CENTRA WELLNESS NETWORK

Board Adopted Procedure		
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CENTRA WELLNESS NETWORK
PROCEDURE 03.22 MEDICAID BENEFICIARY APPEALS/GRIEVANCES

I. PURPOSE STATEMENT:

Centra Wellness Network's (CWN) Governing Body establishes and evaluates policies and related procedures as required by statutory and contractual obligations.
CWN reserves the right in its sole discretion to adopt and implement policies and procedures that ensure a safe, functional and professional workplace that operates with integrity using person-centered focus and planning, trauma informed practices and respect of others, cultural sensitivity and transparency in communication and practice. Organizationally and in practice, CWN is responsive to the needs of clients, community and staff.

Any statements and procedures are subject to review and/or unilateral change, modification, suspension or cancelation in whole or in part of any published/unpublished policies or procedures without notice and without having to give cause, justification, or consideration to any employee. Recognition of these rights and prerogatives of CWN is a term and condition of and maintaining employment.

Policies and Procedures are approved by the Board and/or upon recommendation by the Executive Director or his/her designee.

II. APPLICATION:

Agency Wide.

III. DEFINITIONS:

Adverse Benefit Determination (ABD):

A decision that adversely impact's a Medicaid Beneficiary's claim for services due to:

a. The denial or limited authorization of a requested Medicaid service including the type or level of service.
b. The reduction, suspension, termination of a previously authorized Medicaid service.
c. The denial, in whole or part, of payment for a Medicaid covered service.
d. The 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 services.
e. Failure to make an expedited authorization decision within **72 hours** from the date of receipt of a request for expedited service authorization.
f. 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.
g. Failure of the PIHP/CMHSP to act within **30 calendar days** from the date of a request for a standard appeal.
h. Failure of the PIHP/CMHSP to act within **72 hours** from the date of a request for an expedited appeal.
i. Failure of the PIHP/CMHSP to provide disposition and notice of a local grievance/complaint within **90 calendar days** of the date of the request.

Additional Mental Health Services:

Supports and services available to Medicaid beneficiaries who meet the criteria for Specialty Services and Supports, under the authority of Section 1915 (b)(3) of the Social Security Act. Also referred to as "B3" waiver services.

Adequate Notice of Adverse Benefit Determination:

Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid services requested. Notice is provided on the same day the adverse benefit decision takes effect, or at the time of the signing of the individual plan of services/supports.

Advance Notice of Adverse Benefit Determination:

Written statement advising the beneficiary of a decision to suspend, reduce, or terminate Medicaid covered services that are currently provided. Notice must be provided/mailed at least **10** calendar days in advance of the date of adverse benefit decision.

Appeal:
Request for a review of an adverse benefit decision.

Authorization of Services:
The process for approving first and on-going services.

Beneficiary:
A person who is eligible for Medicaid and who is receiving or may be eligible to receive mental health services through a PIHP/CMHSP.

Consumer:
A person requesting or receiving mental health services delivered and/or managed by PIHP/CMHSP including persons with Medicaid and all others.

Expedited Appeal:
A speedy review of an adverse benefit decision, requested by the beneficiary or the beneficiary's provider when the time for the normal appeal process could jeopardize the beneficiary's life, health, or ability to maintain, attain, or regain maximum function. If requested by the beneficiary, the PIHP/CMHSP determines if an expedited appeal is warranted. If the beneficiary's provider makes or supports the request, the PIHP **MUST** grant the request.

State Fair Hearing (SFH):
Impartial state level review of a Medicaid beneficiary's appeal of an adverse benefit decision presided over by a Michigan Department of Health and Human Services (MDHHS) Administrative Law Judge. Also referred to as an "administrative hearing."

Grievance:
Medicaid Beneficiary's expression of dissatisfaction about any PIHP/CMHSP service issue other than an adverse benefit decision. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the beneficiary.

