BERRIEN MENTAL HEALTH AUTHORITY

PROCEDURE

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| SUBJECT: Grievance, Appeal and Second Opinion Process  For Medicaid Beneficiaries | SECTION: 01-80-01  Page 1 of 14 |
| APPLICATIONS: Customer Service, Recipient Rights, Clinical  Staff  EFFECTIVE DATE: 12/10/98  APPROVED BY: CEO  REVISED: 6/00, 3/02, 3/03, 4/05, 9/06, 4/07, 2/08, 6/09, 8/10, 1/11, 03/12, 7/13, 9/16, 3/18, 3/19, 7/19, 08/19, 1/20/20, 2/2022, 5/2022, 8/2022, 2/2023, 5/2024, 1/2025, 5/2025 | REQUIRED BY: CARF  Federal Law, 42 CFR, Chapter IV,  Subpart C, Sec. 434.32, Balanced Budget Act (BBA) of 1997**;**  SWMBH Policy 6.1  SWMBH Policy 6.4  SWMBH Policy 6.9  MDHHS Master Contract |

### POLICY:

It is the policy of Berrien Mental Health Authority (BMHA) that all customers have access to a fair and efficient process for resolving grievances and disputes related to the denial, reduction, suspension or termination of services and supports. A beneficiary of, or applicant for, public mental health specialty services and supports, may access several options to pursue the resolution of a grievance or appeal. It is important to note that an individual receiving mental health specialty services and supports may pursue grievances or appeals using multiple options. The most current State-developed notice forms will be used. BMHA will handle and process complaints in ways consistent with the policies set forth by Southwest Michigan Behavioral Health (SWMBH).

**STANDARDS:**

1. The grievance system must provide Medicaid beneficiaries:
   * 1. A local appeal process for challenging an “action” taken by BMHA
     2. Access to the state level fair hearing process to appeal an Adverse Benefit Determination taken by BMHA
     3. A local grievance process for expressions of dissatisfaction about any matter other than those that meet the definition of an “Adverse Benefit Determination”.
     4. The right to request, and have, benefits continue while a local PIHP/CMHSP appeal and/or State Fair Hearing is pending.
     5. The right to have a provider, acting on the beneficiary’s behalf and with the beneficiary’s written consent, file an appeal to the PIHP/CMHSP. The provider may file a grievance or request for a State Fair Hearing on behalf of the beneficiary **only if** the State permits the provider to act as the beneficiary’s authorized representative in doing so.
2. Under the Due Process Clause of the U.S. Constitution, Medicaid Enrollees are entitled to “due process” whenever their Medicaid benefits are denied, reduced, suspended or terminated. Due Process requires that Enrollees receive: (1) prior written notice of the adverse action; (2) a fair hearing before an impartial decision maker; (3) continued benefits pending a final decision; and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements. The Medicaid Enrollee Grievance and Appeal System provides a process to help protect Medicaid Enrollee due process rights.
3. Customers of mental health services who are Medicaid Enrollees eligible for Specialty Supports and Services have various avenues available to them to resolve disagreements or complaints. There are several processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievances and appeals for Medicaid beneficiaries who participate in managed care:

• State Fair Hearings through authority of 42 CFR 431.200 et seq.

• PIHP Appeals through authority of 42 CFR 438.400 et seq.

• Local grievances through authority of 42 CFR 438.400 et seq.

• Second Opinion through authority of 42 CFR 438.206 et. seq.

1. Medicaid Enrollees, as public mental health and substance use customers also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, (hereafter referred to as the “Code”) Chapters 2, 7, 7A, 4 and 4A, including:

* Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.)
* Medical Second Opinion through authority of the Mental Health Code (MCL 330.1705)
* Recipient Rights complaints through the authority of the Administrative Rules for Substance Abuse Service Programs in Michigan 325.14301 et seq.
* Mediation through the authority of the Mental Health Code (MCL 330.1206 (a))

1. BMHA will comply with the office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it affects Persons with Limited English Proficiency (LEP) when they provide written notices to customers and engage in oral resolution processes. In addition, BMHA will provide reasonable assistance to persons who have illiteracy, hearing or visual impairments.
2. This policy is based upon the premise that all beneficiaries of, or applicants for, public mental health and substance use services, will receive notice of their rights and an explanation of the grievance and appeal resolution processes. This policy in no way requires the exhaustion of local grievance or appeal resolution processes prior to the filing of a recipient rights complaint, pursuant to Chapter 7 and 7a of the Mental Health Code.
3. Properly structured grievance and appeal processes for customers should promote the resolution of consumer concerns, as well as support and enhance the overall goal of improving the quality of care.

