will address recuse by ensuring that the individual(s) or staff resolving the appeal was not involved in the previous level of review or decision-making. Those involved with the decision-making process associated with both grievances and appeals will be qualified mental health or substance use disorder treatment professionals with appropriate clinical expertise to support issues involving medical necessity or other clinical issues. Selection of the qualified health professional will not be conditional to the professional's involvement within or outside of the agency's provider network.

It is the desire of BCCMHA to have all disputes resolved at the level closest to the service delivery. The BCCMHA client appeal and grievance process and supporting policies shall

serve as the standard appeal and grievance mechanism for clients. The Medicaid beneficiary's right to file a fair hearing request with the Michigan Department of Health and Human Services (MDHHS) cannot be initiated until the local appeal process has been completed. However, if BCCMHA fails to adhere to the notice and timing requirements, a request for a State Fair Hearing may be filed.

For each denial of inpatient care or eligibility for an initial service at the time of the denial, BCCMHA is required to provide the client, his or her guardian, or a minor applicant's parents with written Adequate Notice of Adverse Benefit Determination and a Notice of the Rights to a Second Opinion and the process for doing so. Second opinions are made available at no cost to beneficiaries from a qualified health professional within the network or outside the network if a qualified health professional is not available within the network under Section 438.206(b) of the Balanced Budget Act.

IV DEFINITION

Adverse Benefit Determination – A determination impacting a client'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, requirements of medical necessity, appropriateness, setting, or effectiveness of a covered 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 standard authorization decisions and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service;
5) Failure to make an expedited authorization decision within 72 hours from the date of receipt of a request for expedited service authorization;
6) Failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning and as authorized by BCCMHA;
7) Failure to act within 30 calendar days from the date of a request for a standard appeal;
8) Failure to resolve the appeal and provide notice within 72 hours from the date of a request for an expedited appeal;
9) Failure to resolve grievance and provide notice within 90 calendar days of the date of request.
10) Denial of a request to dispute a financial liability, including cost sharing, copayments, deductibles, coinsurance and other financial responsibilities.

GRIEVANCE AND APPEAL

Appeal - The request to carry a cause or issue from a lower to a higher authority for reconsideration related to the actions of denial, reduction, suspension, or termination of services and supports. A challenge to an action.

Adequate Notice of Adverse Benefit Determination – A written notice advising of a decision to deny or limit authorization of services requested. The individual plan of service, developed through a person-centered planning process and finalized with the client, must include, or have attached, the adequate notice provisions. The notice is provided on the same date the action takes effect, or at the time of the signing of the plan of service.

Advance Notice of Adverse Benefit Determination – An advance notice is a written notice required when action is being taken to reduce, suspend, or terminate services that the client is currently receiving. The advance notice must be provided at least 30 calendar days before the intended action takes effect.

Adverse Action - Denial, reduction, suspension or termination of services and supports outside of the person centered planning process. Adverse action requires advance notice.

Appeal Process - Impartial reviews of a client's appeal of an action presided over by individuals not involved with previous decision-making or review.

Authorization of Service - The processing of requests for initial and continuing service delivery.

Beneficiary/Client/Customer/Individual/Recipient/Applicant – A person who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid services and/or a recipient of behavioral health services or supports and/or a potential consumer/client.

Customer Service Representative – BCCMHA employee whose responsibilities include customer service.

Expedited Appeal - The expeditious review of an action requested by a client and/or provider, when the time necessary for the normal appeal review process could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum function.

Fair Hearing - Impartial state level review of a Medicaid beneficiary appeal of an adverse benefits determination presided over by an MDHHS administrative law judge. Also referred to "Administrative Hearing".

GRIEVANCE AND APPEAL

Grievance - Expression of dissatisfaction about service issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but not limited to, quality of care or services provided, aspects of interpersonal relations between a service provider and the client, failure to respect the client's rights regardless of whether remedial action is requested, or a client's dispute regarding an extension of time proposed by the PIHP to make a service authorization decision. A complaint that challenges anything else other than an action.

Grievance Process – Impartial local level review of a client's grievance (expression of dissatisfaction) about service issues other than an action.

Grievance and Appeal System – Federal terminology for the overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process. This includes processes to collect and track information about same.

Hearing Request - A written request which is received by the Administrative Tribunal within 120 days of the date of the local appeal resolution notification and which is mailed to the following address: Michigan Department of Health and Human Services, Michigan Administrative Hearing System P.O. Box 30763, Lansing, MI 48909, and fax number: 517-763-0146.

