SHIAWASSEE Health & Wellness

Shiawassee Health & Wellness Grievance System

Adverse Benefit Determination Notices

Appeals, Grievance and Customer Services

What is a Grievance System?

It is the overall local system for due process, appeals, and grievances in a managed care system

It provides additional protections to individuals by giving them access to formal processes that allow for expression of their needs, disagreements, and dissatisfactions

Due process is a course of legal proceedings carried out in accordance with established rules

An appeal is a process that challenges an Adverse Benefit Determination

A grievance is an expression or dissatisfaction about service issues, other than an Adverse Benefit Determination or a recipient rights violation

Grievances

"An individual's/legal representative's dissatisfactions about the Pre-Paid Inpatient Health Plan (PIHP), Community Mental Health Services Program (CMHSP), service issues, other than those concerns r/t an Adverse Benefit Determinations or recipient rights violations."

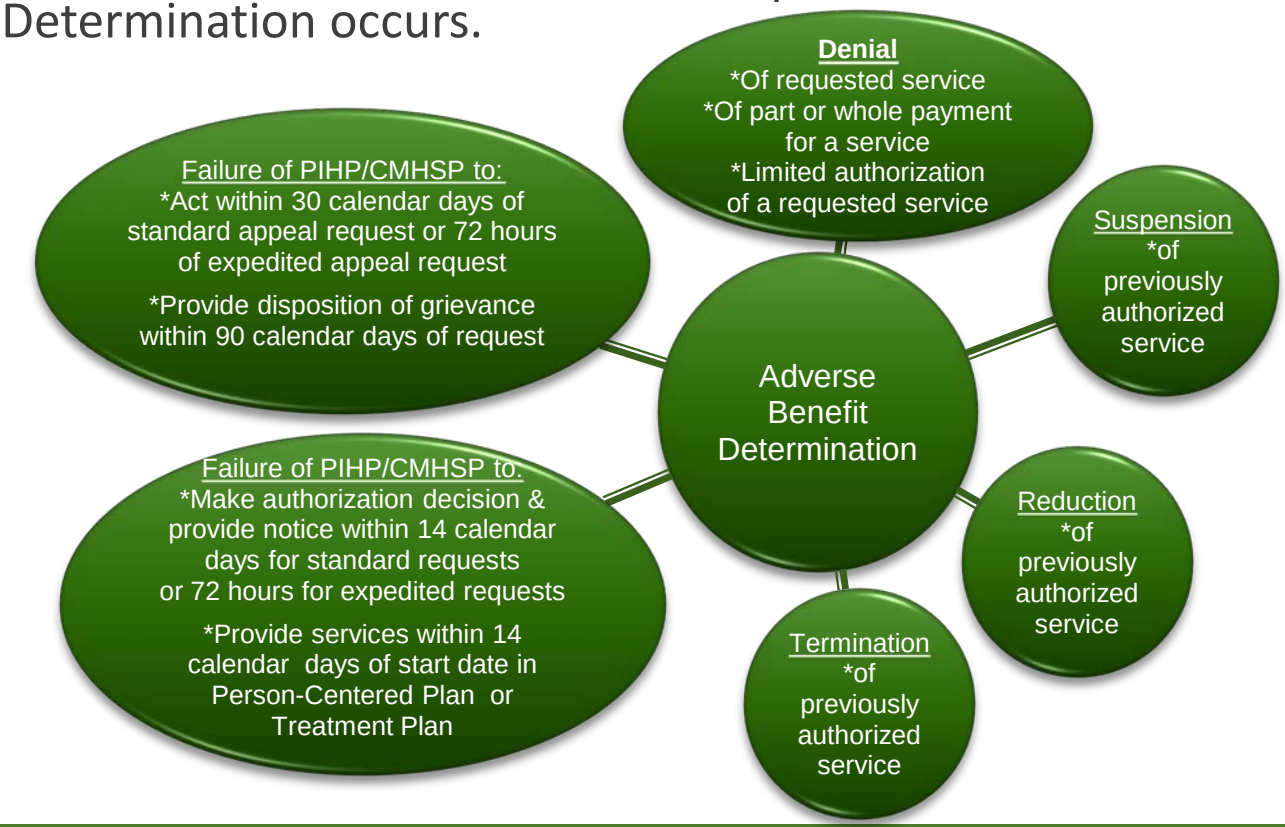
This is a due process right available to individuals/legal representatives, with or without Medicaid, per the Michigan Department of Community Health (MDHHS) and the PIHP/CMHSP contracts.

