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PROCEDURE

1.0 Purpose

To provide a fair and efficient process for resolving concerns or complaints (grievances) from persons served, or applicants for service, related to suspension, termination, reduction or increase, or denial of services and supports managed and/or delivered by The Right Door for Hope, Recovery, and Wellness or its contractors, as well as support and enhance the overall goal of improving quality of care.

2.0 Application

This procedure shall apply to The Right Door for Hope, Recovery and Wellness Customer Service Representative (CSR) and involved staff and contractors. This procedure shall serve as a guide to assure compliance with Board policy regarding Appeals and Grievances.

3.0 Definitions

3.1 Adverse Benefit Determination: A decision that adversely impacts a Medicaid Enrollee's claim for services due to: *(42 CFR 438.400)*

a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. *42 CFR 438.400 (b)(1).*
b. Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2).*
c. Denial, in whole or in part, of payment for a service. *42 CFR 438.400(b)(3).*
d. Failure to make a standard Service Authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service. *42 CFR 438.210(d)(1*).
e. Failure to make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization. *42 CFR 438.210(d)(2).*
f. Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the CMHSP. *42 CFR 438.400(b)(4).*
g. Failure of the CMHSP to resolve standard appeals and provide notice within **30 calendar days** from the date of a request for a standard appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).*

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h. Failure of the CMHSP to resolve expedited appeals and provide notice within **72 hours** from the date of a request for an expedited appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).*

i. Failure of the CMHSP to resolve grievances and provide notice within **90 calendar days** of the date of the request. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*

j. For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under *§ 438.52(b)(2)(ii)*, to obtain services outside the network. *42 CFR 438.400(b)(6).*

k. Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. *42 CFR 438.400(b)(7).*

3.2 **Adverse Action – For Non-Medicaid recipients.** Whenever a currently authorized service or support or currently authorized services are to be suspended, terminated, or reduced by The Right Door for Hope, Recovery and Wellness.

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

3.4 **Advance Notices:**

3.4.1 Advance Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to reduce, suspend or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid Enrollee at least **15 Calendar days** prior (MDHHS requirement is 12 days, Medicaid Managed care rule is at least 10 days, The Right Door has chosen to give 15 days) to the proposed date the Adverse Benefit Determination is to take effect. *42 CFR 438.404(c)(1); 42 CFR 431.211*.

3.4.2 For Non-Medicaid recipients of services: The written statement advising the consumer of a decision to reduce, suspend or terminate services currently provided must be provided/mailed to the person served at least **30 calendar days** prior to the proposed date the Adverse Action is to take effect. The notice shall include:

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a. A statement of what action The Right Door for Hope, Recovery and Wellness intends to take;
b. The reasons for the intended action;
c. The specific justification for the intended action;
d. An explanation of the Local Dispute Resolution Process

Actions taken during the person-centered planning process or those ordered by a physician are not considered an adverse action.

3.5 **Alternative Dispute Resolution Process:** An impartial state level review of a non-Medicaid enrollee's appeal of an action, as reviewed by an agent of Michigan Department of Health and Human Services (MDHHS).

3.6 **Appeal (internal):** A review at the local level of an Adverse Benefit Determination or Adverse Action, as defined above. *42 CFR 438.400*.

3.6.1 Medicaid: The Right Door for Hope, Recovery and Wellness must address any request for a local appeal **received within 60 days** of the date of the adverse action going into effect (effective date). An internal (local) appeal decision must be provided within **30 calendar days** of the receipt of the request.

3.6.2 Non-Medicaid: An internal appeal request must be received **within 30 calendar days of the Action Notice**. A written decision on a **standard appeal must be provided within 45 calendar days** after it was received. The Right Door for Hope, Recovery and Wellness might take longer, but only if it is due to the need for additional information from the person served or if the person served requests the extension. If we are extending the 30 days, notification must be provided to the person served and all applicable parties.

