SUBJECT Medicaid Local Appeal Process		**CHAPTER** 07	**SECTION** 02	**SUBJECT** 04
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 to follow all federal and state requirements to provide a fair and efficient process for resolving complaints and disputes regarding services and supports. Medicaid beneficiaries have the right to request a local appeal to dispute an action. Non-Medicaid consumers have the right to appeal to the CMH in their county of residence. This policy is for the Medicaid Beneficiaries only.

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 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.

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.

Disposition: Written statement of the decision of an appeal or a grievance, provided to the beneficiary.

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 system: The federal term used to refer to the overall system that includes grievances and appeals handled at the PIHP level and access to the State Fair Hearing process.

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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

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

IV. STANDARDS:

Federal regulations provide a Medicaid Beneficiary the right to a local level appeal of an action. Appeals, like those for Fair Hearing, are initiated by an "action."

Beneficiaries are notified of an action from the Notice and Hearing Rights form that includes all required content including the action and instructions for appealing. Beneficiaries are given 45 calendar days to file an appeal, from the date of the notice.

The PIHP must provide that oral inquires seeking to appeal an action are treated as appeal to establish the earliest possible filing date for appeal.

Beneficiaries will be given reasonable assistance in the filing process, including but not limited to:

- Interpreter services;
- Completing forms;
- Explanation of process; and
- Providing toll-free numbers that have adequate TTY/TTD interpreter capability.

A provider may file an appeal on behalf of the beneficiary, as long as they have written permission from the beneficiary. The PIHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's appeal.

A written disposition, from the PIHP, must be completed no later than 45 calendar days from the date of receipt of the appeal filed.

The PIHP will ensure that the individual(s) who make decision on appeals are individuals who are:

- Not involved in any previous level of review or decision making; and/or
- Health Care professionals who have the appropriate clinical expertise, as determined by MDHHS, in treating the beneficiary's condition or disease (regarding an appeal of that is based on lack of medical necessity or an appeal that involves clinical issues).

Beneficiaries may request services continuation if all of the following apply:

- The beneficiary files the appeal in a timely manner, within 12 calendar days of the date of the notice, before or on the effective date indicated on the notice;
- The appeal involves an action of termination, reduction, or suspension of a previously authorized service;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and

- The beneficiary must ask for it.
  - The beneficiary must be notified upon request for continued services during the appeal process, of the potential payback of the cost of services rendered during this time, should the decision not be in their favor.

Benefits must continue until one of the following occurs:

- The beneficiary withdraws the appeal;
- A decision has been made from the local level appeal, unless the beneficiary has requested a Fair Hearing;
- The state Fair Hearing office issues a hearing decision adverse to the beneficiary; or
- The time period of the previously authorized service has ended.

This process is concurrent with the Fair Hearing process.

Beneficiaries may request an expedited appeal. Documentation presented must show that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum functioning. If there is a denial of expedited appeal, the PIHP shall:

- Transfer the appeal to the timeframe for standard resolution; and
- Make reasonable efforts to give the beneficiary prompt oral notice of the denial and follow up within two (2) calendar days with a written notice.

Beneficiates must be provided a reasonable opportunity to present evidence, and allegation of fact or law in person, as well as in writing. In the case of an expedited request, the beneficiary must be notified of the limited time available.

Beneficiaries and his/her representative must be allowed the opportunity, before and during the appeal process, to examine the beneficiary's case file, including medical records and any other documents and records.

Local appeals are to be completed within 45 calendar days from the date of receipt of appeal and three (3) business days for expedited appeals.

Written disposition will be provided to the beneficiary/representative and shall contain:

- The results of the resolution process;
- The date it was completed;
- The right to a state hearing and instructions on how to file; and
- The right to have benefits continue, how to make that request, the requirements, and that the beneficiary may be held liable for the cost of these benefits if the hearing decision upholds the action.

The PIHP will maintain records of appeals.

