ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Date Issued: 07/16/2024

ADMINISTRATIVE DIRECTIVE:
This document is to be attached to the Administrative Procedure listed below. The changes in SECTION II replace applicable portions listed and will remain in effect until the Administrative Procedure is revised.

CHAPTER Access to Services		**CHAPTER** 02	**SECTION** 001	**SUBJECT** 0045
SECTION Access	**SUBJECT** Appeal Process & Second Opinion			
ADMINISTRATIVE DIRECTIVE WRITTEN BY: Sandy O'Neill			**AUTHORIZED BY** Telly Delor	

I. APPLICATION:

☐ SCCCMHA Board
☒ SCCCMHA Providers & Subcontractors
☒ Direct-Operated Programs
☒ Community Agency Contractors
☒ Residential Programs
☒ Specialized Foster Care

II. ADMINISTRATIVE DIRECTIVE:

Effective immediately, the purpose of this Administrative Directive is to revise Administrative Procedure #02-001-0045, Appeal Process & Second Opinion related to:

V. PROCEDURES:

D. Second Opinion (review for denial to enter SCCCMHA services or Inpatient Psychiatric Admission)

Individual Requesting Second Opinion or their Representative

1. Contacts Customer Services for a second opinion if they disagree with a service denial as outlined below:
   If the preadmission screening unit of SCCCMH denies hospitalization, the individual or the person making the application may request a second opinion from the Chief Executive Officer (CEO). The CEO shall arrange for an additional evaluation by a psychiatrist, other physician, or licensed psychologist to be performed within three (3) days, excluding Sundays and legal holidays, after the CEO receives the request. If the conclusion of the second opinion is different from the conclusion of the preadmission screening unit, the CEO, in conjunction with the medical director, shall make a decision based on all clinical information available. The CEO's decision shall be confirmed in writing to the individual who requested the second opinion, and 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. If an individual is assessed and found not to be clinically suitable for hospitalization, the preadmission

screening unit shall provide information regarding alternative services and the availability of those services and make appropriate referrals.

ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

Date Issued 11/23

CHAPTER Access to Services		**CHAPTER** 02	**SECTION** 001	**SUBJECT** 0045
SECTION Access	**SUBJECT** Appeal Process & Second Opinion			
WRITTEN BY Jason Sparks, Lisa K. Morse, Kim Prowse, and Lonnie Sharkey	**REVIWED BY** Latina K. Cates		**AUTHORIZED BY** Tracey Pingitore	

I. APPLICATION:

- ☐ SCCCMHA Board
- ☒ SCCCMHA Providers & Subcontractors
- ☒ Direct-Operated Programs
- ☒ Community Agency Contractors
- ☒ Residential Programs
- ☒ Specialized Foster Care

II. PURPOSE STATEMENT:

St. Clair County Community Mental Health Authority (SCCCMHA) shall ensure that all individuals have the right to a fair and efficient process for receiving a second opinion and resolving disagreements regarding their services and supports. An individual receiving or applying for public mental health services may access several options to pursue the resolution of disagreements. This system includes both mental health and substance use disorder services and treatments. It is the administrative procedure of SCCCMHA to follow all state and federal regulations regarding the resolution of complaints and disputes individuals may have about their services and supports.

This administrative procedure and any corresponding policies in no way requires the individual to utilize the mediation, grievance or appeal processes prior to the filing of a recipient rights complaint pursuant to Chapter 7 and 7a of the Michigan Mental Health Code and SCCCMHA policies relative to the filing of Recipient Rights Complaints. This is also true for the Recipient Rights process for substance use disorder services.

III. DEFINITIONS:

A. Adverse Benefit Determination : A decision that adversely impacts an enrollee's claim for services due to:

1. Denial or limited authorization of a requested service, including the type or level of service requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. Reduction, suspension, or termination of a previously authorized service.
3. Denial, in whole or in part, of payment for a service.
4. Failure to make a standard Service Authorization decision and provide notice about the decision with 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 after receipt of a request for expedited Service Authorization.