3.6.3 If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 calendar days.**

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

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3.8 **CMHSP – Community Mental Health Service Provider** (The Right Door for Hope, Recovery and Wellness)

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

3.10 **Expedited Appeal:**

3.10.1 **Medicaid Expedited Appeal:** The expeditious review of an Adverse Benefit Determination, requested by an Enrollee or the Enrollee's provider. 42 CRF 438.410(a). An Enrollee has the right to request an "expedited" or "fast" appeal if waiting the standard time of **30 calendar days** for the appeal decision would seriously jeopardize their life or health or their ability to attain, maintain, or regain maximum function. A provider may also ask on the behalf of a person served. The Right Door for Hope, Recovery and Wellness will automatically grant an expedited appeal if the doctor of a person served supports their request. If a person served or their provider ask for an expedited appeal without support from a doctor, The Right Door for Hope, Recovery and Wellness will decide if the request requires an expedited appeal. The Right Door for Hope, Recovery and Wellness will give a decision on an expedited appeal within **72 hours** after it is received.

3.10.2 **Non-Medicaid Expedited Appeal:** A person served can request an "expedited" or "fast" appeal if waiting the standard time of 45 calendar days for the appeal decision would seriously jeopardize life or health or ability to attain, maintain, or regain maximum function. The provider of the person served may also ask on their behalf. The Right Door for Hope, Recovery and Wellness will automatically grant an expedited appeal if the doctor of the person served supports their request. If a person served or their provider ask for an expedited appeal without support from a doctor, The Right Door for Hope, Recovery and Wellness will decide if the request requires an expedited appeal. If your request is approved, we will give you a decision on a "fast" appeal within 3 business days, excluding Sunday and legal holidays, after we get your appeal.

3.11 **Grievance**: An expression of dissatisfaction about service issues of an enrollee/person served, other than an adverse benefit determination/adverse action (as defined above), which does not involve a recipient rights complaint (as defined below). Possible subjects for grievances include, but are not limited to,

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quality of care for services provided, aspects of interpersonal relationships between a service provider and the person served/enrollee.

3.12 **Grievance Process:** Impartial local review of a grievance of an enrollee/person served.

3.12.1 Medicaid: An expression of dissatisfaction about service issues by an enrollee/person served, other than an adverse benefit determination (as defined above), which does not involve a recipient rights complaint (as defined below). You can file a grievance at any time. We have 7 calendar days from the date of the grievance to send acknowledgement. We have 90 calendar days from the date of the grievance to send you disposition. If we do not provide disposition in this time frame, you may request a Medicaid Fair Hearing. Possible subjects for grievances include, but are not limited to, quality of care for services provided, aspects of interpersonal relationships between a service provider and the person served/enrollee.

3.12.2 Non-Medicaid: A person served can file a complaint (grievance) at any time. The Right Door for Hope, Recovery and Wellness has 7 calendar days from the date of complaint to send acknowledgement to the person served that the complaint was received. The Right Door for Hope, Recovery and Wellness then has 60 calendar days from the date of the grievance to send the disposition. If a person served does not agree, they can call MDHHS Customer Service 1-844-275-6324.

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

3.14 **Notice of Resolution:** Written statement of the resolution of a Grievance or Internal Appeal, which must be provided to the person served/enrollee.

3.15 **Recipient/consumer:** An individual who receives mental health or substance use services from a Community Mental Health Service Provider or from a provider under contract with a Community Mental Health Service Provider, including Medicaid enrollees.

3.16 **Recipient Rights Complaint:** A written or verbal statement by a person served/enrollee or anyone acting on behalf of the person served/enrollee alleging a violation of a Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

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3.17 **Second Opinion:** A request by an applicant for mental health or substance use services, a person served seeking hospitalization, or their legal representative for another assessment by a professional who was not involved in the original assessment, for eligibility for mental health services or hospitalization. Persons served must be informed verbally and in writing of their right to request a second opinion.

3.17.1 **Medicaid:**

3.17.1.1 **Denial of initial service request:** If an initial service request is denied, a Medicaid enrollee may request a second opinion by writing the Chief Executive Officer (CEO). The CEO must respond **within 5 business days.** Customer Services or Access Clinicians can help an enrollee submit this request.