Legally Appointed Representative - Court appointed guardian or parents of a minor.

Local Appeal Process – Impartial local level review of a client's appeal of an action presided over by staff not involved with decision-making or previous level of review.

MDHHS - Michigan Department of Health and Human Services.

Medicaid Services – Services provided to a Medicaid beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

Notice of Disposition – Written statement of the decision for each local appeal and/or grievance, provided to the client.

Person Centered Planning - A process of planning and supporting the client receiving services. It builds upon the client's capacity to engage in activities that promote community life. It honors the client's preferences, choices, and abilities. The client is given opportunity to express his/her needs and desired outcomes.

PIHP – Prepaid Inpatient Health Plan.

GRIEVANCE AND APPEAL

Regional Service Representative – SWMBH employee located at the PIHP office fulfilling the role of customer service.

SWMBH – Southwest Michigan Behavioral Health (PIHP) for the counties of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren.

BACKGROUND

Conceptually, the grievance system divides client complaints into two categories: 1) Those challenging an action, an appeal; 2) those challenging anything else, a grievance. Appeal and grievance process can often be complex and confusing to clients. The client should experience "no wrong door" when he/she wishes to appeal or file a grievance. The appeal and/or grievance can be placed in writing or orally.

The Due Process Clause of the US Constitution guarantees that Medicaid beneficiaries or those accessing the public behavioral health system must receive "due process" whenever benefits or services are denied, reduced or terminated. Due Process includes: 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.

Clients of behavioral health services who are Medicaid beneficiaries 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. Grievance and appeal process requirements for Medicaid beneficiaries were significantly expanded through federal regulations implementing the Balanced Budget Act of 1997.

Medicaid beneficiaries have rights and dispute resolution protection under federal authority of the Social Security Act, including:

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

Medicaid beneficiaries, as public behavioral health recipients, also have rights and dispute resolution protection 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)

V **STANDARDS**

Federal regulation (42 CFR 438.228) requires the state to ensure through its contracts that an overall grievance system is in place. In addition, the grievance system for Medicaid beneficiaries must comply with Subpart F of Part 438 of the Code of Federal Regulations. The grievance system must provide individuals:

- ✓ A local appeal process for challenging an action taken by BCCMHA or one of its agents.
- ✓ Access to the state level fair hearing process for an appeal of an "action".
- ✓ A local grievance process for expressions of dissatisfaction about any matter other than those that meet the definition of an action.
- ✓ The right to file a local level of appeal of an action, and request a state fair hearing on an action, and file a local level grievance regarding other service complaints. (Note: Medicaid beneficiaries can request a state fair hearing, those clients that are not Medicaid beneficiaries can only request a review of the case by the Michigan Department of Health and Human Services and not a state fair hearing).
- ✓ The right to request a state fair hearing only after exhausting the local level appeal of an action.
- ✓ The right to request, and have, benefits/services continued while a local level appeal and/or state fair hearing or MDHHS review is pending.
- ✓ The right to have a provider, acting on the client's behalf and with the client's written consent, file an appeal to BCCMHA. The provider may file a grievance or request for a state fair hearing on behalf of the beneficiary only if the state permits the provider to act as the beneficiary's authorized representative in doing so.

A notice of action will be provided to a client when a service authorization decision constitutes an action by authorizing a service in amount, duration, or scope less than requested or less than currently authorized, or the service authorization is not made timely. In these situations, BCCMHA will provide a notice of action containing additional information to inform the client of the basis for action taken, or intends to take and the process available to appeal the decision. The notice of action must be either an adequate notice or an advance notice. The adequate notice being provided to the client at the time of each action and the advance notice being provided when an action is being taken to reduce, suspend, or terminate services that a client is currently receiving. The advance notice must be mailed/provided thirty (30) calendar days before the intended action takes effect.

GRIEVANCE AND APPEAL

LOCAL DISPUTE RESOLUTION

The client or the legally empowered guardian expresses a desire to appeal a decision to deny, suspend, reduce or terminate services at the local level. This may be communicated to any behavioral worker, customer services representative, the local office of Recipient Rights, or the Regional Service Representative. The initial contact person will assist the client/guardian with formulating the request for a local dispute resolution grievance (LDSG) and will advise a client of their rights, written or orally, for appeal/grievance. See the Local Dispute Resolution Grievance Policy for details.