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6. Failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning and as authorized by the SCCCMHA.
7. Failure of the PIHP/SCCCMHA to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal.
8. Failure of the PIHP/SCCCMHA to resolve expedited appeals and provide notice within 72 hours (three working days) from the date of a request for an expedited appeal.
9. Failure of the SCCCMHA to resolve grievances and provide notice within 90 calendar days of the request.
10. For a resident of a rural area with only one provider, the denial of an enrollee's request to exercise his or her right to obtain services outside the network.
11. Denial of enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums deductibles, coinsurance, and other beneficiary's financial responsibility.

B. Adequate Notice of Adverse Benefit Determination: Written statement advising the enrollee of a decision to deny or limit authorization of a requested service, which notice must be provided **on the same date the Adverse Benefit Determination takes effect.**

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

D. Appeal: Request for a review of an Adverse Benefit Determination as defined above. Impartial local level review of an individual's appeal of an Adverse Benefit Determination action presided over by individuals not involved with decision-making or previous level of review. This is handled by the PIHP for Medicaid enrollees and by SCCCMHA for non-Medicaid individuals. A second opinion may be appealed if the PIHP has not resolved the complaint (Notice of Disposition) in the allotted timeframes.

E. Applicant: An individual, or his or her guardian, who makes a request for entrance into SCCCMHA services.

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

G. Enrollee: An individual who is receiving or may qualify to receive Medicaid services through PIHP/SCCCMHA provider network.

H. Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by an enrollee or the enrollee's provider, when the appropriate party determines taking the time necessary for the normal appeal review process could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. If the enrollee requests the expedited review, the SCCCMHA/PIHP determines if the request is warranted. If the enrollee's provider makes the request or supports the enrollee's request, the SCCCMHA/PIHP must grant the request for expedited appeal.

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I. Mediation: A confidential process in which a neutral third party facilitates communication between parties, assists in identifying issues, and helps explore solutions to promote a mutually acceptable resolution. A mediator does not have authoritative decision-making power.

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

K. Notice of Resolution: Written statement of the decision for each appeal provided to the enrollee.

L. Recipient Rights Complaint: Written or verbal statement by a person receiving services, or anyone acting on behalf of the person receiving services, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

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

N. State Fair Hearing: Impartial state level review of a Medicaid enrollee's appeal of an Adverse Benefit Determination presided over by a MDHHS Administrative Law Judge. This is also referred to as "Administrative Hearing".

O. State-Level Alternative Dispute Resolution Process: An impartial review, conducted by a MDHHS representative, regarding a decision by the PIHP or SCCCMHA to deny, reduce, suspend, or terminate a non-Medicaid recipient's service or a Medicaid recipient's non-Medicaid service.

IV. STANDARDS:

A. GENERAL

1. Individuals applying for or receiving publicly funded services may access several options to pursue the resolution of complaints. These options may include the right to file a local appeal, grievance or a Recipient Rights complaint. Options may also include the right to request mediation, request a second opinion or a State Fair Hearing.

2. During the initial contact with the Access Center and the Central Intake Unit, the applicant is provided information both verbally and in writing of his/her rights, mediation, the appeals process, and the right to access the appropriate process (Recipient rights process is not available to an applicant.)

3. Individuals who wish to file an appeal may do so independently or with the assistance of Customer Services, other available staff, or a person of their choosing. A provider may not refuse to assist the individual who needs help in creating an appeal and submitting that appeal for resolution.

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4. Non-Medicaid individuals or Medicaid beneficiaries receiving non-Medicaid services are required to exhaust the local appeal process before they can access the MDHHS Alternative Dispute Resolution Process.

5. Should an individual involved with this process have limited-English proficiency, the CMHSP/organizational provider will take necessary and reasonable steps to make any accommodations. This includes, but is not limited to, auxiliary aids and services such as interpreter services, toll-free numbers, TTY/TTD, and/or Video Relay Services, all at no cost to the individual.

6. SCCCMHA provides information about the grievance system (which includes mediation, grievance, appeals, request for second opinion and state fair hearing) to all providers and subcontractors at the time they enter into a contract.

7. Applicants denied entrance into SCCCMHA services receives written notification of the right to request Second Opinion.