It is a formal process that varies from the "Informal Conflict Resolution" process (for day to day problem resolution), Mediation, the Appeal process (for adverse actions), and the Recipient Rights process (for rights violations).

Grievances can include such things as accessing services, quality/type of services being provided, wanting a new provider, disagreement with a diagnosis, treatment, etc. All grievances are addressed through SHW Customer Services.

What is a Adverse Benefit Determination?

Previously known as a “Adverse Action”, it is an action that reduces, denies, suspends, or terminates an individual’s current or requested specialty mental health and/or substance use disorder services. Written notices must be provided to an individual whenever an Adverse Benefit Determination occurs.



Notice Requirements

Types of Notices:

There are two types of Adverse Benefit Determinations Notices: Adequate and Advance

Which Notice to send depends on the Adverse Benefit Determination and the person-centered planning or treatment plan cycle

A written notice (SHIMER Templates must be used) informs a person and/or his/her legal representative:

Something is being done to the mental health and/or substance use disorder services being provided or requested

Specifies exactly what services are being impacted

Specifies the effective date (and time for expedited requests) and the reason for the Adverse Benefit Determination

Identifies the legal authority for the adverse action

Provides options for appeal if the person/legal representative disagrees with the action (options depend on whether Medicaid/Healthy Michigan or General Fund)

Provides information about the right to an expedited appeal process

Explains the right to represent themselves or have another person do so

Adverse Benefit Determination requiring an Adequate Notice

"A written notice provided to an individual/legal representative at the time of EACH Adverse Benefit Determination is made. The individual plan of service, developed through a person-centered process and finalized with the individual, must include, or have attached, the adequate notice provisions."

When such notices are provided:

Individualized Person Centered Plan (PCP) or Treatment Plan (specific Adequate Notice format)

Denial of overall eligibility and/or denial/limited authorization of requested service. This needs to be completed within 14calendar days of request if it is a standard request for service; or within 72 hours of the request if it is an expedited request for service

Denial of payment for services

Failure to provide **services within 14 calendar days of** agreed upon start date during the person-centered planning or treatment plan process

Failure of PIHP/CMHSP to act within 30 calendar days of a standard appeal request or 72 hours of an expedited appeal request

Circumstances that are exempt from an Adequate Notice: Death of person; person/legal representative provides written statement that services are no longer wanted effective immediately; person's whereabouts are unknown and post office returns mail with no forwarding address; person accepted for services by another local jurisdiction or state, change in the level of medical care that is prescribed by a physician

Adverse Benefit Determination requiring an Advance Notice

"A required written notice provided to an individual/legal representative when an Adverse Benefit Determination is being taken to reduce, suspend, or terminate services that the individual is currently receiving. **The advance notice must be mailed no less than 10 calendar days or more before the intended action takes effect."**

<u>When such notices are provided:</u>

Reduction, termination, or suspension of service outside of the PCP or Treatment Plan process.

Can be the result of case decision and/or quantitative utilization management decisions by the PIHP/CMHSP. Some examples are: person repeatedly does not show for appointments, change in diagnosis renders person ineligible for services, person moves outside of eligible county, etc.)

What Options Do Individuals have to Appeal?

"After receiving a Notice, individuals can request a review of the Adverse Benefit Determination." The options available to an individual depend on his/her funding source/insurance.