ADVANCE NOTICE

Advance Notice of Adverse Benefits Determination is a written notice required when an action is being taken to reduce, suspend, or terminate services that the client is currently receiving. The advance notice must be mailed so that the client is provided at least 30 calendar days' notice before the intended action takes effect, in the case of verified fraud, 5 calendar days before the date of action. If a hearing is requested, services may not be terminated or reduced pending the hearing decision except if the sole issue is one of Federal or State Law.

The content of the notice will include an explanation of BCCMHA's intended action to be taken, reason for the action, and the legal authority for the action to place appropriate limits on services based on such criteria as medical necessity, service eligibility or utilization control procedures. Information within the advance notice informing the client of their right to appeal, if the client has a right to request a state fair hearing and instructions for doing so. It should be noted that only Medicaid beneficiaries may request a state fair hearing as public formula funded behavioral health and substance use disorder services are not entitlement programs. The circumstances under which an expedited resolution can be requested and instructions for doing so will be incorporated into the information provided to the client. In addition, the notice must include the circumstances under which services will be continued pending the resolution of the appeal; the circumstances under which expedited resolution can be requested, and instructions for doing so; how to request that services continue; and the circumstances under which the client may be required to pay the costs of the services in question. The client will be informed of their right to represent themselves or use legal counsel, a relative, a friend or other spokesman.

Exceptions to the Notice Rule

There are limited exceptions to the advance notice required and are as follows:

GRIEVANCE AND APPEAL

Exception	Required Action
BCCMHA has factual information confirming the death of the beneficiary.	No Notice
BCCMHA receives a clear written statement signed by the client or his/her legal representative that he/she no longer wishes services.	Adequate Notice
BCCMHA receives a clear written statement signed by the client or his/her legal representative that gives information that requires termination or reduction of services, and that indicates he/she understands that this must be the result of supplying information.	Adequate Notice
The client has been admitted to an institution where he/she is ineligible under Medicaid for further services (i.e., jail).	Adequate Notice
The client's whereabouts are unknown and the post office returns mail directed to him/her indicating no forwarding address.	No Notice
BCCMHA has established the fact that the client has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.	Adequate Notice
The client's physician prescribes a change in the level of medical care.	Adequate Notice
The date the action will occur is less than ten calendar days – planned discharge.	Adequate Notice
If a serious health or safety concern will be present with the client by waiting twelve calendar days for advance notice.	Adequate Notice
The service reduction/suspension/termination/increase is according to the person-centered plan.	No Notice

ADEQUATE NOTICE

Adequate notice is a written notice provided to the client at the time of each action. The plan of service, developed through a person-centered planning process and finalized with the client, must include, or have attached, the adequate notice provisions. The content of the notice will include an explanation of BCCMHA's intended action to be taken, reason for the action, and the legal authority for the action to place appropriate limits on services based on such criteria as medical necessity or utilization control procedures. Information within the adequate notice informs the client of their right to appeal, if the client has a right to request a state fair hearing and instruction for doing so. The notice of action must be mailed at the time of the decision to deny payment for a service; within fourteen calendar days of the request for a standard service authorization decision to deny or limit services; or within 72 hours of the request for an expedited service authorization decision to deny or limit services.

GRIEVANCE AND APPEAL

DENIAL OF FAMILY SUPPORT SUBSIDY

If an application for a family support subsidy is denied or a community mental health services program terminates a family support subsidy, 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 Sections 24.271 to 24.287 of the Michigan Compiled Laws.

Copies of blank application forms, parent report forms, the forms for changed family circumstances, and appeal forms shall be available from BCCMHA. In lieu of a standardized form, families may be asked to write a letter to BCCMHA requesting an appeals hearing.

BCCMHA shall review an application for subsidy 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 application. If the denial is due to insufficiency of the information on the application form or the required attachments, BCCMHA shall identify insufficiency and provide opportunity for the family to obtain and provide that information. 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 BCCMHA within two months (60 days) of the notice of denial or termination.