The Internal and external grievance and appeal processes should be:

* Timely
* Fair to all parties
* Administratively simple
* Objective and credible
* Accessible and understandable to customers
* Cost and resource efficient
* Subject to quality review
* Verbal or written submission is permissible

In addition, the process should:

* Not interfere with communication between customers and their PIHP/CMHSP service providers.
* Assure that service providers who participate in a grievance and appeal process on behalf of enrollees should be free from discrimination or retaliation.
* Assure that customers who file a grievance should be free from discrimination or retaliation.

(Adapted from the Consumer Bill of Rights and Responsibilities, A report to the President of the United States, prepared by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, November 1997.)

1. The PIHP is responsible for all grievances, appeals and second opinions for customers enrolled in the MI Health Link coverage plan.

**DEFINITIONS:**

**Adverse Benefit Determination:** A decision that adversely impacts a Medicaid

Enrollee's claim for services due to: *(42 CFR 438.400)*

* Denial or limited authorization 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.
* 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 Service 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 make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization.
* Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP/CMHSP
* Failure of the PIHP/CMHSP to resolve standard appeals and provide notice within **30 calendar days** from the date of a request for a standard appeal.
* Failure of the PIHP/CMHSP to resolve expedited appeals and provide notice within **72 hours** from the date of a request for an expedited appeal.
* Failure of the PIHP/CMHSP to resolve grievances and provide notice within **90 calendar days** of the date of the request.
* For a resident of a rural [area](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=d6b2c937e28f2e067f124bda4cfe0eb9&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.400) with only one [MCO,](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=1daf12b5f60f2d316a82cf2b0c33d729&term_occur=3&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.400) the denial of an [Enrollee's](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=05539ddefc2d256d3e81e2d4e6e7c852&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.400) request to exercise his or her right, under [*§ 438.52(b)(2)(ii)*,](https://www.law.cornell.edu/cfr/text/42/438.52#b_2_ii) to obtain services outside the [network.](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=80360f4a6529994d1999c43b2ca9249f&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.400)
* Denial of an Enrollee’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility.

**Adequate Notice of Adverse Benefit Determination:** Written statement advising the Enrollee of a decision to deny or limit authorization of Medicaid services requested, which notice must be provided to the Medicaid Enrollee on the same datethe Adverse Benefit Determination takes effect.

**Advance Notice of Adverse Benefit Determination:** Written statement advising the Enrollee of a decision to reduce, suspend or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid Enrollee at least **10 calendar days prior** to the proposed date the Adverse Benefit Determination is to take effect.

**Appeal:** A review at the local level by a PIHP/CMHSP of an Adverse Benefit Determination, as defined above. BMHA will acknowledge receipt of the standard Appeal within five (5) business days.

**Authorization of Services:** The processing of requests for initial and continuing service delivery.

**Consumer:** Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP/CMHSP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

**Enrollee:** A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program**.**

**Expedited Appeal:** The expeditious review of an Adverse Benefit Determination, requested by an Enrollee or the Enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the [Enrollee's](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=05539ddefc2d256d3e81e2d4e6e7c852&term_occur=3&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.410) life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the Enrollee requests the expedited review, the PIHP/CMHSP determines if the request is warranted. If the Enrollee’s provider makes the request, or supports the Enrollee's request, the PIHP/CMHSP must grant the request. BMHA will acknowledge receipt of an expedited Appeal within 72 hours of receipt.

**Grievance:** Enrollee’s expression of dissatisfaction about PIHP/CMHSP service 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 Enrollee, failure to respect the Enrollee’s rights regardless of whether remedial action is requested, or an Enrollee’s dispute regarding an extension of time proposed by the CMHSP to make a service authorized decision.