B. MEDIATION

1. A recipient/recipient's representative may request mediation at any time when there is a dispute related to service planning or the services/supports provided by a CMHSP or services/supports provided by a CMHSP contracted provider. Disputes around services defined in Chapter 2, 330.1206 are open to mediation.

2. A recipient/recipient's representative has the right to request mediation at the same time a local dispute resolution, local appeal, Medicaid Fair hearing process or recipient rights complaint investigation is occurring.

3. A recipient/recipient's representative has the right to request and have other dispute resolution processes suspended unless prohibited by law or precluded by a report of an apparent or suspected violation of rights as delineated in Chapter 7 of the Mental Health Code.

4. Mediation services are provided by a neutral third party contracted through and paid for by the Michigan Department of Health and Human Services.

5. Mediation does not apply to:

   a. Disputes regarding medical necessity determinations.

   b. An Assisted Outpatient Treatment (AOT) court order once granted by a probate judge.

   c. Recipient rights services or to any disputes regarding recipient rights services.

C. NOTICE OF ADVERSE BENEFIT DETERMINATION

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1. SCCCMHA will utilize the Notice of Adverse Benefit Determination for any determinations that adversely impacts individual's services or supports. Notices must meet the language format needs of the individual as specified in 42CFR 438.10. Notice must be in writing and must include:

    a. The Adverse Benefit Determination description that has been taken or is proposed;
    b. The reason for the Adverse Benefit Determination, including the policy/administrative procedure/authority relied upon for the decision;
    c. The effective date of the action;
    d. The right to file an Internal Review/Local Level Appeal through the PIHP Grievance and Appeal Office and instructions for doing so as well as their right to request a state fair hearing thereafter;
    e. The circumstances under which an expedited appeal can be requested and instructions for doing so;
    f. An explanation of how the individual may represent him/herself or use legal counsel, a relative, a friend, or other spokesperson;
    g. The right for the individual to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the individual's Adverse Benefit Determination (including medical necessity criteria, and process, strategies, or evidentiary standards used in setting coverage limits);
    h. The individual's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstance under which the individual may be required to pay the cost of the continued services (Advance Notice only);
    i. That 42CFR 440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

2. At the time of an adverse decision regarding services, SCCCMHA shall complete the appropriate written Notice of Adverse Benefit Determination and give/mail to the individual/guardian.

    a. The requesting provider must be provided notice of any decision by the PIHP/SCCCMHA to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. Notice to the provider does NOT need to be in writing.

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

3. Timing of Notices (see definition of Adverse Benefit Determination):

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a. Adequate Notice must be given/mailed to enrollee/guardian on the same date the Adverse Benefit Determination (see definition A), for all instances, which are considered and related timing. Adequate notices are used for the following determinations:

(1) Denial of payment for service requested (not currently provided), in part or whole, notice must be provided at the time of the action affecting the claim.
(2) Denial of access into mental health service programs.
(3) Denial of access into Substance Use Disorder programs.
(4) Denial or limited denial of requested services, amount, or duration of services.

b. Advance Notice must be given/mailed to the individual/guardian a minimum of 10 calendar days prior to the effective date of the proposed date the Adverse Benefit Determination is to take effect. Advance notices are used for the following determinations:

(1) Termination of services prior to the end of the current authorization.
(2) Reduction of services prior to the end of the current authorization.
(3) Suspension of services prior to the end of the current authorization.

4. Exceptions to Advance Notice:

a. A notice may be mailed/given no later than the date of action of previously authorized services if:

(1) There is factual information confirming the death of an individual.
(2) The PIHP/CMHSP receives a clear written statement signed by an individual that he no longer wishes services, or that gives information that requires the termination or reduction of services, and indicates that the individual understands that this must be the result of supplying that information.
(3) The individual has been admitted to an institution where he/she is ineligible under Medicaid for further services.
(4) There is established fact that the individual has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
(5) The individual's whereabouts are unknown and the United States Post Office returns agency mail directed to him/her indicating no forwarding address.
(6) A change in the level of medical care is prescribed by the individual's physician.
(7) The notice involves an adverse determination made with regards to the preadmission screening requirement of section 19(e)(7) of the Act.
(8) The date of action will occur in less than 10 calendar days.
(9) The PIHP/CMHSP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the individual (PIHP/CMHSP has 5 days in this case).