3.17.1.2 **Denial of inpatient psychiatric hospitalization:** If a Medicaid enrollee is denied inpatient psychiatric hospitalization, they may request a second opinion from the CEO. The second opinion will be completed within 3 calendar days by a psychiatrist, other physician, or licensed psychologist, excluding Sundays and legal holidays, of the request. The CEO/Medical Director will give the disposition within **3 calendar days** verbally and then follow-up in writing within **30 calendar days.**

3.17.2 **Non-Medicaid:**

3.17.2.1 **Denial of initial service request:** If an initial service request is denied, a person served may request a second opinion by writing the Chief Executive Officer (CEO). The CEO must respond within 5 business days. If this is denied, you may file a recipient rights complaint. Customer Services or Access Clinicians can help an enrollee submit this request.

3.17.2.2 **Denial of inpatient psychiatric hospitalization:** If a person served is denied psychiatric hospitalization and requests a second opinion on the denial, the second opinion will be completed within 3 calendar days, excluding Sundays and legal holidays. The person served will be given the disposition verbally within the 3-day timeline and in writing within 30

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calendar days of the decision.

3.18 **Medicaid State Fair Hearing:** Impartial state level review of a Medicaid Enrollee's appeal of an adverse benefit determination, presided over by a Michigan Department of Health and Human Services (MDHHS) Administrative Law Judge (ALJ). Also referred to as "Administrative Hearing." The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

4.0 Information Requirements

4.1 All persons served shall be provided information about grievance, local appeal, and state fair hearing procedures and time frames. The information shall include:

4.1.1 the local appeal process for challenging an "action" taken by The Right Door for Hope, Recovery and Wellness or one of its agents.

4.1.2 how to access the state level fair hearing process for an appeal of a local appeal decision resulting in a denial (if a Medicaid Enrollee).

4.1.3 how to access the Alternative Dispute resolution process for an appeal of a local appeal decision resulting in a denial (if a Non-Medicaid recipient).

4.1.4 how to file a grievance for expressions of dissatisfaction about any matter other than those that meet the definition of adverse benefit determination (Medicaid) or an action (Non-Medicaid) AND the timeframes.

4.1.5 the right to file a State Fair Hearing or Alternative Dispute resolution if The Right Door for Hope, Recovery and Wellness does not respond to a local appeal request at all or provide notice of resolution in the required timeframe.

4.1.6 the right to file a complaint with the PIHP if a complaint is not resolved to satisfaction or timely (if a Medicaid enrollee) or right to file a complaint with MDHHS customer services.

4.1.7 the right of a Medicaid enrollee to request, and have, Medicaid benefits continued while a local appeal is pending, if requested specifically and within 10 days of the effective date of the action notice.

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4.1.8 the right to have a provider, acting on the recipient's behalf and with the recipient's written consent, file an appeal to The Right Door for Hope, Recovery and Wellness. 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. Punitive action may not be taken by The Right Door for Hope, Recovery and Wellness against a provider who acts on the recipient's behalf with the recipient's written consent to do so.

4.1.9 the availability of assistance in the filing process (including providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capacity.),

4.1.10 the toll-free number (1-888-527-1790) that persons served can use to file a grievance or appeal by phone,

4.1.11 the fact that services will continue if requested by the person served/enrollee if a Medicaid enrollee files a local appeal within 10 calendar days of the date of the action notice date or effective date (whichever is later).

4.1.12 the fact that services will continue during a State Fair Hearing IF the Medicaid enrollee had services continued in a local appeal and IF they appeal to a State Fair Hearing within 10 days of the local appeal decision/resolution letter, and

4.1.13 the fact that the person served may be asked to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the person served.

5.0 Medicaid Adverse Benefit Notice Requirements

5.1 Notice is given whenever an adverse benefit determination occurs, and at the time of the development of the Person-Centered Plan. The notice must be in writing and must be provided in the language format needed by the individual to understand the content.

5.2 The forms required to request a local appeal shall accompany the notice to the person served.

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5.3 The appropriate notice to be given, either Advance Notice or Adequate Notice, is based on the type of action being taken and Medicaid eligibility. The notice must also be given within required timeframes.

5.3.1 Adequate is provided at the time of EACH action (like initial denials or denial of hospitalizations) and including the PCP.