Grievance Process:
Impartial local level review of a Medicaid Beneficiary's grievance (expression of dissatisfaction) about PIHP/CMHSP service issues **other than an** adverse benefit decision.

Appeal and Grievance System:
The overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process. A poster and brochures on this system shall be publicized and available in CWN lobbies, and information shall be given to beneficiaries upon initiation of services.

Local Appeal Process:
Impartial local level PIHP/CMHSP review of a Medicaid beneficiary's appeal of an adverse benefit decision presided over by individuals not involved with decision-making or previous level of review.

Medicaid Services:
Services provided to a beneficiary under the Medicaid state plan, Habilitation Supports Waiver and/or 1915(b)(3) waiver of the Social Security Act.

Notice of Disposition:
Written statement of the PIHP/CMHSP decision for each local appeal and/or grievance, provided to the beneficiary.

PIHP:
Prepaid Inpatient Health Plan. CWN is an affiliate member of the Northern Michigan Regional Entity PIHP.

Recipient Rights Complaint:
Written or verbal statement by a consumer, or anyone acting on their behalf, alleging a violation of a Michigan

Mental Health Code protected right cited in Chapter 7, which is resolved through the Recipient Right process (Chapter 7a).

IV. POLICY STATEMENT:

The intent of this procedure is to ensure notification of the recipient his/her right to file appeals and grievances, including local appeals and grievances and State Fair Hearings. To provide a fair and efficient process for resolving appeals and grievances from recipients of Medicaid services or applicants for Medicaid services, related to suspension, termination, reduction or denial of services and supports and/or grievances related to services delivered by Manistee Benzie Community Mental Health and its contracted providers.

V. PROCEDURES

A. CWN is delegated by the PIHP the responsibility for the appeals/grievance processes via a written agreement consistent with 42.CFR 438.230. The complaint resolution or grievance system in place for Medicaid beneficiaries is compliant with federal regulation (42 CFR 438.228) that complies with Subpart F of part 438.

B. Characteristics of complaint resolution system:
   1. All processes will promote the resolution of concerns and improvement of the quality of care.
   2. Complaints should be resolved at the level closest to service delivery when possible but information regarding access to all complaint resolution processes will be provided to the beneficiary of services.
   3. The CWN Customer Service Specialist will be the contact point for the appeals/grievance system.
   4. Beneficiaries have access to the state level fair hearing process for an appeal of an "adverse benefit decision" that includes the right:
      a. To request a State fair hearing only after exhausting the local level appeal of an "adverse benefit decision" and no later than 120 calendar days from the date of the local decision.
      b. To have services continued when a local appeal and/or state fair hearing is pending. The beneficiary must be informed that he/she may be responsible for the costs of the services provided while the appeal is pending based on his/her ability to pay.
      c. To have a provider file an appeal and represent a beneficiary with the beneficiary's written consent. A provider may file a grievance or request for 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. Punitive action may not be taken by CWN or the PIHP against a provider who acts on the beneficiary's behalf.
   5. A local grievance process for expressions of dissatisfaction about any matter other than those that meet the definition of an "adverse benefit decision".
   6. All ABD, grievance and appeal notices shall utilize State-mandated templates and language taglines.

C. Service Authorizations Decisions:
   1. CWN is delegated by the PIHP the responsibility for providing each Medicaid beneficiary a written service decision as required in this procedure and as quickly as the beneficiary's health condition requires (standard or expedited authorization).
   2. Service Authorizations Requirements:
      a. Standard Authorization – Notice must be provided as expeditiously as the beneficiary's health condition requires and no later than 14 calendar days following receipt of the request for services.
      b. Expedited Authorization - In cases which a provider indicates, or CWN/PIHP determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, then CWN/PIHP must make an expedited authorization decision and provide prompt oral notice of the decision as expeditiously as the beneficiary's health condition requires, and no later than **72 hours** after the receipt of the request for service.