D. APPEAL (also known as PIHP Internal Review/Appeal) (Medicaid Appeal)

1. Individuals may pursue the option to dispute or appeal any Adverse Benefit Determination.

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2. Individuals are to be directed to the PIHP Grievance and Appeal Office for filing appeals relating to both Medicaid services (mental health) and substance use disorders. This is NOT a delegated function to CMHSPs or SUD providers. Appeals relating to Non-Medicaid services are handled by the CMHSP (see section G on Non-Medicaid Appeals).

3. The PIHP Appeal is the first step of appeal and must be completed prior to the State Fair Hearing.

4. Individuals are given **60 calendar days** from the date of the Notice of Adverse Benefit Determination to request the appeal with the PIHP.

5. The individual may request an appeal either orally or in writing. The PIHP must provide the oral inquiries seeking to appeal an Adverse Benefit Determination are treated as requests for filing to establish the earliest possible filing date for the appeal. For standard appeal requests filed orally, the PIHP will send a written request form to the individual to be completed and returned, pursuant to federal regulations.

6. A CMHSP or other organizational provider may file an appeal on behalf of the individual, as long as it has written permission from the individual. The PIHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an individual's appeal. The provider may not request service continuation on behalf of the individual.

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

8. Individuals may request an expedited appeal. Documentation must show that taking the time for a standard resolution could seriously jeopardize the individual's life or health or ability to attain, maintain or regain maximum functioning.

    a. If there is a denial of a request for the expedited appeal the PIHP shall:

        (1) Transfer the appeal to the timeframe for standard resolution; and
        (2) Make reasonable efforts to give the individual prompt oral notice of the denial and follow up within two (2) calendar days with a written notification.
        (3) Provide the individual the option to file a grievance about the denial of the expedited appeal request.
        (4) Resolve the appeal as quickly as the individual's health condition requires but not to exceed 30 calendar days.

    b. If the request is granted the PIHP shall resolve the appeal and provide Notice of Resolution within 72 hours after the PIHP receives the request.

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9. The PIHP may extend the timeframe of resolution of appeal up to 14 calendar days if the individual requests an extension or if evidence can prove the need for additional information will benefit the individual. All of the following must be met:

    a. Make reasonable efforts to give the individual prompt oral notice of the delay;
    b. Within two (2) calendar days give the individual written notice of the reason for the decision to extend the timeframe and inform the individual of the right to file a grievance if they disagree with the decision;
    c. Resolve the appeal as expeditiously as the individual's health condition requires and not later than the date the extension expires.

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

11. Individuals and/or their representative must be allowed the opportunity before and during the appeal process, to examine the individual's case file, including medical records and any other documents and records relied upon during the appeal process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for the appeal.

12. The PIHP will ensure the individual making the decision on appeals are individuals:

    a. Who were not involved in the previous level of review or decision-making, nor a subordinate of that individual;
    b. Who, if deciding either of the following, are healthcare professionals who have the appropriate clinical expertise, as determined by MDHHS, in treating the individual's condition or disease.

        (1) An appeal of denial that is based on lack of medical necessity, or
        (2) An appeal that involved clinical issues.

    c. Must take into account all comments, documents, records, and other information submitted by the individual or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

13. A Notice of Resolution, in writing from the PIHP upon completion of the PIHP appeal, will be given to the individual no later than 30 calendar days from the date of receipt of request for a standard appeal; 72 hours for expedited appeal.

E. STATE FAIR HEARING

1. Individuals with Medicaid have the right to an impartial review by a state level administrative law judge (State Fair Hearing) after Notice of Resolution of the PIHP appeal upholding an Adverse Benefit Determination.

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2. A State Fair Hearing is allowed if the PIHP/SCCCMHA fails to adhere to the notice and timing requirement for the resolution of Medicaid grievances (90 days) and Medicaid appeals (30 days).

3. The PIHP/SCCCMHA may not limit or interfere with an enrollee's freedom to make a request for a State Fair Hearing.

4. Individuals are given **120** calendar days from the date of the Notice of Resolution from the PIHP appeal process to file a State Fair Hearing.