V. PROCEDURES:

1. Notice is given to the applicant of or beneficiary of publically funded services. Refer to Notice of Action in PIHP Policy 07-02-02.

2. The beneficiary has 45 days from the date of the notice to contact the Due Process Office of the PIHP to file a local Medicaid Appeal. For non-Medicaid consumers, they will contact the designated staff at the local CMH who has the authority to facilitate the appeal process.

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3. Upon receipt of request for appeal, written acknowledgment letter will be sent to beneficiary.

4. Appeal process will commence, tasks associated with process will occur.

5. Upon decision of review, completed by appropriate staff, written disposition is sent to beneficiary.

6. PIHP logs appeal, process, and disposition in PIHP EMR.

VI. EXHIBITS:
Acknowledgement letter
Disposition letter

VII. REFERENCES:
42 CFR 438 et. al.
MDHHS/PIHP Contract Attachment 6.3.2.1
MDHHS/CMHSP Contract Attachment 6.3.2.1

REGION 10 PREPAID INPATIENT HEALTH PLAN
Promoting Opportunities for Recovery, Discovery, Health and Independence

Michael McCartan
Chief Executive Officer

Lori Curtis
Chairman

Robert Kozfkay
Vice Chairman

Gary Jones
Secretary

Stephen Armstrong
Treasurer

March 21, 2016

NAME
ADDRESS
CITY, STATE, ZIP

RE: Local Appeal

Dear NAME,

Thank you for filing a Local Appeal on DATE FILED, with Region 10, partner with NAME OF CMH. You contacted the Due Process Office and explained that ISSUE.

At this time your appeal will be processed and a decision will be made on or before DATE (45 DAYS FROM FILING DATE).

You or your Representative may examine the beneficiary's case file. If you wish to review these records please contact the Due Process Office at (810) 424-6065.

If you have any additional questions you may contact the Due Process Office at (810) 424-6065.

If you have **Medicaid**, you may also file a Medicaid Fair Hearing. If you have any questions about a Medicaid Fair Hearing you may contact the Michigan Administrative Hearing System at 1-877-833-0870. If you would like assistance with filing a Medicaid Fair Hearing you may contact your local Customer Services Department. Numbers for local departments.

Sincerely,

PIHP Designee
PIHP Due Process Office

REGION 10 PREPAID INPATIENT HEALTH PLAN
Promoting Opportunities for Recovery, Discovery, Health and Independence

Michael McCartan
Chief Executive Officer

Lori Curtis
Chairman

Robert Kozfkay
Vice Chairman

Gary Jones
Secretary

Stephen Armstrong
Treasurer

March 21, 2016

NAME
ADDRESS
CITY, STATE, ZIP

RE: Local Appeal

Dear NAME,
This letter is to notify you that the Local Medicaid Appeal filed with Region 10, partner with NAME OF CMH, on DATE FILED, has been processed and completed.

You contacted the Due Process Office and explained that STATE ISSUE.

After careful review of the matter is was determined that the ACTION was APPROPRIATE/NOT APPROPRIATE at this time.
EXPLAINATION OF STEPS TAKEN IN PROCESS.
INFORMATION OF BENEFITS UNDER OTHER INSURANCE TYPE
This matter is considered closed at this time.

If you do not agree with this decision you also have the following option:

> Request a Medicaid fair hearing by completing the enclosed form titled "Request for Hearing" and send it in the envelope also enclosed to the Michigan Administrative Hearing System. If you have any questions about a Fair Hearing please contact the Administrative Tribunal directly at 1-877-833-0870. If you would like assistance with completing the form you may contact Customer Services at PHONE. You have 90 calendar days from the date of the notice to make your request. If this action was a termination, reduction, or suspension of a previously authorized service you may request services to remain, until a decision is made. If the decision is not in your favor you may be asked to repay any services rendered during the appeal process.

If you have any additional questions please contact the Due Process Office at (810) 424-6065.

Sincerely,

PIHP DESIGNEE