D. Notice of Adverse Benefit Determination (adequate or advance):
   1. CWN is delegated by the PIHP the responsibility to provide notice of adverse benefit decision to Medicaid beneficiaries when the authorized service decision constitutes an "adverse benefit decision" that is less in amount, scope, or duration than requested, or is reduced, terminated, or suspended, or when the authorization decision is not timely. In these situations, a notice of adverse benefit decision must be provided to inform the beneficiary of the basis for the adverse benefit decision taken by CWN, or intends to take and the process available to appeal the decision.
   2. Notice of Adverse Benefit Determination requirements:

a. Be in writing in the primary language of the beneficiary and at a level that can be understood by the beneficiary.
b. Be provided to the requesting provider if the requested service is denied or authorized in an amount, scope, and duration that is less than requested.
c. If a Medicaid beneficiary or representative requests a local appeal within **10** calendar days of the date of adverse benefit decision the services will be reinstated until the disposition of the appeal is received.
d. If authorized services were reduced, terminated or suspended without advance notice, the services must be reinstated to the level before the adverse benefit decision.
e. 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 decision, and requires a written notice of adverse benefit decision.
f. Incentives are not present for the denial, limitation or discontinuation of services to any beneficiary.

3. The notice of adverse benefit decision must be either Adequate or Advance:
   a. Adequate notice: is a written notice provided to the beneficiary at the time of EACH adverse benefit decision. The individual plan of service, developed through a person-centered planning process and finalized with the beneficiary, must include, or have attached, the adequate adverse benefit decision provisions.
   b. Advance notice: is a written notice required when an adverse benefit decision is being taken to reduce, suspend or terminate services that the beneficiary is currently receiving. The advance notice must be mailed 10 calendar days before the intended adverse benefit decision takes effect.
4. The content of both adequate and advance notices must include an explanation of what adverse benefit decision the CMHSP/PIHP intends to take:
   a. The reason(s) for the adverse benefit decision.
   b. 42 CFR 440.2309(d) is the basic legal authority for an adverse benefit decision to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.
   c. The beneficiary's or provider's right to file a CMHSP/PIHP appeal, and instructions for doing so.
   d. The beneficiary's right to request a State fair hearing and instructions for doing so.
   e. The circumstances under which expedited resolution can be requested and instructions for doing so.
   f. An explanation that the beneficiary may represent himself or use legal counsel, a relative, a friend, or other spokesperson.
   g. In addition, an Advance notice must include and explanation of:
      - The circumstances under which services will be continued pending resolution of the appeal,
      - How to request that the services be continued, and
      - When a beneficiary may be required to pay for the services.
5. In the unlikely event of a denial of payment for services requested, notice will be provided to the beneficiary at the time of the action affecting the claim.

E. Exceptions to Advance Notice:
1. Factual evidence of the death of the beneficiary.
2. Signed statement by the beneficiary that he/she no longer wishes the services.
3. Beneficiary gives information that must result in reduction or termination of service.
4. Beneficiary has been admitted to an institution and is no longer eligible for the services(s).
5. Beneficiary's whereabouts are unknown and/or the post office returns mail indicating no forwarding address.
6. Beneficiary is receiving services elsewhere.
7. The beneficiary's physician prescribes a change in level of medical care.
8. The date of the adverse benefit decision will occur in less than 10 calendar days.