	Medicaid/Healthy Michigan	**Non-Medicaid**
Local Appeal	X *Standard *Expedited	X *Standard *Expedited
Medicaid Fair Hearing (NOTE: an individual no longer has access to a Medicaid Fair Hearing simultaneously to a Local Appeal. A denial must be upheld at the local level before Medicaid Fair Hearing is an option)	Only after local appeal options are exhausted	
MDHHS Alternative Dispute Resolution		X
Informal Conflict Resolution	X	X
Second Opinion (for Mental Health only)	X	X
Recipient Rights Complaint	X	X

Local Appeal Process

When individuals/legal representatives (such as guardians) do not agree with the Adverse Benefit Determination specified in the Notice letter or do not agree with the service type, amount, scope, or duration in the PCP or Treatment Plan, they have the right to appeal to their local PIHP/CMHSP. They can appeal with or without Medicaid coverage.

How does one request a local appeal?

An individual/legal representative can request an appeal through the Customer Services Department either verbally or in writing. For consumers with Medicaid the request for standard local appeal must be made within 60 calendar days from the date of the Notice letter. For General Fund consumers, a request for standard local appeal must be made within 30 calendar days from the date of the Notice letter.

An individual/legal representative can request an "expedited" or "fast" appeal if waiting the standard time frame for an appeal determination would seriously jeopardize the individuals' life or health or their ability to attain, maintain, or regain maximum function.

A provider can request an appeal on behalf of the individual/legal representative if the individual/legal representative confirms that he/she agrees with the request for an appeal. This must be confirmed in a written request.

Medicaid plan's appeals process can have only one level of internal (local) appeal. The state fair hearing process is available **only after** the appeal is not resolved "wholly in favor" of the Enrollee through the Local Appeal process. The MDHHS Alternative Dispute Resolution Process is only available to Non-Medicaid consumers **only after** the local appeal is not resolved "wholly in favor" of the consumer.

Local Appeal: Responsibilities of the PIHP/CMHSP Processing the Appeal

The PIHP/CMHSP must ensure timelines for resolution of the appeal are met and must take other steps as part of the appeal process including but not limited to:

Provide reasonable assistance to complete forms and take other procedural steps throughout the appeal process, which may include interpreter assistance.

Acknowledge receipt of the appeal request with an Appeal Acknowledgement Letter (SHW Notice Templates in SHIMER must be used) sent to the individual/legal representative/provider (if applicable).

Afford the individual the opportunity:

- to present evidence and allegations of fact or law in person as well as in writing.
- before and during the appeal process, to examine the individual's file, including medical records and any other documents pertaining to the appeal process.
- to include as parties to the appeal, the individual and/or his/her legal representative.

Information regarding the right to a MDHHS Alternative Dispute Resolution (if Non-Medicaid consumer).

A written Disposition of Appeal letter (SHIMER Templates must be used).

Information regarding the right to a Medicaid Fair Hearing will be provided (if Medicaid/Healthy Michigan recipient) only if an adverse determination to a local appeal is upheld. A local appeal and a Medicaid Fair Hearing cannot be submitted simultaneously.

It is prohibited for an individual/legal representative/provider to experience any retribution for filing an appeal.

Local Appeal Process: Differences for Individuals with Medicaid and without Medicaid

Although the Local Appeal Process is available to all individuals disagreeing with Adverse Benefit Determinations, there remains differences in the appeal process depending on whether or not they are covered by Medicaid.

MEDICAID/Healthy Michigan	NON-MEDICAID
Must utilize the local appeal process BEFORE utilizing the Medicaid Fair Hearing process.	MUST utilize local appeal process BEFORE utilizing MDHHS Alternative Dispute Resolution.
Possibly can have the implementation of the adverse benefit determination "frozen" until the outcome of a Local Appeal. That means they can continue to receive impacted services up to the time a disposition is offered. Must be requested in the time frame the ABD is issued and becomes effective.	The adverse action is implemented on the effective date and remains such throughout the appeal process and MDHHS Alternative Dispute Resolution process. The adverse benefit determination is only overturned if either the local or MDHHS appeal process determines otherwise.
If the CMH fails to adhere to notice and timing requirements as previously outlined, the enrollee is deemed to have exhausted the local appeal process. The enrollee may initiate a state fair hearing at that time.	