5.3.2 Advance is provided prior to suspending, terminating or reducing any CURRENT service.

5.4 Notification of a denial of services is sent to both the person served/enrollee and the provider, as appropriate.

5.5 The adequate and advance notice must include:

5.5.1 The reason(s) for the action and the policy relied upon to make your determination, 42 CFR 440.230(d) is the basic legal authority for an action to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures,

5.5.2 The enrollee's or provider's right to file a local appeal, and instructions for doing so,

5.5.3 The enrollee's right to request a State fair hearing, and instructions for doing so,

5.5.4 The circumstances under which expedited resolution can be requested, and instructions for doing so,

5.5.5 An explanation that the enrollee may represent themselves or use legal counsel, a relative, a friend or other spokesman.

5.6 The advance notice must ALSO include an explanation of:
5.6.1 The circumstances under which services will be continued pending resolution of the appeal,

5.6.2 How to request that benefits be continued, and

5.6.3 The circumstances under which the beneficiary may be required to pay the costs of these services.

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6.0 Non-Medicaid Action Notice Requirements

Whenever a currently authorized service or support or currently authorized services are to be suspended, terminated, or reduced by The Right Door for Hope, Recovery and Wellness, we must inform the person served with written notification of the change at least 30 days prior to the effective date of the action. The notice shall include:

a. A statement of what action The Right Door for Hope, Recovery and Wellness intends to take;
b. The reasons for the intended action;
c. The specific justification for the intended action;
d. An explanation of the Local Dispute Resolution Process

Actions taken during the person-centered planning process or those ordered by a are not considered an adverse action.

7.0 Advance Notice of Adverse Benefit Decision/Action Notice Exceptions

7.1 An advance notice is not required if:

7.1.1 The Right Door for Hope, Recovery and Wellness has factual information confirming the death of a person served,

7.1.2 The Right Door for Hope, Recovery and Wellness receives a clear written statement signed by the person served or their legal representative that: they no longer wishes services, or give information that requires termination or reduction of services and indicates that they understand that this must be the result of supplying the information.

7.1.3 the person served has been admitted to an institution where they are ineligible for further services.

7.1.4 the individual's whereabouts are unknown, and the post office returns The Right Door for Hope, Recovery and Wellness' mail directed to them indicating no forwarding address.

7.1.5 The Right Door for Hope, Recovery and Wellness establishes the fact that the person served has been accepted for services by another CMH.

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7.1.6 A change in the level of medical care is prescribed by the individual's physician, or the physician of the person served makes a determination that a particular service is not medically needed.

7.1.7 The date of the action will occur in less than ten (10) calendar days due to a compelling and/or emergent reason the change must occur, for example a health or safety issue.

7.2 The Right Door for Hope, Recovery and Wellness may shorten the period of advance notice to 5 days (42 CFR: 431.214) before the date of action if –

7.2.1 The agency has facts indicating that action should be taken because of probable fraud by the beneficiary; and

7.2.2 The facts have been verified, if possible, through secondary sources.

8.0 Maintaining Services

8.1 If a Medicaid Enrollee is receiving a Medicaid service and they file an appeal by the "effective date" listed on the advanced action notice, they have the right to continue to receive the same level of services while the local appeal is pending. This will not automatically happen. It must be requested at the time of the appeal.

8.2 The Right Door for Hope, Recovery and Wellness may seek reimbursement from the person served for a portion of the services received during the appeal process if the appeal outcome upholds the decision being appealed. This is NOT always true, but if required, The Right Door for Hope, Recovery and Wellness will notify the person served of the amount. The Right Door for Hope, Recovery and Wellness may seek reimbursement from the person served for the cost of any services provided to the person served during this period of time, up to the individual's ability to pay as determined by the Code.

8.3 Continuation of Services during a Medicaid Fair Hearing:

8.3.1 If The Right Door for Hope, Recovery and Wellness previously approved coverage for a service but then decided to change or stop the service before the authorization ended, a person served can in some cases, continue their benefits during the State Fair Hearing process.

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8.3.2 Benefits for that service(s) will continue if the person served qualified for continuation of benefits during the local appeal and a State Fair Hearing was requested from the Michigan Administrative Hearing System (MAHS) within 10 calendar days from the date of the denial of local appeal resolution notice. The person served must state in the request that they want their service(s) to continue.

8.3.3 If benefits are continued during a State Fair Hearing, a person served can keep getting service(s) until one of the following happens:

1) the person served withdraws a State Fair Hearing request; or

2) MAHS gives a decision denying the appeal request.