5. Individuals may request service continuation if:

   a. All conditions are met in Section E of this administrative procedures; and
   b. The request was made within 10 calendar days of the date of the Notice of Resolution from the PIHP appeal.

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

7. The parties to the State Fair Hearing include the PIHP, the individual and his/her representative. The Recipient Rights Officer (Mental Health) shall not be appointed as the Hearings Officer because of the inherent conflict of roles and responsibilities. The SCCCMHA is not a party to the State Fair Hearing and is not responsible to facilitate this process.

8. Expedited hearings are available.

F. CONTINUATION OF BENEFITS PENDING APPEAL OR STATE FAIR HEARING

1. Individuals with Medicaid may request services to continue while waiting for appeal if all of the following are true:

   a. The individual files the appeal in a timely manner, within 60 calendar days of the date from the date on the Adverse Benefit Determination notice;
   b. The individual files the request for continuation of benefits timely on or before the latter of:

      (1) 10 calendar days from date of notice of Adverse Benefit Determination, or
      (2) the intended effective date of the proposed Adverse Benefit Determination.

   c. The appeal involved an Adverse Benefit Determination of termination, reduction, or suspension of a previously authorized service;
   d. The services were ordered by an authorized provider;
   e. The original period covered by the original authorization has not expired;
   f. The individual has asked for the continuation of services.

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2. Benefits must continue (if all conditions above are met) until one of the following occurs:

    a. The individual withdraws the appeal or State Fair Hearing request;
    b. The individual fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the PIHP sends the individual the Notice of Resolution, upon completion of the appeal;
    c. The State Fair Hearing offices issues a hearing decision adverse to the individual;
    d. The duration of the previously authorized service has ended.

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

4. If the PIHP or the MDHHS fair hearing administrative law judge reverses a decision to deny authorization of services, and the individual received the disputed services while the appeal was pending, the PIHP or State must pay for those services in accordance with state policy and regulations.

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

6. If the PIHP or the MDHHS fair hearing administrative law judge upholds the Adverse Benefit Determination, the SCCCMHA may consistent with the state's usual policy on recoveries and as specified in the SCCCMHA's contract, recover the cost of services furnished to the Beneficiary while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of the these requirements.

G. LOCAL APPEAL PROCESS (NON-MEDICAID ONLY)

Federal regulations provide a Medicaid beneficiary the right to a local level appeal of an Adverse Benefit Determination. SCCCMHA is extending this right to non-Medicaid covered individuals as well. SCCCMHA appeals are initiated by an Adverse Benefit Determination. The individual served may request a local appeal under the following conditions:

1. The non-Medicaid individual has 30 calendar days from the date of Notice of Adverse Benefit Determination is received (for reduction, suspension or termination) to request a local appeal.

2. A resolution to the appeal must be made by the SCCCMHA within 45 calendar days and conveyed in writing to the non-Medicaid individual.

3. Individuals reviewing/making the decisions on appeal:

a. Shall be health care professionals with appropriate clinical expertise in treating the person's condition or disease when the appeal is of a denial based on lack of medical necessity or involves other clinical issues;
b. Shall have the authority to require corrective action and to act upon the recommendations of the dispute resolution process.
c. Shall not be the same person(s) who made the initial decision that is subject to dispute.

4. There shall be a mechanism for expedited review of an appeal involving denial of psychiatric hospitalization (and also entitled to a Second Opinion for this same type of denial).

   a. In the event that a physician or licensed psychologist external to the CMHSP attests in writing that the individual meets the definition of an "emergency situation" as defined in Section 100a 25(a) or 25(c) of the Code, the CMHSP must assess the individual to determine if the individual meets the inpatient admission certification criteria, as defined in the Code. If psychiatric inpatient services are denied, the individual, his/her guardian, or his/her parent in the case of a minor child, must be informed of their right to the Local Dispute Resolution Process with the decision from that process to be reached within three (3) business days.
   b. If the CMHSP does not recommend hospitalization and an alternative service requested by the individual, his/her guardian, or in the case of a minor child, his/her parent is denied, the CMHSP must inform those same individual(s) of his/her ability to access the Local Dispute Resolution Process. The decision from that process for these persons must be reached within three (3) business days.
   c. The CMHSP must communicate the decision of the Local Dispute Resolution Process and inform the individual, his/her guardian, or his/her parent of a minor child of the right to access the MDHHS Alternative Dispute Resolution Process if not satisfied with the outcome of the local dispute resolution process.

