SUBJECT Notice of Action		**CHAPTER** 07	**SECTION** 02	**SUBJECT** 02
CHAPTER Rights of Persons Served	**SECTION** Grievances and Appeals			
WRITTEN BY R. Kleinedler	**REVIEWED BY**		**AUTHORIZED BY**	

I. APPLICATION:

☒ PIHP Board ☒ CMH Providers ☒ SUD Providers
☒ PIHP Staff ☒ CMH Subcontractors

II. POLICY STATEMENT:

It is the policy of Region 10 to follow all federal and state requirements regarding the notification of beneficiary's rights to Due Process. This policy is in place to ensure that all beneficiaries are notified in a timely, understandable and fair manner of an action, actual or proposed. It is the expectation of Region 10 that any individual, staff of Region 10, partner CMH's, or contracted providers, making a decision about a beneficiary's services resulting in an action will follow this policy.

III. DEFINITIONS:

Action: A decision that adversely impacts a beneficiary's claim for services due to:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service.
- Failure to provide service within 14 calendar days of the start date agreed upon during the person-centered planning and as authorized by Region 10.
- Failure of the PIHP to act within 45 calendar days from the date of a request for a standard appeal.
- Failure of the PIHP to act within three working days from the date of a request for an expedited appeal.
- Failure of the PIHP/CMH to provide disposition and notice of a grievance/complaint within 60 calendar days of the date of the request.

*The authorization of services as identified in the Individual Plan of Service is also considered an action.

Appeal: A request for review of an action, as "action" is defined above.

Applicant: A person or his/her legal representative who makes a request for mental health services.

Beneficiary: An individual who has been determined eligible for Medicaid.

Fair Hearing: Impartial state level review for a Medicaid beneficiary's appeal of an action presided over by an Administrative Law Judge. Also referred to as "Administrative Hearing."

Grievance: An expression of dissatisfaction about any matter other than an action, as "action" is defined above.

Local Appeal Process: Impartial review of a Medicaid beneficiary's appeal for an action presided over by individuals not involved with decision-making or previous level of review, completed by the PIHP.

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

Notice: The written notification given/mailed to the beneficiary of an action and appeal rights.

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

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

State-Level Alternative Dispute Resolution Process: An impartial review, conducted by a MDHHS representative, regarding a decision by the PIHP or CMHSP to deny, reduce, suspend, or terminate services.

Supervisor: For the purpose of this policy and related policies, a supervisor can be at any level (e.g. the supervisor's supervisor).

IV. STANDARDS:

Notice requirements:

- Must be in writing;
- Must meet the language format needs of the beneficiary;
- Must contain the following:
  - That action that has been taken or is proposed;
  - The reason for the action;
  - The effective date of the action;
  - The right to file a local appeal through the PIHP Due Process Office and instructions for doing so;
  - The right to file a state fair hearing, and instructions for doing so, if appropriate;
  - The circumstances under which an expedited appeal can be requested and instructions for doing so;
  - An explanation of how the beneficiary may represent him/herself or use legal counsel, a relative, a friend, or other spokesman;
  - The option and requirements for an expedited appeal; and
  - The legal citation for which the decision of action has been based.
- Timing notice
  - Adequate Notice given at the time of the decision.
  - Denial of access into mental health service programs.
  - Denial of access into Substance Use Disorder programs.
  - Denial of requested services, amount, or duration of services.
  - The authorization of the IPOS/Addendum.
    *Notice to be given at the time the copy of the IPOS/Addendum is given to the beneficiary within 15 calendar days of completion.

- Advance Notice is given/mailed to the beneficiary/guardian a minimum of 12 calendar days prior to the effective date of the action.
  - Termination of services prior to the end of the current authorization.
  - Reduction of services prior to the end of the current authorization.
  - Suspension of services prior to the end of the current authorization.

- Additional content for Advance Notice:

- The circumstances under which services will be continued pending resolution of appeal.
- How to request services continue until resolution.
- The circumstance under which a beneficiary may be required to repay the costs of the services requested to continue and received during the appeal process.

- Exceptions to Advance Notice:

  A notice may be mailed/given not later than the date of action of previously authorized services IF:
  - There is factual information confirming the death of the beneficiary.
  - There is a clear written statement signed by the beneficiary that he/she no longer wishes services or given written information indicating the termination of services.
  - The beneficiary has been admitted to an institution where he/she is ineligible under Medicaid for further services.
  - There is established fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
  - The beneficiary's whereabouts are unknown and the United States Post office returns mail directed to him/her indicating no forwarding address.
  - A change in the level of medical care is prescribed by the beneficiary's physician.
  - The date of the action will occur less than ten calendar days.

All Medicaid notices given/mailed to a beneficiary must be accompanied with a "Request for Hearing" form a pre-paid envelope addressed to the State of Michigan Administrative Hearing System for the Department of Health and Human Services.

V. PROCEDURES:

A notice is generated in Electronic Medical Record (EMR) systems of the PIHP, partner CMH's, and contracted providers and then given/mailed to beneficiary when an action is to occur or has occurred.