Notification and Appeal Timeframes for Medicaid and Non-Medicaid Grievances and Appeals

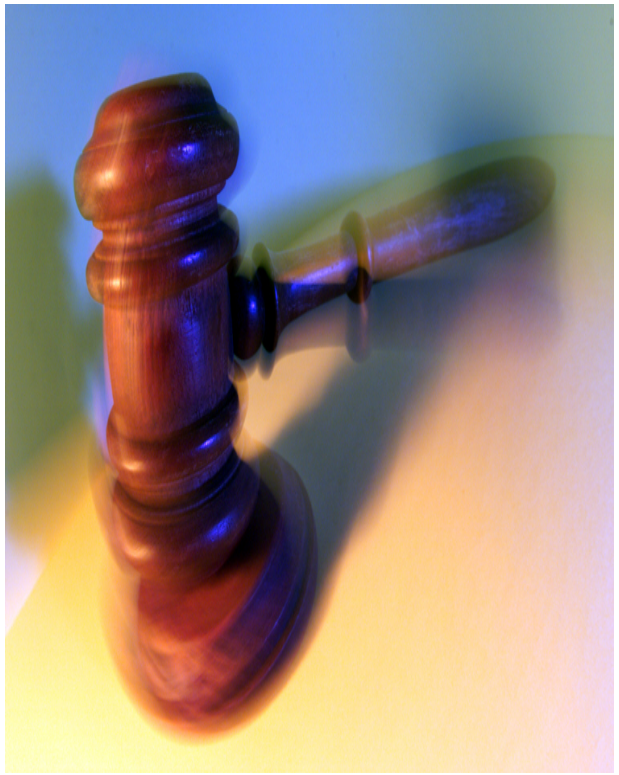
	Medicaid / Health Michigan		Non-Medicaid	
	Appeal	Grievance	Appeal	Grievance
Advance Notice	At least 10 Calendar Days before end of services	Not Applicable	At least 30 calendar days before end of services	Not applicable
CS Notice of Receipt of a Request for Appeal/Grievance	CS sends acknowledgement Letter in 7 calendar days	CS sends acknowledgement Letter in 7 calendar days	CS sends acknowledgement Letter in 7 calendar days	CS sends acknowledgement Letter in 7 calendar days
Disposition must occur within…	Standard = 30 calendar days Expedited = 72 hours	90 Calendar Days, there is not an option for an expedited grievance	Standard = 45 calendar days Expedited = 3 business days	60 Calendar Days, there is not and option for a expedited grievance
Time frame to request Medicaid Fair Hearing	120 days if not wholly in favor of Enrollee	Only if SHW fails to offer disposition in 90 Calendar Days	Not applicable	Not applicable
Time frame to request MDHHS Alternative Dispute Resolution	Not applicable	Not applicable	10 Calendar Days from appeal disposition letter	No appeal option, can call MDHHS Customer Services

Noticeable Changes based on the Medicaid Managed Care Final Rule

The disposition of an expedited appeals must be made within 72 hours. That is why we have started to track the time of the request for expedited appeals.

Enrollee has 120 days to request State Fair Hearing. State can offer and arrange external medical review. *Must implement a reversal of an adverse benefit determination and provide services no later than 72 hours from overturn.*

Medicaid Fair Hearing Process



Federal/State regulations provide individuals with Medicaid the right to an impartial review/hearing of an Adverse Benefit Determination made by a PIHP/CMHSP.

For adverse actions, enrollees must file a request for a fair hearing no later than 120 calendar days from the date of the of the Appeal Disposition letter.

If enrollees requested a continuation of services at the request for a local appeal, and, before the effective date of the Adverse Benefit Determination, services can continue through the fair hearing decision.

Enrollees also have the right to request a fair hearing if a disposition of a grievance request is not given within 90 calendar days of filing the grievance.