5. When a currently authorized service or support or currently authorized services are to be suspended, terminated, or reduced by the CMHSP or its provider network, whether through a utilization review (UR) function, or when the action is taken outside of the person-centered planning process when the CMHSP does not have an identifiable UR unit, the CMHSP must inform the individual with written notification of the change at least 30 days prior to the effective date of the action. The notice must include:

   a. A statement of what action the CMHSP 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 as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action.

6. The non-Medicaid individual shall be provided with written notification of the local dispute resolution process decision and subsequent avenues available to the individual if he/she is not satisfied with the result, including the right of individuals without Medicaid coverage to access

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the MDHHS Alternative Dispute Resolution process after exhausting local dispute resolution procedures (notice shall include the mailing address in Lansing for the Alternative Dispute Resolution Process)

a. Access to the MDHHS Alternative Dispute Resolution process does not require agreement by both parties and can be initiated solely by the individual.
b. The non-Medicaid individual has 10 days from the written notice of the Local Dispute Resolution process outcome to request access to the MDHHS Alternative Dispute Resolution process.

7. MDHHS responsibilities regarding the Alternative Dispute Resolution Process for individuals not receiving Medicaid:

a. MDHHS shall review all requests within two (2) business days of receipt.
b. If the MDHHS representative, using a "knowledge of mental health services access" standard believes that the denial, suspension, termination or reduction of services and/or supports will pose an immediate and adverse impact upon the individual's health and safety, the issue is referred within one (1) business day to the Community Services Division within Mental Health and Substance Abuse Services for contractual action consistent with Section 8.0 of the MDHHS/CMHSP contract.
c. In all other cases, the MDHHS representative will attempt to resolve the issue with the individual and the CMHSP within 15 business days. The recommendations of the MDHHS representative are non-binding in those cases where the decision poses no immediate impact to the health and safety of the individual. If MDHHS agrees with the CMHSP, the individual may be required to pay for the extended services.

8. SCCCMHA staff will utilize the Appeals module in the electronic health record to document all appeal activities, generate correspondence, and track data for reporting purposes.

H. RECORD KEEPING

1. SCCCMHA is required to keep records of the Non-Medicaid mental health appeals that are processed (the PIHP maintains records of Medicaid appeals). The MDHHS will review the CMH appeals to ensure compliance with requirements, and as part of the state quality strategy.

2. Records must contain the minimum:

a. A description of the reason for the appeal.
b. The date received.
c. The date of review.
d. The resolution of the appeal.
e. The date of the resolution.
f. The name of the covered individual for whom the appeal was filed.

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V. PROCEDURES:

A. Notice of Adverse Benefit Determination

Central Intake Unit Staff or Primary Case Holders

1. Provides Notice of Adverse Benefit Determination to any Medicaid and non-Medicaid individual/guardian verbally and in writing at the time of an adverse decision regarding services.

2. Provides Notice as follows:

   a. Adequate Notice – given/mailed to individual/guardian **on the effective date.**

      (1) Sent to notify of denial of payment for service requested (not currently provided).
      (2) Sent to notify of denial of access to mental health service programs.
      (3) Sent to notify of denial of access to Substance Use Disorder programs.
      (3) Sent to notify of denial or limited denial of requested services, amount, or duration of services.

   b. Advance Notice – given/mailed to individual/guardian a **minimum of 10 calendar days prior to the effective date of the action.**

      (1) Sent to notify of termination of services prior to the end of the current authorization.
      (2) Sent to notify of reduction of services prior to the end of the current authorization.
      (3) Sent to notify of suspension of services prior to the end of the current authorization.