**Grievance Process:** Impartial local level review of an Enrollee’s Grievance**.**

**Grievance and Appeal System:** The processes the  [PIHP/CMHSP](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=04b13365cdf0c37f21582e1c74c6bf02&term_occur=5&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.400) implements to handle [Appeals](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=7bc2fd55f34646d2019b9fd8fad3703c&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.400) of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them.

**Medicaid Services:** Services provided to an Enrollee under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

**Notice of Resolution:** Written statement of the PIHP of the resolution of a Grievance or Appeal, which must be provided to the Enrollee as described in *42 CFR 438.408*.

**Recipient Rights Complaint:** Written or verbal statement by an Enrollee, or anyone acting on behalf of the Enrollee, 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**: PIHP/CMHSP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing 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 Enrollee's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

### GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS:

Federal regulation *(42 CFR 438.228)* requires the State to ensure through its contracts with PIHPs, that each PIHP has a grievance and appeal system in place for Enrollee’s that complies with Subpart F of Part 438.

The Grievance and Appeal System must provide Enrollees:

* An Appeal process (one level, only) which enables Enrollees to challenge Adverse Benefit Determinations made by the PIHP/CMHSP or its agents.
* A Grievance Process.
* The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints.
* Access to the State Fair Hearing process to further appeal an Adverse Benefit Determination, after receiving notice that the Adverse Benefit Determination has been upheld by the PIHP/CMHSP level Appeal.
* Information that if the PIHP/CMHSP fails to adhere to notice and timing requirements as outlined in PHIP Appeal Process, the Enrollee is deemed to have exhausted the PIHP/CMHSP’s appeals process. The Enrollee may initiate a State fair hearing.
* The right to request, and have, current Medicaid covered benefits continued while a local PIHP/CMHSP Appeal and/or State Fair Hearing is pending.
* With the written consent from the Enrollee, the right to have a provider or other authorized representative, acting on the Enrollee's behalf, file an Appeal or Grievance to the PIHP/CMHSP, or request a State Fair Hearing. The provider may file a grievance or request a state fair hearing on behalf of the Enrollee sincethe State permits the provider to act as the Enrollee's authorized representative in doing so. Punitive action may not be taken by the PIHP/CMHSP against a provider who acts on the Enrollee’s behalf with the Enrollee’s written consent to do so.

### NOTICE OF ADVERSE BENEFIT DETERMINATION:

A PIHP/CMHSP is required to provide timely and “adequate” notice of any Adverse Benefit Determination.

A. Content & Format: The notice of Adverse Benefit Determination must meet the following requirements:

1. Enrollee notice must be in writing, and must meet the requirements of 42 CFR 438.10(i.e., “…manner and format that may be easily understood and is readily accessible by such enrollees

and [potential enrollees,](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=fa40dc6b10a33ea7e048b595be894a56&term_occur=4&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:A:438.10)” meets the needs of those with limited English proficiency and or limited reading proficiency); and CFR 438.404.

1. Notification that *42 CFR 440.230(d)* provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures;
2. Description of Adverse Benefit Determination;
3. The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;
4. Notification of the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee’s Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);
5. Notification of the Enrollee’s right to request an Appeal, including information on exhausting the PIHP/CMHSP’s single local appeal process, and the right to request a State Fair Hearing thereafter;
6. Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal;
7. Notification of the Enrollee’s right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the Enrollee may be required to pay the costs of the continued services (only required when providing “Advance Notice of Adverse Benefit

Determination”;

1. Description of the procedures that the Enrollee is required to follow in order to exercise any of these rights; and
2. An explanation that the Enrollee may represent him/herself or use legal counsel, a relative, a friend or other spokesman.

B. Timing of Notice:

1. Adequate Notice of Adverse Benefit Determination:

1. For a denial of payment for services requested (not currently provided), notice must be provided to the Enrollee at the time of the action affecting the claim.
2. For a Service Authorization decision that denies or limits services notice must be provided to the Enrollee within 14-days following receipt of the request for service for standard authorization decisions, or within 72-hours after receipt of a request for an expedited authorization decision.
3. For Service Authorization decisions not reached within 14-days for standard request, or 72-hours for an expedited request, (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.