9.0 Reinstatement of Services

9.1 Local appeal:
The Right Door for Hope, Recovery and Wellness will implement a Local Appeal decision that results in reversal of an adverse benefit determination and provide services within 14 calendar days, excluding Sundays and legal holidays.

9.2 Medicaid Fair Hearing:
The Right Door for Hope, Recovery and Wellness must implement a Medicaid Fair Hearing decision that results in reversal of an adverse benefit determination and provide services within 72 hours from the overturn.

10.0 Appeals and Grievance Resolution Processes

10.1 The person served has a number of choices for resolution of appeals and grievances, based on the type of action being taken and Medicaid eligibility.

10.2 Complaints should be resolved at the level closest to service delivery when possible, and information regarding access to all complaint resolution processes will be provided to the enrollee/recipient of services.

10.3 Local dispute resolution processes may be engaged concurrently with an appeal to the Office of Recipient Rights.

10.4 The Right Door for Hope, Recovery and Wellness may offer mediation services as an alternative to formal dispute resolution processes. The contracts department should be contacted for assistance in providing mediation services.

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10.5 An aggregated report of appeals shall be periodically reported through The Right Door for Hope, Recovery and Wellness's Quality Improvement Program for review.

11.0 Local Dispute/Appeals Resolution

11.1 Appeals Requirements:

11.1.1 Oral requests for appeals are accepted, but must be confirmed in writing, unless the person served requests expedited resolution. The date that an oral request for an appeal is received will be considered the filing date.

11.1.2 Reasonable assistance must be given to the person served in completing forms and taking other steps to complete the appeals process, including, but not limited to, the use of interpreter and/or translation services.

11.1.3 Reasonable opportunity is given to the person served to present evidence, and allegations of fact or law, in person as well as in writing. In the case of an expedited resolution, The Right Door for Hope, Recovery and Wellness must inform the person served of limited time frames.

11.1.4 Opportunity is given to the person served, or his/her representative, to examine before and after the appeals process, the case file of the person served, including medical records and any other documents considered during the appeal process.

11.1.5 Parties to the appeal must include the person served and his/her representative; or the legal representative of the estate of a deceased person served.

11.2 Appeal Process:

11.2.1 Appeal (internal): A review at the local level of an Adverse Benefit Determination or Adverse Action, as defined above. 42 CFR 438.400.

11.2.1.1 Medicaid: The Right Door for Hope, Recovery and Wellness must address any request for a local appeal

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received within 60 days of the date of the adverse action going into effect (effective date). An internal (local) appeal decision must be provided within 30 calendar days of the receipt of the request.

11.2.1.2 Non-Medicaid: An internal appeal request must be received within 30 calendar days of the Action Notice. A written decision on a standard appeal must be provided within 45 calendar days after it was received. The Right Door for Hope, Recovery and Wellness might take longer, but only if it is due to the need for additional information from the person served or if the person served requests the extension. If we are extending the 30 days, notification must be provided to the person served and all applicable parties.

11.2.1.3 If your appeal is for payment of a service you've already received, we'll give you a written decision within 60 calendar days.

11.2.2 The Customer Services/Recipient Rights Office shall:

i) log the receipt of the appeal,

ii) acknowledge receipt of the appeal within 7 calendar days, excluding Sundays and legal holidays, (For a Medicaid beneficiary receiving a Medicaid service, shall notify the beneficiary, his/her legal representative, or parent/guardian in the case of a minor, of their right to request a MDHHS Fair Hearing in lieu of, or in addition to, the appeal. This must include information on the process for filing a request, an explanation of time frames, and circumstances under which services will be continued pending the hearing decision.)

iii) After consulting with the CEO or designee, submit the appeal for review by appropriate staff, including:

a) a health care professional who has the appropriate clinical expertise in treating the condition of the person served , and

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b) a CMH administrator with the authority to require corrective action, all of whom were not involved in the initial determination of the action.

iv) facilitate a review of the appeal and provide a resolution notice within **forty-five (45) calendar days for non-Medicaid** OR **within thirty (30) calendar days for Medicaid** from receipt of the appeal, or assure an expedited review within three (3) business days (for Non-Medicaid) OR seventy-two (72) calendar hours (for Medicaid) of receipt of an appeal if the appeal involves an emergent situation where the standard time frame would seriously jeopardize the health or life of the individual.