SECOND OPINIONS AND DENIAL OF HOSPITALIZATION

If an inpatient psychiatric pre-admission screening requested by the individual, their guardian, parent of a minor child, or designated patient advocate, executed by BCCMHA or designated screening unit denies hospitalization, a request for a second opinion may be made at no cost to the client. The request for the second opinion shall be processed in compliance with the Michigan Mental Health Code (Sections 409(4), 498e(4), and 498h(5)). If the conclusion of the second opinion is different from the conclusion of the inpatient psychiatric pre-admission screening, the Executive Director, in conjunction with the Medical Director shall review the second opinion and make a decision based upon all clinical information available within one business day, excluding Saturdays, Sundays and holidays. If the request for a second opinion is denied, the client or someone on his or her behalf may file a Recipient Rights Complaint with the local Recipient Rights Office.

The Executive Director's decision to uphold or reject the findings of the second opinion is confirmed in writing to the requestor; this writing contains the signatures of the Executive Director and Medical Director or verification that the decision was made in conjunction with the Medical Director.

If the initial request for inpatient psychiatric admission is denied, and the client is a current

recipient of other behavioral health services, the client or someone on his/her behalf may file a Chapter 7 complaint alleging a violation of his/her right to treatment suited to condition. If the second opinion determines the client is a current recipient of other behavioral health services, and a recipient rights complaint has not been filed previously on behalf of the client, the client or someone on his/her behalf may file a complaint with the BCCMHA's Recipient Rights Office for processing under Chapter 7A.

DENIAL OF AGENCY SERVICES

If an initial applicant for behavioral services is denied such services, the applicant or his/her guardian, parent of a minor child, or designated patient advocate will be informed of their right to request a second opinion of the Executive Director at no cost to the individual. The request will be processed in compliance with the Michigan Mental Health Code (Section 705) and will be resolved within five business days. The applicant may not file a recipient rights complaint for denial of services; however, he/she may file a rights complaint if the request for a second opinion is denied. It should be noted that those individuals seeking substance use disorder services and addiction treatment are not afforded the right to a second opinion under the Michigan Mental Health Code.

SERVICE AUTHORIZATIONS

When a service authorization is processed, either an initial request or continuation of service, BCCMHA will provide the individual with a written service authorization decision within specified timeframes and as expeditiously as the individual's health condition requires (standard within 30 days and expedited within 72 hours). The service authorization must meet the requirements for either standard authorization or expedited authorization.

Standard Authorization – Notice of the authorization decision must be provided as expeditiously as the individual's health condition requires, but no later than 14 days following receipt of a request for services. If the individual or provider requests an extension or if BCCMHA justifies (to the state agency upon request) a need for additional information and how the extension is in the best interest of the individual, BCCMHA may extend the 14 calendar day time period by up to 14 additional calendar days.

Expedited Authorization – In cases in which a provider indicates, or BCCMHA determines, that following the standard timeframe could seriously jeopardize the individual's life or health or ability to attain, maintain or regain maximum function, BCCMHA will make an expedited authorization decision and provide notice of the decision as expeditiously as the individual's health condition requires, and not later than 72 hours after receipt of the request. Notification of the decision will be made both orally and in writing. If the individual or provider requests an extension or if BCCMHA justifies (to the state agency upon request) a

need for additional information and how the extension is in the best interest of the individual, BCCMHA may extend the three (3) working day time period by up to 14 calendar days.

When a standard or expedited authorization of service decision is extended, BCCMHA must give the individual written notice of the reason for the decision to extend the timeframe, and inform the individual of the right to file an appeal if he or she disagrees with that decision. BCCMHA must issue and carry out its determination as expeditiously as the individual's health condition requires and no later than the date the extension expires. Written notice will also be given to the provider outlining any decisions to deny, limit, or discontinue authorization of services in situations involving contractual behavioral health providers.

The following is an outline of the actions required with their notices and corresponding time frames.

Action	**Type of Notice**	**Time Frame of 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 action
Reduction, suspension, or termination of service currently being received and failure to provide services in a timely manner.	Advance	30 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 72 hours of request*
Unreasonable delay of start of service	Adequate	At the time of the action
Delayed authorization decisions for which an extension has not been agreed to	Adequate	Must be provided on the 14th day (or on the 2nd working day for an expedited authorization)

* The timeframe may be extended up to another 14 days at the request of the beneficiary or provider. If the timeframe is extended, the client shall receive written notice, no later than the date the current timeframe expires, which explains the reason for the extension and that they have the right to file an appeal if they disagree with the decision.

STATE FAIR HEARING:

The formalized appeal/grievance process that a client/guardian/parent may engage in that brings the case before a state level administrative law judge.

BCCMHA shall not limit or interfere with a client's freedom to make a request and shall provide clients with written notice that they are entitled to a State Fair Hearing when an

"action" takes place.