• NOTE, however, that the PIHP/CMHSP may be able to extend the standard Service Authorization timeframe in certain circumstances.*.* If so, the PIHP/CMHSP must: (i)provide the [Enrollee](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=05539ddefc2d256d3e81e2d4e6e7c852&term_occur=7&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.404) written [notice](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=056aed00403d12615cf8673ac47ed44e&term_occur=5&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.404) of the reason for the decision to extend the timeframe and inform the [Enrollee](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=05539ddefc2d256d3e81e2d4e6e7c852&term_occur=8&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.404) of the right to file a [Grievance](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=3b0a2e73ccb28af32d7e4b1502dd72aa&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.404) if he/she disagrees with that decision; and (ii) issue and carry out its determination as expeditiously as the [Enrollee's](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=05539ddefc2d256d3e81e2d4e6e7c852&term_occur=9&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.404) health condition requires and no later than the date the extension expires.

2. Advance Notice of Adverse Benefit Determination:

* 1. Required for reductions, suspensions or terminations of previously authorized/ currently provided Medicaid Services.
  2. Must be provided to the Enrollee at least ten (10) calendar days prior to the proposed effective date**.**
  3. Limited Exceptions: The PIHP/CMHSP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, IF**:**

1. The PIHP/CMHSP has factual information confirming the death of an Enrollee;
2. The PIHP/CMHSP receives a clear written statement signed by an Enrollee that he no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the Enrollee understands that this must be the result of supplying that information;
3. The Enrollee has been admitted to an institution where he is ineligible under the plan for further services;
4. The Enrollee’s whereabouts are unknown and the post office returns [agency](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=bd51e09ddebcb96c4bc06cab4f0f5067&term_occur=4&term_src=Title:42:Chapter:IV:Subchapter:C:Part:431:Subpart:E:Subjgrp:11:431.213) mail directed to him indicating no forwarding address;
5. The PIHP/CMHSP establishes with MDHHS that the Enrollee has been accepted for [Medicaid](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=0e504496534ec33a1f9a4f95c7a8fa57&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:431:Subpart:E:Subjgrp:11:431.213) services by another local jurisdiction, State, territory, or commonwealth;
6. A change in the level of medical care is prescribed by the Enrollee’s physician;
7. The [notice](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=4562f09c7e98b4e9a32adb7fdc2cd0a1&term_occur=3&term_src=Title:42:Chapter:IV:Subchapter:C:Part:431:Subpart:E:Subjgrp:11:431.213) involves an [adverse determination](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=f484acf99811d23f7b2f5e7ff8f4fd42&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:431:Subpart:E:Subjgrp:11:431.213) made with regard to the preadmission screening requirements of section 1919(e)(7) of the [SSA;](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=3d07eea841654df2266f7a9fd3632f4c&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:431:Subpart:E:Subjgrp:11:431.213)
8. The [date of action](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=908f811b50e60a8b61326cdfbfbee940&term_occur=2&term_src=Title:42:Chapter:IV:Subchapter:C:Part:431:Subpart:E:Subjgrp:11:431.213) will occur in less than 10 calendar
9. The PIHP/CMHSP has facts (preferably verified through secondary sources) indicating that [action](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=afb09e5aeb6917b775ad61a5557c1406&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:431:Subpart:E:Subjgrp:11:431.214) should be taken because of probable fraud by the Enrollee (in this case, the PIHP/CMHSP may shorten the period of advance [notice](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=4562f09c7e98b4e9a32adb7fdc2cd0a1&term_occur=2&term_src=Title:42:Chapter:IV:Subchapter:C:Part:431:Subpart:E:Subjgrp:11:431.214) to 5 [days](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=22279f24e7d9fe484dd3e6548a3773e4&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:431:Subpart:E:Subjgrp:11:431.214) before the [date of action)](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=908f811b50e60a8b61326cdfbfbee940&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:431:Subpart:E:Subjgrp:11:431.214).

