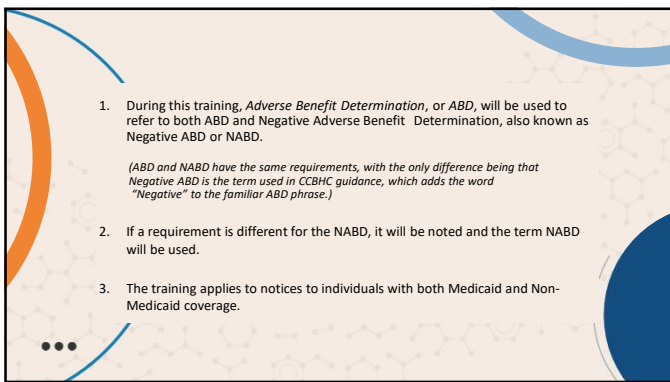
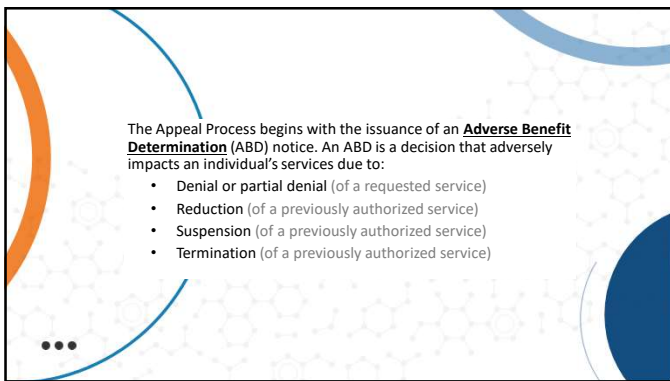


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Due Process Rights

Under the Due Process Clause of the U.S. Constitution, Medicaid and public benefit recipients are entitled to "Due Process" whenever their benefits are denied, reduced, suspended, and/or terminated.

Due Process requires that individuals receive:

- (1) prior written notice of a decision that adversely impacts services;
- (2) a fair hearing before an impartial decision maker;
- (3) continued benefits pending a final decision; and
- (4) a timely decision that begins from the date the grievance and/or appeal is first made.

Due Process rights are intended to protect individuals. These rights and dispute resolution protections are granted through the authority of [42 CFR Subpart F – Grievance and Appeal System](#).

4

The timing of the effective date for an ABD is defined as either Adequate or Advance:

- **Adequate Notice:** is a decision to deny or partially deny requested services on the **same date** the Adverse Benefit Determination takes effect/is provided.
- **Advance Notice:** is a decision to reduce, suspend, or terminate services currently provided, with notice **at least 10 calendar days prior** to the proposed date the Adverse Benefit Determination takes effect (*for non-CCBHC services*) and **at least 30 calendar days prior** to the proposed date the Negative Adverse Benefit Determination takes effect (*for CCBHC services*).

Note: If an individual has an active authorization and is receiving services, an **Advance Notice** must be provided before services are impacted.

5

Advance notice exceptions:

The provider may give an Adequate Notice instead of an Advance Notice for services currently provided **IF:**

- Substantiated information is received confirming the death of the individual.
- A written statement signed by the individual is received that states the individual no longer wishes to receive services.
- A written statement signed by the individual that gives information requiring a termination or reduction of services and indicates that the individual understands this must be done because of the supplied information.
- If individual has been admitted to an institution where they are ineligible under the plan for further services. (i.e., incarceration)
- If the individual's whereabouts are unknown, and the post office returns the provider's mail directed to the individual without a forwarding address.
- A change in the level of medical care is prescribed by the individual's physician.
- The date of action must occur in less than 10 calendar days for non-CCBHC or 30 calendar days for CCBHC. (discharged due to violating program rules).

* Please refer to Appeals and Grievance Technical Requirement for the full list of exceptions.

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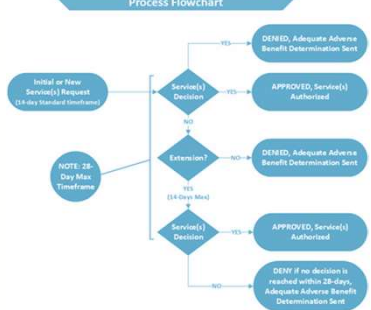
Denial (or partial denial):

A Denial could occur when: (see definitions section)

- The individual does not meet medical necessity for the requested service(s).
- The Beneficiary does not meet Medicaid eligibility for services as a person with a serious mental illness, a person with a development disability, a child with a serious emotional disorder or a person with a substance use disorder.
- Clinical documentation provided does not establish medical necessity.
- Other insurance or resources are available to meet the requested service (Medicaid is a payer of last resort).
- A duplication of service(s) is currently being provided.
- The individual resides in a setting (institution) such as a jail, state hospital or a Child Caring Institution where the provider cannot provide services.