MDHHS Alternative Dispute Resolution

The MDHHS Alternative Dispute Resolution Process is only available to individuals/legal representatives without Medicaid. They have a right to this process **ONLY AFTER** they have completed the local appeal process with their PIHP/CMHSP.

Individuals/legal representatives are notified of this option in the SHW Appeal Disposition letter.

They must file a request with MDHHS for an Alternative Dispute Resolution within 10 calendar days of the appeal disposition letter from their PIHP/CMHSP.

MDHHS will review the request within 2 business days of receipt and will resolve the issue within 15 business days. Unless the adverse action poses an immediate and adverse impact on the individual's health/safety; then the review will be referred within one business day.

A written notice of the resolution is sent by MDHHS to the individual/legal representative and the PIHP/CMHSP.

Second Opinion, Recipient Rights, Mediation & Informal Conflict Resolution

Individuals with or without Medicaid can choose to use other local processes when they disagree with an adverse action at their PIHP/CMHSP. The availability of options depends on the situation. Additional options include:

- Second Opinion Process (available only in mental health system)
- Recipient Rights (available in both mental health and substance use disorder systems except for adverse actions in substance use disorder system)
- Informal Conflict Resolution (available in both mental health and substance use disorder systems)
- MDHHS has implemented a mediation process which can be carried out simultaneously with existing due processes such as local dispute resolution, a local appeal, or a state Medicaid fair hearing. Mediation is handled by a mediation agency, not the CMHSP.

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Second Opinion Process

A right protected by the Michigan Mental Health Code

Available only to individuals/legal representatives who wish to access specialty mental health services (includes emergency services but excludes substance use disorder services) within the PIHP/CMHSP.

If access to those services are denied, an individual/legal representative, who does not agree with the denial, can request a “second opinion” from the Chief Executive Officer (CEO) of the CMHSP.

The CEO appoints a master’s level clinician to review the initial denial of services using clinical and other information. The review may include a face-to-face assessment by the appointed clinician. The individual/legal representative should be informed of the disposition orally on the assessment date with a written disposition letter placed in the mail no later than that same date.

Please note this type of second opinion differs from the second opinion in which an individual/legal representative asks for another professional to assess a previously given diagnosis, treatment intervention, and/or medication regimen. [Example: An individual does not agree with the diagnosis and medication regimen prescribed by a psychiatrist. He/she can request a “second opinion” to be done by another psychiatrist within the provider network through the Shiawassee Health and Wellness (SHW) Customer Services Department.

Recipient Rights Process

A process protected by the Michigan Mental Health and Public Health Codes

If an individual/legal representative/provider ACTIVE IN SERVICES feels a right has been violated, a recipient rights complaint can be filed by the individual or on his/her behalf at any time. This applies to both mental health and substance use disorder services.

If an individual/legal representative is denied a second opinion regarding access to services, he/she should contact the Recipient Rights Office of the CMHSP.

Recipient Rights Office staff investigate the allegation, issue a determination if a defined right has been violated, and provide written notification regarding the disposition of the complaint.

Informal Conflict Resolution

For both mental health and substance use disorder services, individuals/legal representatives always have the option to collaborate with their assigned staff, staff's supervisor or director to verbalize concerns, questions, dissatisfactions, or disagreements.

Informal conflict resolution should be explored prior to contacting Customer Services

SHW Customer Services and Recipient Rights: Working Collaboratively to Protect Individual Due Process

SHW Customer Services and Recipient Rights Officers work in one department to identify grievance and rights issues. A particular complaint could be partly a grievance as well as a recipient rights issue. There is no wrong door. The individual or their legal representative only have to make one call.

If you have any questions about any of these processes, or wonder what your responsibilities, or that of the PIHP/CMHSP are, contact SHW Customer Services and/or your immediate supervisor for assistance.

Congratulations!

You have finished reviewing the course content.

Remember: this course is NOT complete until you pass the final exam/test and complete the survey.

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