C. Required Recipients of Notice of Adverse Benefit Determination:

* 1. The Enrollee must be provided written notice.
  2. The requesting provider must be provided notice of any decision by the PIHP/CMHSP to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. Notice to the provider does NOT need to be in writing.
  3. PIHP/CMHSP cannot delay service authorization decisions based upon the availability of providers.

* 1. If the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an adverse benefit determination, and requires a written notice of action.

### MEDICAID SERVICES CONTINUATION OR REINSTATEMENT:

1. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the PIHP/CMHSP MUST continue the Enrollee’s benefits if all of the following occur:
   1. The Enrollee files the request for Appeal timely (within 60 calendar days

from the date on the Adverse Benefit Determination Notice);

* 1. The Enrollee files the request for continuation of benefits timely (on or before the latter of (i) 10 calendar days from the date of the notice of Adverse Benefit Determination, or (ii) the intended effective date of the proposed Adverse Benefit Determination); and
  2. The period covered by the original authorization has not expired.

1. Duration of Continued or Reinstated B**e**nefits**.** If the PIHP/CMHSP continues or reinstates the Enrollee’s benefits, at the Enrollee’s request, while the Appeal or State Fair Hearing is pending, the PIHP/CMHSP must continue the benefits until one of following occurs:

* 1. The [Enrollee](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=05539ddefc2d256d3e81e2d4e6e7c852&term_occur=6&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.420) withdraws the [Appeal](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=7bc2fd55f34646d2019b9fd8fad3703c&term_occur=5&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.420) or request for[State](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=00d98f9e39c6bc2b1389fcc385bfaeca&term_occur=3&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.420) Fair Hearing;
  2. The Enrolleefails to request a State Fair Hearing and continuation of benefits within 10 calendar days afterPIHP/CMHSP sends the Enrollee notice of an adverse resolution to the Enrollee’s Appeal;
  3. A State Fair Hearing office issues a decision adverse to the [Enrollee.](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=05539ddefc2d256d3e81e2d4e6e7c852&term_occur=9&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.420)

1. If the final resolution of the [Appeal](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=7bc2fd55f34646d2019b9fd8fad3703c&term_occur=7&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.420) or [State Fair Hearing](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=00d98f9e39c6bc2b1389fcc385bfaeca&term_occur=6&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.420)  upholds the PIHP/CMHSP’s Adverse Benefit Determination, the  [PIHP/CMHSP](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=04b13365cdf0c37f21582e1c74c6bf02&term_occur=8&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.420) may, consistent with the [state's](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=ca92247e53beeed90570e93dd9ef3baa&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.420) usual policy on recoveries and as specified in the [PIHP/CMHSP’s](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=04b13365cdf0c37f21582e1c74c6bf02&term_occur=9&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.420) contract, recover the cost of services furnished to the [Enrollee](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=05539ddefc2d256d3e81e2d4e6e7c852&term_occur=11&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.420) while the [Appeal](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=7bc2fd55f34646d2019b9fd8fad3703c&term_occur=8&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.420) and [State Fair Hearing](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=00d98f9e39c6bc2b1389fcc385bfaeca&term_occur=7&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.420) was pending, to the extent that they were furnished solely because of these requirements.

1. If the Enrollee's services were reduced, terminated or suspended without an advance notice, the PIHP/CMHSP must reinstate services to the level before the action.

1. If the PIHP/CMHSP, or the MDHHS fair hearing administrative law judge reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, the PIHP/CMHSP or the State must pay for those services in accordance with State policy and regulations.

1. If the PIHP/CMHSP, or the MDHHS fair hearing administrative law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP/CMHSP must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

### PIHP/CMHSP APPEAL PROCESS:

1. Upon receipt of an adverse benefit determination notification, federal regulations 42 CFR 400 et seq., provide Enrollees with the right to appeal the determination through an internal review by the PIHP/CMHSP. Each PIHP/CMHSP may only have one level of appeal. Enrollees may request an internal review by the PIHP/CMHSP, which is the first of two appeal levels, under the following conditions:

* 1. The Enrollee has **60 calendar days** from the date of the notice of Adverse Benefit Determination to request an Appeal.
  2. The Enrollee may request an Appeal either orally or in writing.