7

Standard Service Authorization Request Process Flowchart



8

Reduction:

A reduction may occur when(see definitions section):
The current level of service is reduced in the amount, scope, or duration as previously authorized due to...

- Services are determined to be no longer medically necessary in the amount, scope, or duration as previously authorized,
- The individual or guardian requests the reduction in services,
- The individual refuses to fully participate or is not participating in services,
- A temporary incapacity of the provider to fully fulfill the service(s) in the amount, scope, or duration as authorized.

9

Suspension:

The authorized service(s) could be suspended (put on a temporary hold) when (see definitions section):

- The individual is temporarily residing in a location in which the provider cannot authorize services, such as jail, prison, extended care facility, or state hospital.
- When the provider lacks the capacity to provide the authorized service.
- The conduct of the person served caused the subcontracted provider to discontinue services and the service is on hold until a different provider begins.
- When the individual/guardian requests the service to be temporarily on hold.
- Lack of participation in a service that has been previously authorized.

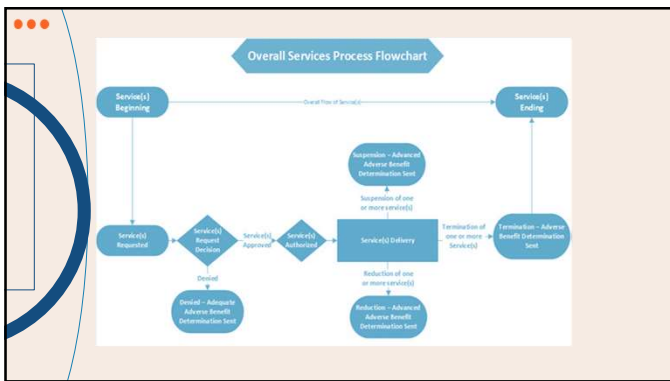
10

Termination:

Services may be terminated (current authorization ends) when (see definitions section):

- The active Person-Centered Plan goals are met.
- The individual requests to end their service.
- The individual moves outside of the service area.
- The individual is no longer actively engaged (using) the service(s).
- The individual is residing in a location for an extended period in which the provider cannot authorize services, such as jail, prison, extended care facility, or state hospital. (may have been previously suspended)

11



12

Example

An individual requests an increase in direct service, but the increase is not medically necessary. Do I send an Adverse Benefit Determination Notice?

- Yes, it would be a denial.
- Since the increase is being denied, an ABD must be sent.

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Example

The assigned Community Living Support (CLS) staff quits without giving notice. The CLS provider indicated that it will be 3 weeks, at minimum, until they have another staff trained and ready to provide CLS services. The individual is authorized to received 4 hours of CLS per week. Should an Adverse Benefit Determination Notice be sent?

- Yes, it would be a suspension.
- The service would be suspended until staff becomes available since the Individual Plan of Service (IPOS) is specific that 4 hours of CLS will be provided per week. When a service is not able to be provided according to the authorized amount in the IPOS, an ABD is required. It should also be noted how the current CLS need will be met until the new staff is hired and trained.
- A cancellation, short illness, or rescheduled time would not require an ABD to be sent.

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Example

An individual requests to terminate all of their services. Should an Adverse Benefit Determination Notice be sent?

- Yes, it would be a termination of services.
- If the individual requests to terminate services in writing, an Adequate Notice would be provided to them with the date the action would take effect being the date in which they provided the request.
- If the individual provided the request verbally, an Advance Notice would be provided to them with the date the action will take effect being no less than 10 days from the date of the request for non-CCBHC services and no less than 30 days from the date of the request for CCBHC services.

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Example

An individual has requested a service that in my clinical opinion is not medically necessary. Do I need to provide them with an Adverse Benefit Determination Notice?

- Yes, it would be a denial.
- Anytime a decision is made to deny an individual a requested service, an Adequate Adverse Benefit Determination Notice is required.

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Example

An individual requests to terminate their outpatient therapy service while keeping their other services. Would I need to send an Adverse Benefit Determination Notice?

- Yes, it would be a termination for that specific service.
- A Person-Centered Plan Addendum should be completed with the individual removing all goals and objectives related to the service being terminated in addition to early terminating the authorization.

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Example

An individual was arrested. They will be in jail for at least 90 days. Before their arrest they received daily CLS through a CLS provider, Case Management, and quarterly medication reviews. Would an Adverse Benefit Determination Notice need to be sent?