a) Medicaid Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by an Enrollee or the Enrollee's provider. 42 CRF 438.410(a). An Enrollee has the right to request an "expedited" or "fast" appeal if waiting the standard time of 30 calendar days for the appeal decision would seriously jeopardize their life or health or their ability to attain, maintain, or regain maximum function. A provider may also ask on the behalf of a person served. The Right Door for Hope, Recovery and Wellness will automatically grant an expedited appeal if the doctor of a person served supports their request. If a person served or their provider ask for an expedited appeal without support from a doctor, The Right Door for Hope, Recovery and Wellness will decide if the request requires an expedited appeal. The Right Door for Hope, Recovery and Wellness will give a decision on an expedited appeal within 72 hours after it is received.

a. If a request for expedited resolution is denied, we must:

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

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

iii. Within 2-calendar days, give the Enrollee

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written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision. 42 CFR 438.408(c)(2), 438.410(c)(2).

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

b) 3.10.2 Non-Medicaid Expedited Appeal: A person served can request an "expedited" or "fast" appeal if waiting the standard time of 45 calendar days for the appeal decision would seriously jeopardize life or health or ability to attain, maintain, or regain maximum function. The provider of a person served may also ask on their behalf. The Right Door for Hope, Recovery and Wellness will automatically grant an expedited appeal if the doctor of a person served supports their request. If a person served or their provider ask for an expedited appeal without support from a doctor, The Right Door for Hope, Recovery and Wellness will decide if the request requires an expedited appeal. If the request is approved, the agency will give a decision on a "fast" appeal within 3 business days, excluding Sunday and legal holidays, after the appeal is received.

a. If a request for expedited resolution is denied, we must:

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

ii. Make reasonable efforts to give the Enrollee prompt oral notice of the denial.

iii. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision.

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

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exceed 45 calendar days.

c) provide resolution notice as defined in section 11.3 below.

11.3 Resolution Notice:

11.3.1 Content -The appeal resolution notice must include the following information:

i) the results of the resolution process and date it was completed.

ii) for appeals not resolved wholly in favor of a Medicaid beneficiary's dispute of an action impacting a Medicaid covered service, information regarding:

a) the right to request an MDHHS Fair Hearing, and how to do so, including an offer of assistance, and

b) the right to request to receive services while the hearing is pending if the request is made within 10 calendar days from the date of the resolution notice AND services stayed in place during the local appeal (the request must be made by contacting customer services), including an offer of assistance, and

c) the cost of services for which the beneficiary may be held liable if the hearing upholds the CMH's action.

iii) for appeals not resolved wholly in favor of the dispute of the person served of an action impacting a non-Medicaid service, information regarding:

a) the right to seek MDHHS alternative dispute resolution, and how to do so, including an offer of assistance.

iv) for appeals resolved to the satisfaction of the person served and/or his legal representative, an explanation of, and an offer of assistance in the process for withdrawing any request filed for a MDHHS Fair Hearing.

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11.3.2 Timing

i) Medicaid: Written resolution notice must be submitted to the person served or his/her legal representative within thirty (30) calendar days following receipt of the appeal.

ii) Non-Medicaid: Written resolution notice must be submitted to the person served or his/her legal representative within forty-five (45) calendar days following receipt of the appeal.

ii) Medicaid: For notice of an expedited appeal, The Right Door for Hope, Recovery and Wellness must make reasonable efforts to provide verbal notice within 72 hours followed by written notice within two (2) business days following receipt of the appeal.

12.0 Denial of Hospitalization

12.1 If a person served or his/her legal representative requests a second opinion, the request shall be processed in compliance with Sections 409(4), 498e(4) and 498h(5) of the Code.

12.1.1 Section 330.1409(4), 330.1498e(4), and 330.1498h(5) state: If the preadmission screening unit or children's diagnostic and treatment service of the community mental health services program denies hospitalization, the individual or the person making the application may request a second opinion from the executive director. The executive director shall arrange for an additional evaluation by a psychiatrist, other physician, or licensed psychologist to be performed within 3 calendar days, excluding Sundays and legal holidays, after the executive director receives the request. If the conclusion of the second opinion is different from the conclusion of the preadmission screening unit (Prescreen Clinician) the executive director, **in conjunction with the medical director**, shall make a decision based on all clinical information available. The executive director's decision shall be confirmed in writing to the individual who requested the second opinion within 30 calendar days.