NOTE: Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal).

* 1. In the circumstances described under the section G entitled “Reinstatement or Continuation of Medicaid Services” Riverwood will be required to continue/reinstate Medicaid Services while the appeal or state fair hearing is pending, until one of the events described in that section occurs.

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1. PIHP/CMHSP Responsibilities when Enrollee Requests an Appeal:

* 1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate Michigan Relay Center (MRC) and /or TTY/TDD and interpreter capability.
  2. Acknowledge receipt of each Appeal within five (5) business days.
  3. Acknowledge receipt of each Expedited appeal within 72 hours.
  4. Maintain a record of appeals for review by the State as part of its quality strategy*.*
  5. Ensure that individual(s) who make the decision on appeals are individuals:
     + 1. Who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual.
       2. Who when deciding an Appeal that involves either clinical issues, or a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the Enrollee’s condition or disease.
       3. PREST and Associates Inc. may be utilized as appropriate to review and make determination ensuring no conflict of interest and appropriate clinical expertise, as determined by the State, in treating the Enrollee’s condition or disease.
       4. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
  6. Provide the Enrollee a reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing, and inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals;
  7. Provide the Enrollee and his/her representative the Enrollee’s case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP/CMHSP in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. It will be documented in the notes section of the Appeal.
  8. Provide opportunity to include as parties to the appeal the Enrollee and his/her representative, or the legal representative of a deceased Enrollee's estate;
  9. Provide the Enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one.

1. Appeal Resolution Timing and Notice Requirements:

* 1. Standard Appeal Resolution (timing): The PIHP/CMHSP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed **30 calendar days** from the day the PIHP/CMHSP receives the Appeal.
  2. Expedited Appeal Resolution (timing):

* + - 1. Available where the PIHP/CMHSP determines (for a request from the Enrollee) or the provider indicates (in making a request on the Enrollee’s behalf or supporting the Enrollee’s request) that the time for a standard resolution could seriously jeopardize the Enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function.
      2. The [PIHP](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=04b13365cdf0c37f21582e1c74c6bf02&term_occur=3&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.410)/CMHSPmay not take punitive action against a [provider](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=1a0ce7d7a3bfcb5dc5fe14032dc4305c&term_occur=2&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.410) who requests an expedited resolution or supports an [Enrollee's](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=05539ddefc2d256d3e81e2d4e6e7c852&term_occur=4&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.410) [appeal.](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=7bc2fd55f34646d2019b9fd8fad3703c&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.410)
      3. If a request for expedited resolution is denied, the PIHP/CMHSP must:

* + - 1. [Transfer](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=98f2d9c1e461596dd61babfb6c4ca4bf&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.410) the [appeal](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=7bc2fd55f34646d2019b9fd8fad3703c&term_occur=3&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:F:438.410) to the timeframe for standard resolution.
      2. Make reasonable efforts to give the Enrollee prompt oral noticeof the denial.
      3. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision**.**
      4. Resolve the Appeal as expeditiously as the Enrollee’s health condition requires but not to exceed 30 calendar days.

d. If a request for expedited resolution is granted, the PIHP/CMHSP must resolve the Appeal and provide notice including oral notice of resolution to the affected parties no longer than **72-hours** after the PIHP/CMHSP receives the request for expedited resolution of the Appeal. Oral notice will be documented.

3. Extension of Timeframes: The PIHP/CMHSP may extend the resolution and notice timeframe by up to **14 calendar days** if the Enrollee or provider requests an extension, or if the PIHP/CMHSP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the Enrollee’s interest.

a. If the PIHP/CMHSP extends resolution/notice timeframes (not at the request of the enrollee), it must complete all of the following:

* + - 1. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;
      2. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision.
      3. Resolve the Appeal as expeditiously as the Enrollee’s health condition requires and not later than the date the extension expires.