SWMBH and BCCMHA will coordinate while going through the Fair Hearing for Administrative Tribunal Hearings for Medicaid beneficiaries.

Federal regulations provide a Medicaid Beneficiary the right to an impartial review of a decision made by the local agency or its agent.

- A Medicaid Beneficiary has the right to request a fair hearing when the PIHP or its contractor takes an advance benefits determination, or a grievance request is not acted upon within 30 calendar days. The beneficiary does have to exhaust local appeals before he/she can request a fair hearing.
- The agency must issue a written notice of action to the affected beneficiary.
- The agency may not limit or interfere with the beneficiary's freedom to make a request for a fair hearing.
- Beneficiaries are given 120 calendar days from the date of the notice to file a request for a fair hearing. State can offer and arrange external medical review.
- If the beneficiary, or representative, requests a fair hearing not more than 12 calendar days from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing by the administrative law judge.
- If the beneficiary's services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the action.
- The parties to the state fair hearing include the PIHP, the beneficiary and his/her representative, or the representative of a deceased estate. A Recipient Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.
- Expedited hearings are available.

MAINTAINING SERVICES AND SUPPORTS

BCCMHA will continue services previously authorized while the local appeal and/or state fair hearing (for Medicaid beneficiaries) is pending if:

- ✓ The client specifically requests to have the services continued, and
- ✓ The client or provider files the appeal timely; and
- ✓ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and
- ✓ The services were ordered by an authorized provider; and
- ✓ The original period covered by the original authorization has not expired.

When BCCMHA or SWMBH continues or reinstates the client's services while the appeal is pending, the services must be continued until one of the following occurs:

GRIEVANCE AND APPEAL

- ✓ The client withdraws the appeal.
- ✓ Twelve calendar days pass after BCCMHA mails the notice of disposition providing the resolution of the appeal against the individual, unless the client, within the 12 day timeframe, has requested a State Fair Hearing with continuation of services until a State Fair Hearing decision is reached.
- ✓ A State Fair Hearing office issues a hearing decision adverse to the client. The time period or service limits of the previously authorized services has been met.

If SWMBH or the Michigan Department of Health and Human Services Fair Hearing Administrative Law Judge reverses a decision to deny authorization of services, and the client received the disputed services while the appeal was pending, SWMBH or the State must pay for those services in accordance with State policy and regulations.

If SWMBH or the Michigan Department of Fair Hearing Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, SWMBH or BCCMHA must authorize or provide the disputed services promptly, and as expeditiously as the client's health condition requires.

NOTIFICATION

Clients will receive written information concerning their rights as recipients of behavioral health services. This includes the appeals and grievance process. This information will be provided as a routine part of the intake process, annually thereafter.

When a service recipient appeals a service request or files a complaint, BCCMHA will make contact with that client, either by phone or in writing, to acknowledge receipt of the appeal or complaint and immediately begin the resolution process.

The client will receive written notice of the decision resulting from an appeal, grievance or complaint regarding the denial, reduction, suspension or termination of services and supports. In situations involving an external service provider, a written notice will also be given to the provider outlining any decisions to deny, limit, or discontinue authorization of services.

REINSTATEMENT OF SERVICES

BCCMHA may reinstate services if a client or his/her legal representative requests a DCH hearing not more than 12 days after the date of action. The decision to reinstate services will be made by the Executive Director. Possible reason for reinstatement can include any of the following:

1. Failure to provide Advance Notice.

2. Request for a Fair Hearing was made within 12 days of the notice of action.
3. Action resulted from factors other than the application of Federal or State Law or policy.
4. The action may result in serious, adverse harm to the individual or the community.
5. The whereabouts of the service recipient were unknown as indicated by unforwardable mail and the whereabouts became known during the time of service eligibility.

EXCEPTIONS

Clients who are not currently receiving behavioral health services may not file a recipient rights complaint nor may they request a fair hearing from the MDHHS. They may, however, file a complaint or request a hearing if they are denied the right for a second opinion when BCCMHA services or hospitalization are denied.

Clients who are not Medicaid recipients must first file a grievance with the Customer Service Representative before filing a request for an Alternative Dispute Resolution. If the findings are not consistent with the facts or with law, rules, policies or guidelines, the client may then request access to the MDHHS Alternative Dispute Resolution Process. MDHHS will review such requests within two business days and will attempt to resolve the issue with the client within 15 calendar days. Recommendations of MDHHS are not binding where the decision poses no immediate impact to the health and safety of the client.