F. Timeframes for mailing Notice of Action:
1. **At least 10 calendar days** before the date of adverse benefit decision to terminate, suspend, or reduce previously authorized Medicaid covered service(s). **(Advance)**
2. **At the time of the decision** to deny payment for a service. **(Adequate)**
3. **Within 14 calendar days** of the request for a standard service authorization decision to deny or limit service(s). **(Adequate)**
4. **Within 72 hours of** the request for an expedited service authorization decision to deny or limit service(s). **(Adequate)**

G. Extension of timeframes –If the beneficiary or provider requests an extension of the service authorization decision or if CWN justifies (to the state agency upon request) a need for additional information and how the extension is in the beneficiary's interest, then CWN may extend the standard 14 calendar day time period or the expedited 72 hour time period by up to 14 additional calendar days. If CWN extends the timeframe NOT at the request of the beneficiary, CWN must make reasonable effort to give prompt oral notice of delay and within 2 calendar days provide written notice to the beneficiary of the reason to extend timeframe and inform the beneficiary of the right to file a grievance if they disagree with that decision. If an extension is needed, the authorization process must be carried out as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

H. Medicaid Services Continuation or Reinstatement:
1. CWN must continue Medicaid services previously authorized while a Local Appeal or State Fair Hearing is pending if:
    a. The beneficiary requests that the services are continued, and
    b. The appeal is filed timely, and
    c. The appeal involves a termination, suspension, or reduction of a previously authorized service, and
    d. The services were ordered by any authorized provider, and
    e. The period covered by the original authorization has not expired.
2. If reinstated, the services must continue until:
    a. The beneficiary withdraws the appeal, or
    b. **10** calendar days have passed since the notice of action was mailed and an appeal has not been filed, or
    c. An appeal decision is reached that is adverse to the beneficiary, or
    d. The authorization has expired.
3. If the appeal results in a decision to reverse an action by CWN, CWN must pay for those services.
4. If the outcome of a local appeal reverses a decision by CWN to deny, limit, or delay services that were not furnished while the appeal was pending, CWN must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's condition requires but no later than 72 hours from the date it receives notice reversing the determination; immediately if overturned at the State Fair Hearing level.

I. State Fair Hearing Appeal Process (also known as Administrative Hearing):
1. Federal regulations provide a Medicaid beneficiary the right to an impartial review (fair hearing) by a state level administrative law judge, of a decision (action) made by the local agency or its agent.
2. A Medicaid beneficiary has the right to request a fair hearing when CWN/PIHP or its contractor takes an "adverse benefit decision," or a grievance request is not acted upon within **90 calendar days.** The beneficiary has to exhaust local appeals before they can request a fair hearing.
3. Beneficiaries are given 120 calendar days from the notice to file a request for a fair hearing.
4. If the beneficiary, or representative, requests a Fair Hearing no later than 120 calendar days from the date of the local decision, the benefits must continue unchanged until a disposition is received.
5. If the beneficiary's services were reduced, terminated, or suspended without advance notice, CWN/PIHP must reinstate services to the level before the adverse benefit determination.
6. The parties to the state fair hearings include CWN/PIHP, the beneficiary and his or her representative, or the representative of a deceased beneficiary's estate. A Recipient Rights officer shall not be appointed to as Hearings Officer due to the inherent conflict of roles and responsibilities.
7. Expedited hearings are available.
8. CWN responsibilities:
    a. CWN is delegated by the PIHP to represent itself in Fair Hearings for appellants served by CWN.
    b. Provide adequate and advance notice and a "Request for Hearing" form with envelope to the beneficiary when adverse benefit determination is taken.
    c. Provide the address for mailing the Fair Hearing Request:

Michigan Office of Administrative Hearings and Rules
Michigan Department of Health and Human Services
PO Box 30763
Lansing, MI 48909
Fax (517)763-0146

d. Provide assistance to the beneficiary in completing a request for hearing form as needed. The beneficiary must request the hearing in writing.
d. Complete and submit the CWN hearing summary with supporting documents to the Administrative Tribunal within 6 days after the hearing is scheduled.
e. Not limit or interfere with the beneficiary's freedom to make a request for a fair hearing.