12.1.2 If the conclusion of the second opinion is different from the conclusion of the previous decision, the CEO in conjunction with the Medical Director shall make a decision based upon all clinical information available within one (1) business day.

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12.1.3 The CEO's decision shall be confirmed in writing within 30 calendar days to the individual who requested the Second Opinion. The confirming document shall include the signatures of the CEO and Medical Director or verification that the decision was made in conjunction with the Medical Director.

12.1.4 If the request for a Second Opinion is denied, the individual or someone on their behalf may file a Recipient Rights Complaint with the Recipient Rights Office.

12.1.5 If the initial request for inpatient admission is denied and the individual is a current person served of other CMHSP services, the individual or someone on their behalf is informed that they may file a Recipient Rights Complaint with the Recipient Rights Office alleging a violation of the right to treatment suited to condition.

12.1.6 If the Second Opinion determines the individual is not clinically suited for hospitalization and the individual is a current person served of other services provided by The Right Door for Hope, Recovery and Wellness, and a recipient rights complaint has not been filed previously on behalf of the individual, the individual or someone on their behalf may file a complaint with the Recipient Rights Office.

12.1.7 In the event that a physician or licensed psychologist external to The Right Door for Hope, Recovery and Wellness attests in writing that the individual (applicant or current recipient) meets the definition of an emergency situation as defined in Section 100a (23)(a) or (c) of the Michigan Mental Health Code, The Right Door for Hope, Recovery and Wellness must assess the individual to determine if the individual meets the inpatient admission certification criteria, as defined in the MDHHS Service Selection Guidelines. If psychiatric inpatient services are denied, the individual, their guardian, or parent in the case of a minor child, must be informed of their right to a Second Opinion.

12.3 A Recipient Rights complaint may be filed by the person served or someone acting on their behalf at any time during the denial and second opinion process.

13.0 Denial of Access to Services for Individuals Not Receiving Any CMH Services

13.1 If an individual applicant for services is denied such services, the applicant or their 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 CEO or designee. The request

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shall be processed in compliance with 705 of the Code and must be resolved within **five (5) business days**.

13.1.1 The executive director will secure a second opinion from a physician, licensed psychologist, registered professional nurse, or master's level social worker or master's level psychologist.

13.1.2 If the individual providing the second opinion determines that the applicant has a serious mental illness, serious emotional disturbance, developmental or intellectual disability or substance use disorder, or is experiencing an emergency situation or urgent situation, The Right Door for Hope, Recovery and Wellness will provide services to the applicant.

13.2 The applicant or their guardian may not file a recipient rights complaint for denial of services suited to condition as they do not have standing as a person served of mental health services.

13.3 The applicant or their guardian may, however, file a rights complaint if the request for a second opinion is denied.

14.0 Denial of Family Support Subsidy:

14.1 If an application for a family support subsidy is denied, or a family support subsidy is terminated by an The Right Door for Hope, Recovery and Wellness service program, the parent or legal guardian of the affected eligible minor shall be informed of their right to appeal the decision.

14.2 The parent or legal guardian may request in writing, within two (2) months of the notice of denial or termination, a hearing by The Right Door for Hope, Recovery and Wellness service 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, Sections 24.271 to 24.287 of the Michigan Compiled Laws.

14.3 The Right Door for Hope, Recovery and Wellness shall make available for the purposes of the appeal copies of blank applications forms, parent report forms, the forms for changed family circumstances, and appeal forms/request (families are to write a letter to The Right Door for Hope, Recovery and Wellness Customer Services requesting an appeals hearing, in lieu of a standardized appeal form).

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14.4 If a denial is due to insufficiency of information on the application form or required attachments, The Right Door for Hope, Recovery and Wellness shall identify the insufficiency in the denial notice.

14.5 If an appeals hearing is held at The Right Door for Hope, Recovery and Wellness and the presiding officer upholds the family's appeal in violation of Mental Health Code language, The Right Door for Hope, Recovery and Wellness will reimburse MDHHS the disputed amount.