- Yes, services would be terminated.
- The jail is an institution which takes on the obligation of care.
- Situations such as this fall under the Limited Exceptions to Advance Notice therefore, an Adequate Notice would need to be sent suspending services effective the date of determination.

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Example

An individual did not show for their Psychiatric Evaluation. When the case manager called the number on file, it was no longer in service. A follow-up letter was sent but was returned indicating "no forwarding address on file." It has been 2 months since their last contact. Should an Adverse Benefit Determination Notice be sent?

- Yes, services would be terminated due to lack of engagement.
- At times in which the recipient's whereabouts are unknown and the post office has no forwarding address on file, an Adequate Notice should be completed, saved in the file, and a note added stating that the individual's whereabouts are unknown.

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Example

A 15-year-old individual was placed in a juvenile detention center for 30 days. Before this placement they were receiving Therapy and Med reviews services. Would I need to send an Adverse Benefit Determination Notice?

- Yes, due to the short duration, services would be Suspended.
- Services would resume when the individual becomes available to return to services.

20

Definitions:

Adverse Benefit Determination: A decision that adversely impacts an individual's claim for services due to: (42 CFR 438.400)

- Denial or partial denial 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).
- Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2).
- Denial, in whole or in part, of payment for a service. 42 CFR 438.400(b)(3).
- Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service. 42 CFR 438.210(d)(1).
- 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).
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning (PCP) meeting and as authorized by the PIHP. 42 CFR 438.400(b)(4).

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Definitions:

Adverse Benefit Determination (cont'd): A decision that adversely impacts an individual's claim for services due to: (42 CFR 438.400)

- Failure to resolve standard appeals and provide notice within **30 calendar days (for Medicaid) or 45 calendar days (for non-Medicaid)** from the date of a request for a standard appeal. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).
- Failure 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).
- Failure to timely resolve grievances and provide notice of resolution. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).
- Denial of the individual's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other individual financial responsibility. 42 CFR 438.400(b)(7).

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Definitions:

- **Adequate Notice of Adverse Benefit Determination:** Written statement advising the individual of a decision to deny or partially deny services requested, which notice must be provided to the individual on the same date the Adverse Benefit Determination takes effect. 42 CFR 438.404(c)(2).
- **Advance Notice of Adverse Benefit Determination:** Written statement advising the individual of a decision to reduce, suspend, or terminate services currently being provided, which notice must be provided to the individual at least **10 calendar days** prior to the proposed date the Adverse Benefit Determination takes effect. 42 CFR 438.404(c)(1); 42 CFR 431.211.
- **Advance Notice of Negative Adverse Benefit Determination (CCBHC):** Written statement advising the individual of a decision to reduce, suspend, or terminate services currently being provided, which notice must be provided to the individual at least **30 calendar days** prior to the proposed date the Adverse Benefit Determination takes effect. See MDHHS Health Services, CCBHC Appeal and Grievance Resolution Processes, pages 6-7. Document link located at <https://Michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/ccbhc/provider>
- **Appeal:** A review at the local level by the PIHP of an Adverse Benefit Determination, as defined above. 42 CFR 438.400.
- **Authorization of Services:** The processing of requests for initial and continuing services delivery. 42 CFR 438.210(b).

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Definitions:

- **Expedited Appeal:** The expeditious review of an Adverse Benefit Determination, requested by the individual or the individual's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the individual's life, physical, or mental health, or ability to attain, maintain, or regain maximum function. If the individual requests the expedited review, the PIHP determines if the request is warranted. If the individual's provider makes the request, or supports the individual's request, the PIHP must grant the request. 42 CFR 438.410(a).
- **Grievance:** The individual's expression of dissatisfaction about the PIHP and/or the CMHSP services issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the individual, failure to respect the individual's rights regardless of whether remedial action is requested, or the individual's dispute regarding an extension of time proposed by the PIHP to make a service authorized decision. 42 CFR 438.400.
- **Grievance Process:** Impartial local level review of the individual's Grievance.

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Definitions:

- **Grievance and Appeal System:** The processes implemented to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them. *42 CFR 438.400.*
- **Medicaid Services:** Services provided to the individual under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act (SSA).
- **Notice of Resolution:** Written statement of the resolution of an Appeal or Grievance, which must be provided to the individual as described in *42 CFR 438.408.*
- **Recipient Rights Complaint:** Written or verbal statement by the individual, or anyone acting on behalf of the individual, 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.
- **Service Authorization:** The processing of requests for initial and continuing authorization of services, either approved or denied as requested, or authorized in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to *42 CFR 438.210.*
- **State Fair Hearing:** Impartial state-level review of a Medicaid beneficiary's appeal of an Adverse Benefit Determination presided over by a MDHHS Administrative Law Judge. Also referred to as an "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

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Questions?

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