Region 10 PIHP

Date Issued: 3/16
Date Revised: ____

SUBJECT Medicaid Fair Hearings		**CHAPTER** 07	**SECTION** 02	**SUBJECT** 03
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 PIHP and its partners to provide a fair and efficient process for resolving complaints and disputes regarding services and supports. Medicaid enrolled beneficiaries have the right to dispute an action to the State Level in an Appeal process called Medicaid Fair Hearing. This process is for beneficiaries to dispute actions in regards to mental health and substance use disorder services and supports.

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, by the regional Utilization Management System.
- Failure to provide service within 14 calendar days of the start date agreed upon during the person-centered planning process.
- 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.

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."

Fair Hearing Officer (FHO): Staff person assigned to coordinate the Fair Hearing, representing the PIHP.

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IV. STANDARDS:

A Medicaid Beneficiary has the right to request a Fair Hearing when the PIHP/CMH/contracted provider:

- Takes an action; or
- A grievance request is not acted upon or resolved within 60 calendar days of receipt of the grievance.

The agency must issue a written notice of action to the affected Beneficiary. A "Request for Hearing" form and pre-paid, self-addressed envelope must accompany the notice.

The agency may not limit or interfere with the Beneficiary's freedom to make a request for a Fair Hearing.

Assistance must be given to the beneficiary for filing the appeal, including:

- Assistance with completing paperwork; and
- Providing the toll-free number to the Michigan Administrative Hearing System.

Beneficiaries are given 90 calendar days from the date of the notice to file a request for a Fair Hearing.

The Beneficiary has the right to choose an authorized Hearing Representative, which may be a family member, a friend, legal counsel, or other spokesperson.

If the Beneficiary or representative requests a Fair Hearing not more than twelve (12) calendar days from the date of the notice of action, or before the effective date and requests that services stay in place, the services must be continued until there is a decision from the Hearing. The authorization must not be expired, the action must be a termination, reduction, or suspension, and the Beneficiary must be notified of the potential repayment of services rendered during should the decision not be in their favor.

If the Beneficiary's services were terminated, reduced or suspended without advance notice, the CMH must reinstate services to the level before the action.

The parties to the Fair Hearing include the Beneficiary and his/her authorized hearing representative, and the PIHP Fair Hearing Officer.

This process may be concurrent with the Local Appeal Process. Refer to Local Medicaid Appeal Process policy 07-02-04 for additional information.

V. PROCEDURES:

Beneficiary's responsibility:

The beneficiary receives a Notice of Action, a Request for Hearing form, and a return envelope. The beneficiary completes the form and mails it in the envelope provided to the Michigan Administrative Hearing System (MAHS).

PIHP responsibilities:

- Fair Hearing Officer (FHO) receives copy of Request for Hearing form.
- FHO prepares hearing summary and gathers relevant evidence.
- FHO receives hearing date and time, which is also mailed to the beneficiary/representative.
- FHO coordinates and secures room within the appropriate CMH location

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- Hearings will be held in the county of beneficiary residence at the local CMH building
- Evidentiary hearing occurs.
- Decision and Order to follow, mailed to FHO and beneficiary.

CMH responsibilities:

- Provides information on Fair Hearing Process (i.e. linking to FHO).
- Provides assistance with beneficiary with/during hearing process.

VI. EXHIBITS:
Request for Hearing form

VII. REFERENCES:
42 CFR 438 et. al.
42 CFR 431 et. al.
MDHHS/PIHP Contract Attachment 6.3.2.1
MAHS Pamphlet

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 مينتشيجن.	**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 Region 10 PIHP			AGENCY Contact Person Name Rebekah Kleinedler, MSA
AGENCY Address (No. & Street, Apt. No.) 725 Mason Street			AGENCY Telephone Number **(810) 424-6065**
City Flint	State MI	ZIP Code 48503	State Program or Service being provided to this appellant 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