NOTICE QUICK GUIDE

Action	Type of Notice	Time frame for Notice
Denial of service requested	Adequate	At the time of decision
Termination of services	Advance	Twelve (12) calendar days prior to action, minimum
Reduction of amount of services	Advance	Twelve (12) calendar days prior to action, minimum
Suspension of services	Advance	Twelve (12) calendar days prior to action, minimum
Person-Centered Plan development	Adequate	At the time of plan completion
Increase of benefits (amount, scope, duration)	Adequate	At the time of action
Standard authorization decision, that denies or limits service requested	Adequate	Within fourteen (14) calendar days from the date of receipt of a request
Expedited authorization decision, that denies or limits service requested	Adequate	Within three (3) working days from the date of the receipt of a request
Unreasonable delay of start of services	Adequate	At the time of action
Failure to provide disposition of appeal or	Adequate	At the time of action

grievance in allotted timeframe		
Denial, in part or whole, of payment for service	Adequate	At the time of action
Failure to make an authorization decision within 14 calendar days	Adequate	At the time of action
Failure to make an expedited authorization request, within 3 business days	Adequate	At the time of action
Request for additional information for authorization decision*	Adequate	At the time of action

*extends the timeframe an additional 14 calendar days for standard authorization. Documentation must show that there is a need for additional information and how the delay is in the beneficiary's interest. For any extension not requested not by the enrollee must give written notice for the reason of the delay.

Providers requesting services on behalf of beneficiaries will be notified of action, but is not required to be in writing.

VI. <u>EXHIBITS:</u>
Hearing form

VII. <u>REFERENCES:</u>
42 CFR 438 et. al.
MDHHS/PIHP Contract Attachment 6.3.2.1
MDHHS/CMHSP Contract Attachment 6.3.2.1
MI Mental Health Code
Administrative Rules

REQUEST for HEARING

INSTRUCTIONS

You may use this form to request a hearing. You may also submit your hearing request in writing on any paper.

A hearing is an impartial review of a decision made by the Michigan Department of Community Health or one of its contract agencies that client believes is wrong.

GENERAL INSTRUCTIONS:

- Read ALL instructions FIRST, then remove this instruction sheet before completing the form.
- Complete **Section 1**.
- Complete **Section 2** only if you want someone to represent you at the hearing.
- **Do NOT** complete Section 4.
- Please use a PEN and PRINT FIRMLY.
- If you have any questions, please call toll free: **1 (877) 833 - 0870**.
- Remove the BOTTOM (**Yellow**) copy and save with the instruction sheet for your records.
- After you complete this form, mail it in the enclosed self addressed, postage paid envelope or mail to:

STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30763
LANSING MI 48909

- You may choose to have another person represent you at a hearing.
  - → This person can be anyone you choose but he/she must be at least 18 years of age.
  - → You MUST give this person written permission to represent you.
  - → You may give written permission by checking **YES** in **SECTION 2 and having the person who is representing you complete SECTION 3**. **You MUST still complete and sign SECTION 1.**
  - → Your guardian or conservator may represent you. A copy of the Court Order naming the guardian/conservator must be included with this request.

- The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.
- If you need help with reading, writing, or hearing, you are invited to make your needs known to the Department of Community Health.

If you do not understand this, call the Department of Community Health at (877) 833-0870. Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria. إذا لم تفهم هذا، اتصل بإدارة الصحة المحلية التابعة لو لاية ميتشيجن.	**1 (877) 833 - 0870**

Completion:	Is Voluntary

See the Request Form Underneath

REQUEST FOR HEARING

STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH

PO BOX 30763
LANSING, MI 48909
1 (877) 833-0870

SECTION 1 – To be completed by PERSON REQUESTING A HEARING:

Your Name	Your Telephone Number ( )	Your Social Security Number
Your Address (No. & Street, Apt. No.)	Your Signature	Date Signed
City / State / ZIP Code		
What **Agency** took the action or made the decision that you are appealing.	Case Number	

I WANT TO REQUEST A HEARING: The following are my reasons for requesting a hearing. ***Use Additional Sheets if Needed.***

____
____
____
____
____
____

Do you have physical or other conditions requiring special arrangements for you to attend or participate in a hearing?

☐ **NO**
☐ **YES** (Please Explain in **Here**):

SECTION 2 – Have you chosen someone to represent you at the hearing?

Has someone agreed to represent you at a hearing?

☐ **NO** ☐ **YES** (If YES, have the individual complete section 3)

SECTION 3 – Authorized Hearing Representative Information:

Name of Representative	Representative Telephone Number ( )	
Address (No. & Street, Apt. No.)	Representative Signature	Date Signed
City / State / ZIP Code		

SECTION 4 – To be completed by the AGENCY distributing this form to the client

Name of Agency			AGENCY Contact Person Name
Region 10 PIHP			Rebekah Kleinedler, MSA
AGENCY Address (No. & Street, Apt. No.)			AGENCY Telephone Number
725 Mason Street			**(810) 424-6065**
City	State	ZIP Code	State Program or Service being provided to this appellant
Flint	MI	48503	Mental Health and Substance Use Disorder services for Genesee, Lapeer, Sanilac, and St. Clair Counties.

DISTRIBUTION: WHITE (2nd page) Administrative Tribunal, YELLOW - Person Requesting Hearing