VI PROCEDURES

When services for a client are denied, reduced, suspended or terminated, the Appeals/Grievance and Fair Hearing guidelines and policy will be used to determine what appropriate actions are to be taken and followed through.

The client will receive adequate notice at the Person Centered Planning (PCP) meeting and/or case review (Periodic or Quarterly Review) of any changes to be made to services that the client is receiving. Upon the decision of the client, he/she may file an appeal, grievance, or complaint. The appeal, grievance or complaint is addressed and the designated staff person who has that authority renders a decision. The client will then be provided with the decision in writing.

NOTE: All grievances and complaints are routed through the local Customer Services Representative.

At the time of the annual PCP meeting, the primary clinician/case

manager provides the client with adequate notice of the person's right to appeal the service plan. The client may then request a fair hearing only after completing the local dispute process.

The local Customer Service Representative and/or health plan customer service representative will help the client understand and access options available for appeal/complaint/grievance resolution. The Customer Service Representative will log all local disputes and fair hearings.

LOCAL GRIEVANCE PROCESS

In complying with federal regulations, BCCMHA will provide Medicaid beneficiaries information about the local grievance process for issues that are not "actions." For each grievance filed, BCCMHA Customer Service Representative is required to:

- Acknowledge the receipt of the Grievance in writing to the member or complainant if other than the member.
- Log receipt of the Grievance for reporting to SWMBH and internally.
- Assess whether the Grievance is a Recipient Rights issue and provide assistance as needed to file a recipient rights complaint with the Recipient Rights officer.
- Provide the beneficiary reasonable assistance to complete forms and take other procedural steps, including but not limited to, translation and literacy support.
- Ensure the individual(s) resolving the Grievance were not involved in the previous level review or decision-making.
- Ensure that individual(s) who makes the decisions on the Grievance is a health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease if the Grievance:
  -involves clinical issues, or
  -involves the denial of an expedited resolution of an appeal (of an action).
- Submit the written Grievance to appropriate staff including a BCCMHA administrator with the authority to require corrective active, none of who shall have been involved in the initial determination.
- Provide the beneficiary with ***written*** notice within 90 calendar days from the date the Grievance was received. The content of the Notice of Disposition much include:
  -The results of the grievance process.
  -The date the grievance process was concluded.
  -The Medicaid beneficiary's right to request a local appeal or a fair hearing if the notice of disposition is more than 90 days from the date of the request for a grievance.
  -How to access the fair hearing process.

GRIEVANCE AND APPEAL

Beneficiary Grievances

- Shall be filed with the Customer Service Unit responsible for facilitating resolution of the grievance.
- May be filed at any time by the beneficiary, guardian or parent of a minor child or his/her legal representative.
- Do not have access to the State Fair Hearing process unless, BCCMHA fails to respond to the grievance within 90 calendar days. This constitutes an "action" and can be appealed for fair hearing to the MDCH Administrative Tribunal.

LOCAL APPEAL PROCESS

In complying with federal regulations, BCCMHA will provide clients information about the right to a local level appeal of an "Action" as outlined within the Local Dispute Resolution Policy. The client or their representative may file an appeal with the Customer Service Representative under the following conditions:

- ✓ It has been no more than 60 calendar days from the date of the notice of action;
- ✓ An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request may be confirmed in writing, if more information or clarification is needed, but not if the beneficiary requests expedited resolution.
- ✓ The request is made by the client, provider (acting on the client's behalf and with consent) or other legal representative.

When a local appeal is requested, BCCMHA shall:

- ✓ Ensure that the verbal request for an appeal establishes the earliest filing date and is followed up with a written request for an appeal if needed.
- ✓ Acknowledge the receipt of the appeal in writing to the client and/or person requesting the appeal on behalf of the client;
- ✓ Log receipt of the request for an appeal;
- ✓ Provide the client reasonable assistance to complete forms and take other procedural steps, including but not limited to, translation and literacy support;
- ✓ Ensure that the person resolving the appeal has not been involved in the previous level review or decision-making;
- ✓ Ensure that if the appeal is clinical in nature, the individuals making the decisions are health care professionals with appropriate clinical expertise when the appeal is of a denial based on lack of medical necessity or involves other clinical issues;
- ✓ Provide the client or representative with:
    - o Reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;

- Opportunity before, during and after the appeal process to examine the client's case file, including medical records and any other documents or records considered during the appeals process;
- Opportunity to include, as parties to appeal, the client's and his or her representative or the legal representative of a deceased client's estate;
- Information regarding the right to a Fair Hearing and the process to request this hearing if covered by Medicaid.