4. Appeal Resolution Notice Format:

* + - 1. The PIHP/CMHSP must provide Enrollees with written notice of the resolution of their Appeal, and must also make reasonable efforts to provide oral notice in the case of an expedited resolution.
      2. The notice templates for grievance and appeals must incorporate the information needed to meet the requirement of grievance and appeal recordkeeping in 42 CFR 438.416. Specifically, 42 CFR 438.416 indicates the State must require the PIHP maintain records with (at minimum) the following information:

* + - 1. A general description of the reason for the appeal or grievance.
      2. The date received.
      3. The date of each review or, if applicable, review meeting.
      4. Resolution at each level of the appeal or grievance if applicable.
      5. Date of resolution at each level, if applicable.
      6. Name of the covered person for whom the appeal or grievance was filed.

Further this recordkeeping must be “accurately maintained in a manner accessible to the state and available upon request to CMS.”

IF the PIHP chooses not to use the recommended notice templates the alternatives used by the PIHP must include the required information under 42 CFR 438.416 as noted above.

c. Enrollee notice of appeal resolution must meet the requirements of 42 CFR 438.10(c)(1) that states “each PIHP entity must provide all required information in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees,” and meets the needs of those with limited English proficiency and/or limited reading proficiency.

5. Appeal Resolution Notice Content:

* + - 1. The notice of resolution must include the results of the resolution and the date it was completed.
      2. When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee’s:
      3. Right to request a state fair hearing, and how to do so;
      4. Right to request to receive benefits while the state fair hearing is pending, and how to make the request; and
      5. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP/CMHSP’s Adverse Benefit Determination

### GRIEVANCE PROCESS:

1. Federal regulations provide Enrollees the right to a grievance process to seek resolution to issues that are not Adverse Benefit Determinations.

1. Generally:

* 1. Enrollees must file Grievances with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating resolution of Grievances.
  2. Grievances may be filed at any time by the Enrollee, guardian, or parent of a minor child or his/her legal representative orally or in writing.
  3. Enrollee’saccess to the State Fair Hearing process respecting Grievances is onlyavailable when the PIHP/CMHSP fails to resolve the grievance and provide resolution within **90 calendar days** of the date of the request. This constitutes an “Adverse Benefit Determination" and can be appealed to the MDHHS Administrative Tribunal using the State Fair Hearing process.

1. PIHP/CMHSP Responsibility when Enrollee Files a Grievance:

* 1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate Michigan Relay Center (MRC) and /or TTY/TDD and interpreter capability.
  2. Acknowledge receipt of the Grievance within 5 business days
  3. Maintain a record of grievances for review by SWMBH Quality Management Team and/or the State as part of its quality strategy.
  4. Submit the written grievance to appropriate staff including a PIHP/CMHSP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination. In cases of Medical Director, the grievance will be submitted to the CEO and appropriate Mental Health Professional.
  5. Ensure that the individual(s) who make the decisions on the Grievance:

* + 1. 1. Who were neither involved in any previous level of review or decision-making, nor a subordinate of any such individual;
       2. Who are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee’s condition or disease; for a grievance regarding denial of expedited resolution of an appeal and/or a grievance that involves clinical issues.
       3. Who consider all comments, documents, records, and other information submitted by the Enrollee and/or the enrollee’s representative without regard to whether such information was submitted or considered previously.

1. Grievance Resolution Timing and Notice Requirements

* 1. Timing of Grievance Resolution: Provide the Enrollee a written notice of resolution not to exceed **90 calendar days** from the day the PIHP/CMHSP received the Grievance.
  2. Format and Content of Notice of Grievance Resolution:

* + 1. Enrollee notice of Grievance resolution must meet the requirements of 42 CFR 438.10 (i.e., “…in a manner and format that may be easily understood and is readily accessible by such [enrollees](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=05539ddefc2d256d3e81e2d4e6e7c852&term_occur=4&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:A:438.10) and [potential enrollees,](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=fa40dc6b10a33ea7e048b595be894a56&term_occur=4&term_src=Title:42:Chapter:IV:Subchapter:C:Part:438:Subpart:A:438.10)” meets the needs of those with limited English proficiency and or limited reading proficiency).
    2. The notice of Grievance resolution must include:
       1. The results of the Grievance process;
       2. The date the Grievance process was concluded;
       3. Notice of the Enrollee’s right to request a State Fair Hearing, if the notice of resolution is more than **90-days** from the date of the Grievance; and
       4. Instructions on how to access the State Fair Hearing process, if applicable.