J. Local Appeal Processes:

1. The federal regulations provides a Medicaid beneficiary the right to a local appeal of an adverse benefit determination. CWN/PIHP appeals, like those for fair hearings, are initiated by an "adverse benefit determination".
2. CWN is responsible for hearing Local Appeals as delegated by the PIHP.
3. A beneficiary/consumer may request a local appeal within **60** calendar days from the date of the notice of adverse benefit determination.
4. The request may be oral or in writing.
5. If the beneficiary/representative requests the local appeal within **10** calendar days of the notice, the service must be reinstated until a determination is reached.
6. CWN responsibility includes:
   a. Ensuring that correspondence letters regarding appeals are professional, grammatically correct, free from errors, have abbreviations spelled out with first use, and are written to the member.
   b. Give reasonable assistance to the beneficiary/consumer to complete forms and other procedural steps including but not limited to interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. CWN toll free number is 877-398-2013.
   c. Provide the beneficiary and their representative if applicable, the beneficiary's case file if requested, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated in connection with the appeal of the adverse benefit determination. This information must be provided by mail or in-person pick-up, free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in this policy. In the case of an expedited appeal, the case file shall be provided within 24 hours should the beneficiary request it.
   d. Acknowledge receipt of appeal within 5 business days.
   e. Maintain a log of appeal requests and report to PIHP and the PIHP Quality Improvement Program as required.
   f. Ensure that individual(s) hearing the local appeal were neither involved in any previous level of review or decision-making nor a subordinate of any such individual, and that they have the appropriate clinical expertise, as determined by the State, in treating the beneficiary's condition or disease when deciding any of the following:
      i. An appeal of a denial that is based on lack of medical necessity.
      ii. An appeal that involves clinical issues.

   This individual and their credentials will be documented in the appeal file.
   g. Provide the beneficiary the opportunity to present information in person and/or in writing.
   h. Allow the beneficiary to include his/her representative in the appeal.
   i. Provide written notice of disposition and oral notice if expedited.
7. Notice of Disposition requirements:
   a. An explanation of the decision and the date it was completed.
   b. When the disposition is not fully in the appellant's favor, notify him/her of:
      i. The right to a fair hearing and how to request it.
      ii. The right to receive disputed services while the State Fair Hearing is pending, if the hearing is requested within 120 days of the CWN disposition being issued.
      iii. The possibility that the beneficiary may be held liable for the costs of the disputed services if the outcome of the hearing upholds the CWN action.
      iv. A standard appeal must be resolved and Notice of Disposition provided within 30 calendar days from when the appeal was received.
      v. An expedited appeal must be resolved and Notice of Disposition provided no longer than 72 hours of receipt of the request for an expedited appeal.
      vi. CWN may extend the timeframe by up to 14 calendar days if the beneficiary requests an extension, or if it can demonstrate to the State that the delay is in the best interest of the beneficiary. If CWN extends the resolution timeframe, it must make reasonable efforts to

give the beneficiary prompt oral notice of the delay and follow-up written notice within 2 calendar days that must also inform the beneficiary of their right to file a grievance if they disagree with that decision and must then resolve the appeal as expeditiously as the beneficiary's health condition requires, and not later than the date the extension expires.

vii. If CWN denies an expedited appeal, it must follow the timeframes for a standard appeal. The beneficiary must receive prompt oral notice of the denial and follow-up written notice within 2 calendar days that must also inform the beneficiary of their right to file a grievance if they disagree with that decision.

viii. That requests for disputed services to be continued must be made to the case manager, supports coordinator, or primary therapist.