14.6 Families wishing to appeal the decision of The Right Door for Hope, Recovery and Wellness' hearings officer may do so through circuit court in their county of residence.

14.7 If The Right Door for Hope, Recovery and Wellness approves an application in violation of Mental Health Code language or without full documentation proving eligibility, MDHHS shall require that The Right Door for Hope, Recovery and Wellness reimburse MDHHS the disputed amount.

15.0 Grievance Process

15.1 The person served, guardian, or parent of a minor child or their legal representative may file a grievance at any time regarding dissatisfaction with any aspect of service provision other than an action as defined in this procedure or an allegation of a recipient rights violation.

15.2 The person served must be given reasonable assistance in completing forms for filing a grievance.

15.3 The grievance shall be filed with The Right Door for Hope, Recovery and Wellness' Customer Services/Recipient Rights Office.

15.4 The Customer Services/Recipient Rights Office shall:

15.4.1 log receipt of the verbal or written grievance,

15.4.2 determine whether the grievance is more appropriately a Recipient Rights complaint, and if so, refer the grievance, with permission of the person served, to the Office of Recipient Rights,

15.4.3 acknowledge to the person served receipt of the grievance with a notice within 7 calendar days,

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15.4.4 ensure that health care professionals who have the appropriate clinical expertise in treating the beneficiary's condition or disease and do not have previous involvement in review or decision-making review clinical issues,

15.4.5 provide written notice of the disposition within ninety (90) calendar days (FOR MEDICAID) and sixty (60) calendar days from the date of filing (FOR NON-MEDICAID).

15.4.6 If the notice of disposition is more than the required timeframe for providing disposition, the disposition notice must include the right to a Medicaid Fair Hearing and how to access it if a Medicaid Enrollee OR the number for MDHHS Customer Service if a non-Medicaid recipient .

15.4.7 The notice must include:

i The results of the grievance process
ii The date the grievance process was conducted
iii The beneficiary's right to request a fair hearing if the notice of disposition is more than ninety (90) calendar days from the date of the request for a grievance.
iv How to access the fair hearing process
v Where to mail a fair hearing request

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15.5 An aggregated report of grievances shall be periodically reported through The Right Door for Hope, Recovery and Wellness's Quality Improvement Program for review.

16.0 Medicaid Fair Hearing (Medicaid Enrollees)

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

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

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

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

16.3 The Right Door for Hope, Recovery and Wellness may not limit or interfere with an Enrollee's freedom to make a request for a State Fair Hearing.

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

16.5 The Right Door for Hope, Recovery and Wellness is required to continue benefits, if the following occurs:

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

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

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

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

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

16.8 Expedited hearings are available.

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

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

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OR

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

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

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

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

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

17.0 Appeals and Grievances Record-keeping and Reporting Requirements

17.1 The Right Door for Hope, Recovery and Wellness shall inform Mid-State Health Network (MSHN) when a fair-hearing is scheduled by sending a copy of the notice(s) to MSHN. The disposition of all fair-hearings must also be sent to MSHN.

17.2 The Right Door for Hope, Recovery and Wellness shall maintain a record of appeals and grievances and their disposition that is available for review by PIHP and MDHHS staff, upon request.

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17.3 The records shall contain sufficient information to accurately reflect:

16.3.1 the process in place to track requests for services denied by The Right Door for Hope, Recovery and Wellness or any of its providers.

16.3.2 the volume of denied claims for services in the most recent fiscal year.

17.4 The record of appeals and grievances and their disposition shall be periodically reported to and reviewed through The Right Door for Hope, Recovery and Wellness's Quality Improvement Program.

18.0 Incentives Not Present

Incentives are not present for the denial, limitation, or discontinuation of services to any consumer/enrollee.

References

- P.A. 258 of 1974, as amended (Michigan Mental Health Code)
- Michigan Department of Health and Human Services, Medicaid Provider Manual
- Michigan Department of Health and Human Services, PIHP Appeal and Grievance Technical Requirement.
- Michigan Department of Health and Human Services/Community Mental Health Service Provider Specialty Services Managed Care Contract - CMHSP LOCAL DISPUTE RESOLUTION PROCESS

Kerry Possehn, Chief Executive Officer	Date		