### STATE FAIR HEARING APPEAL PROCESS:

1. Federal regulations provide an Enrollee the right to an impartial review by a state level administrative law judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances:

* 1. After receiving notice that the PIHP/CMHSP is, after Appeal, upholding an Adverse Benefit Determination.
  2. When the PIHP/CMHSP fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals, as described in *42 CFR 438.408.*

1. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the Enrollee, free to Enrollee, independent of State and PIHP, and not extend any timeframes or disrupt continuation of benefits).

1. The PIHP/CMHSP may not limit or interfere with an Enrollee's freedom to make a request for a State Fair Hearing.

1. Enrollees are given **120 calendar days** from the date of the applicable notice of resolution to file a request for a State Fair Hearing.

1. The PIHP/CMHSP is required to continue benefits, if the conditions described in Section V,

MEDICAID SERVICES CONTINUATION OR REINSTATEMENT are satisfied, and for the durations described therein.

1. If the Enrollee's services were reduced, terminated or suspended without advance notice, the PIHP/CMHSP must reinstate services to the level before the Adverse Benefit Determination.

1. The parties to the State Fair Hearing include the PIHP, the CMHSP, the Enrollee and his or her representative, or the representative of a deceased Enrollee's estate. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.

1. Expedited hearings are available.

Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at:

<http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html>

OR Department of Licensing and Regulatory Affairs

Michigan Office of Administrative Hearings and Rules

State Fair Hearing

<http://www.michigan.gov/lara/0,4601,7-154-10576_61718_77732---,00.html>

**BMHA Internal Second Opinion Request Process**

Notice of Second Opinion Rights is provided when**:**

1. Individual denied access for all (intake) mental health and or hospitalization services, will receive Notice of Second Opinion Rights in person or by mail from the appropriate mental health professional.
2. Individual may request a Second Opinion up to 45 business days after intake denial and three calendar days after hospitalization denial.
3. Second Opinion Request may be made via telephone or in writing to Customer Service.
4. Customer Service will coordinate second opinion appointment with appropriate mental health professional within two business days.
5. The appropriate mental health professional will provide documentation of decision to Customer Service.
6. Notice of Second Opinion Decision letter will be provided in writing to the consumer by Customer Service.

### RECORDKEEPING REQUIREMENTS:

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The PIHP/CMHSP is required to maintain records of Enrollee Appeals and Grievances, which will be reviewed by the PIHP/CMHSP as part of its ongoing monitoring procedures, as well as by State staff as part of the State’s quality strategy.

A PIHP/CMHSP’s record of each Grievance or Appeal must contain, at a minimum:

1. A general description of the reason for the Grievance or Appeal;
2. The date received;
3. The date of each review, or if applicable, the review meeting;
4. The resolution at each level of the Appeal or Grievance, if applicable;
5. The date of the resolution for each Appeal or Grievance, if applicable;
6. Name of the covered person for whom the Grievance or Appeal was filed.

PIHP/CMHSP’s must maintain such records accurately and in a manner accessible to the State and available upon request to CMS. Grievance and appeal records are retained for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

### RECIPIENT RIGHTS COMPLAINT PROCESS:

Enrollees, as recipients of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health Code. Recipient Rights complaint requirements are articulated in CMHSP Managed Mental Health Supports and Services contract, Attachment C6.3.2.1 - CMHSP Local Dispute Resolution Process.

**REVIEWER:** Customer Services

**REVIEWED:** 6/09, 8/10, 1/11, 10/11, 3/12, 10/12, 7/13, 6/14, 6/15, 3/16, 2/17, 3/18, 3/19, 7/19, 08/19, 1/2020, 5/2021, 2/2022, 5/2022, 8/2022, 2/2023, 5/2024, 1/2025, 5/2025