B. Appeals (Medicaid Only)

Individual Requesting Appeal or their Representative

1. Disagrees with the action taken by SCCCMHA.

   a. Contacts PIHP Grievance and Appeal Office within 60 calendar days of the date of the Adverse Benefit Determination Notice to file an Appeal. (If individual or their representative contacts SCCCMHA staff regarding the appeal, they are to be directed to the PIHP Grievance and Appeal Office for assistance).

C. Appeals (Non-Medicaid Only)

Individual Requesting Appeal or their Representative

1. Disagrees with the action taken by SCCCMHA.

2. Contacts SCCCMHA Chief Operating Officer within 30 days from the time the Notice of Adverse Benefit Determination is received to file the Appeal. May request mediation in lieu of other dispute resolution processes or in tandem with those processes.

SCCCMHA Chief Operating Officer

3. Reviews the appeal information and conveys appeal information to the appropriate SCCCMHA Assistant Division Director for processing.

4. Reviews requests for mediation and contacts the mediation center in medication matters.

5. Forwards a complaint to the Recipient Rights Office if appeal is related to a rights violation.

SCCCMHA Assistant Division Director

6. Acknowledges the appeal in writing within five (5) business days, including a notification to the recipient/recipient's representative of the right to request mediation.

7. Completes an investigation by taking the steps necessary to gather information to create the best resolution.

    a. Designated staff shall:

        (1) Acknowledge and log each appeal received;
        (2) Ensure the individual(s) who make decisions on appeals are individuals

            (a) Who were not involved in the original complaint or any previous level of review or decision making
            (b) Are healthcare professionals who have the appropriate clinical expertise, as determined by the State, in treating the individual's condition or disease;
            (c) Have the authority to require corrective action if necessary.
            (d) Shall take into account all comments, documents, records and other information submitted by the individual/representative without regard to whether such information was submitted or considered in the initial complaint.

8. Provides a written Notice of Resolution of the appeal to the individual/representative within 45 calendar days.

    a. Notice of Resolution shall contain:

        (1) A general description of the reason for appeal.
        (2) The date received.
        (3) Action(s) taken to resolve the appeal.
        (4) Results of the appeal process.
        (5) The date of resolution.

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(6) Notice of the individual's right to request MDHHS Alternative Dispute Resolution Process and instructions for doing so if unhappy with the outcome of the appeal.

b. Appeals shall not be closed in the appeals module until full resolution. This includes contacting the individual/representative to discuss his/her satisfaction with the proposed resolution. After two (2) documented unsuccessful attempts to contact the individual/representative to discuss the resolution, a resolution letter may be sent.

9. Logs all non-Medicaid appeals and information into the electronic health record.

SCCCMHA Chief Operating Officer

10. Submits monthly appeal reports to the PIHP as required per contract.

Primary Caseholder

11. Provides assistance to the individual/guardian with further instruction on filing with the MDHHS Alternative Dispute Resolution process if requested.

D. <u>Second Opinion (review for denial to enter SCCCMHA services or Inpatient Psychiatric Admission)</u>

Individual Requesting Second Opinion or their Representative

1. Contacts Customer Services for second opinion if they disagree with a service being denied.

Customer Services

2. Informs Access Specialty Benefit Manager or Medical Director of second opinion request.

   a. Supports the initial decision that payment for inpatient psychiatric admission is not met and deny services, or;
   b. Directs that inpatient psychiatric admission is a suitable service to be provided.

   NOTE: Clinically suitable services must also be a part of the benefit package available to the individual.

VI. <u>REFERENCES</u>:

A. Region 10 PIHP/St. Clair CMHSP Contract, Appeal and Grievance Resolution Processes Technical Requirement

B. MDHHS/St. Clair CMHSP Contract, CMHSP Local Dispute Resolution Process, Attachment C.6.3.2.1.

C. Michigan Mental Health Code

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D. Region 10 Policy 07-02-01 Grievance and Appeal System

E. 42 CFR 438 et al

F. Region 10 PIHP/St. Clair CMHSP Contract, Mediation in Mental Health Dispute Resolution Technical Requirement

VII. EXHIBITS:

None Available

VIII. REVISION HISORY:

Dates issued 05/14, 05/15, 03/17, 05/18, 05/19, 11/20, 11/21, 11/22.