NOTICE OF DISPOSITION REQUIREMENTS

BCCMHA will provide written notice of the disposition of the appeal to the client within 30 calendar days from the date the appeal was received. In the event that the client requests an extension, or BCCMHA is able to satisfy the State's requirements for an extension. BCCMHA may extend this timeframe by up to 14 calendar days. In the event of an expedited appeal, BCCMHA shall provide notice of disposition no longer than 72 hours after the appeal was requested and granted. If request for an expedited appeal was denied, reasonable efforts must be made to provide the client prompt oral notice of the denial, and must be given written notice within two calendar days. Denied requests for an expedited appeal shall then be subject to the timeframe for standard resolution. The written notice shall include an explanation of the results of the resolution and the date it was completed.

When the appeal is not wholly in favor of the client, the notice of disposition must also include:

- ✓ The right to request a State Fair Hearing and how to do so;
- ✓ The right to request to receive benefits while the State Fair Hearing is pending if requested within 10 calendar days of BCCMHA mailing of the notice of disposition and how to make the request;

REPORTING REQUIREMENTS

BCCMHA shall maintain logs of any and all denials of services, adhering to the established reporting guidelines applicable to grievance and appeals and second opinion requirements. All denials of services for Medicaid beneficiaries will be reported to SWMBH. In addition, BCCMHA will document requests for second opinions. All second opinions associated with Medicaid beneficiaries will be entered into the SWMBH Grievance, Appeals, and Second Opinion Database directly by designated staff. The Customer Service Representative will maintain grievance service system records of appeals and grievances for review as part of the service system to support and enhance the quality of care.

GRIEVANCE AND APPEAL

Type	Reporting Requirement
Grievance	Acknowledgement letter of grievance received should be sent within 10 days
Grievance Outcome	Acknowledgement of the outcome of the grievance should be sent within 90 days of filing
Appeal	Decision should be made as quickly as possible but no longer than 30 calendar days from the date it was filed
Expedited Appeal	No longer than 72 hours from the date the expedited appeal was requested

The Customer Service Representative is responsible for maintaining and submitting local data to SWMBH Customer Services who will monitor, track and trend all denials, state fair hearings, grievance and appeals and second opinion requests and dispositions.

REFERENCE AND CITATION SECTION

42 CFR 438.10
42 CFR 438.206(b)(3)
42 CFR 438.210 et seq.
42 CFR 438.225
42 CFR 438.228
42 CFR 438.400 et seq.
42 CFR 438.404
42 CFR 438.406(a)(2)
MCL 330.1772 et seq.
MCL 330.1705
R 330.1616
R 330.1641
R 330.1643
Due Process Clause of the US Constitution
Medicaid Master Contract Attachment P. 6.3.2.1.
General Fund Master Contract Attachment C.6.3.2.1.
Grievance and Appeal Technical Requirement PIHP Grievance System for Medicaid Beneficiaries
Section 942 of P.A. 269 of 2016

ATTACHMENTS

See Appeal and Grievance/Fair Hearing/Second Opinion Forms Packet

GRIEVANCE AND APPEAL

QUALITY IMPROVEMENT

This policy/procedure will be evaluated by the Quality Improvement Committee on an annual basis to enhance and improve the quality.

At any time employees can request in writing, on the form provided, that this policy or items in this policy be reviewed by the Quality Improvement Committee. Employee's written requests can be given to any Quality Improvement Committee member.
When an area for improvement is indicated, the process for improvement as identified in the Quality Improvement Plan will be followed.

APPROVED BY:

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Richard Thiemkey Date
Executive Director

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Lynn Bennett Date
Customer Service Representative

____

Tamie Case, MPA, CHC Date
Corporate Compliance Officer

DATE REVIEWED

11/22/00
02/11/02
03/13/03
05/26/04
02/22/06
01/26/07 – Updated Administrative Tribunal Contact Information
08/08/07
07/23/08
05/04/09 – SA Merger
11/04/09
10/20/10
04/27/11
07/13/11
03/28/12
09/19/12
07/03/13
07/02/14
04/01/15
07/06/16
01/18/17
07/05/17
12/06/17