K. Local Grievance Process:

1. Federal regulations provide Medicaid beneficiaries the right to a local grievance process **for issues that are not** "adverse benefit determination."
2. CWN is delegated by the PIHP the responsibility for grievances.
3. A beneficiary/consumer, guardian or parent of a minor child or his/her legal representative, may request a grievance from CWN at any time.
4. Local grievances may be filed orally or in writing. Upon request, staff will assist the individual in filing the appropriate forms to access appeal/grievance processes.
5. The beneficiary does not have access to a State Fair Hearing unless CWN fails to respond to the request for a grievance within **90** calendar days. This becomes an adverse benefit determination and then may be appealed.
6. CWN responsibility includes:
   a. Ensuring that correspondence letters regarding grievances are professional, grammatically correct, free from errors, have abbreviations spelled out with first use, and are written to the member.
   b. Giving reasonable assistance to the beneficiary/consumer to complete forms and other procedural steps including but not limited to interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. CWN toll free number is 877-398-2013.
   c. Acknowledging receipt of grievance within 5 business days.
   d. Maintaining a log of grievance requests to report to the PIHP and the PIHP Quality Improvement Program as required.
   e. Ensure that individual(s) who makes the decisions on the grievance was neither involved in any previous level of review or decision-making nor a subordinate of any such individual, and that they have the appropriate clinical expertise, as determined by the State, in treating the beneficiary's condition or disease when deciding any of the following:
      i. A grievance regarding denial of expedited resolution of an appeal.
      ii. A grievance that involves clinical issues.
      ix. e. Providing written notice of the disposition within **90** calendar days from the date of filing grievance/complaint. CWN may extend the timeframe by up to 14 calendar days if the beneficiary requests an extension, or if it can demonstrate to the State that the delay is in the best interest of the beneficiary. If CWN extends the resolution timeframe, it must make reasonable efforts to give the beneficiary prompt oral notice of the delay and follow-up written notice within 2 calendar days that must also inform the beneficiary of their right to file a grievance if they disagree with that decision and must then resolve the grievance as expeditiously as the beneficiary's health condition requires, and not later than the date the extension expires.
   f. The notice must include:
      1. The results of the grievance process.
      2. The date the grievance process was concluded.
      3. The beneficiary's right to request a State Fair Hearing if the notice of disposition is more than **90** days from the date of the request for a grievance.
      4. How to access the State Fair Hearing process.
      5. Where to mail a fair hearing request:

Michigan Office of Administrative Hearings and Rules
Michigan Department of Health and Human Services
PO Box 30763
Lansing, MI 48909
Fax (517)763-0146

L. Recordkeeping requirements of beneficiary appeals and grievances:
1. CWN will maintain a record of appeals and grievances for at least 10 years ~~log~~ which includes:
   a. A general description of the reason for the appeal or grievance.
   b. The date received.
   c. The date of each review or, if applicable, review meeting.
   d. Resolution at each level of the appeal or grievance, if applicable.
   e. Date of resolution at each level, if applicable.
   f. Name of the covered person for whom the appeal or grievance was filed.
   g. Verification that the individual making decisions was not involved in the previous level of review or decision-making.
2. CWN will submit quarterly, a log of all appeal, grievance and second opinion requests with related dispositions to the PIHP.
3. CWN will record the number of requests for Medicaid services, and the number of denials of Medicaid services. This will be reported to the PIHP as required.

M. Recipient Rights Complaint Process:
1. Medicaid beneficiaries, as recipients of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health Code.
2. Local grievances must be reviewed for possible rights violations. If it is determined that a grievance is more appropriately a rights complaint, with permission of the recipient, the written complaint will be referred to the Office of Recipient Rights.
3. Recipient Rights complaint requirements are articulated in CWN Procedure 03.25 Recipient Rights Complaints.

VI. EXHIBITS

N/A

VII. REFERENCES:

Authority and Related Directives Trace	
Federal	Social Security Act: 42 CFR 431.200 et seq. (Fair Hearings); 42 CFR 438.400 et seq. (Local Appeals); 42 CFR 438.400 et seq. (Local Grievances)
State	Michigan Department of Health and Human Services, Grievance and Appeal Technical Requirement, July 2020; Michigan Mental Health Code (MHC) MCL 330.1772 (Recipient Rights Complaints), MCL 330.1705 (Medical Second Opinion); MCL 330.1786 (Notice of Decision; Appeal).
NMRE	NMRE Administrative Manual (Beneficiary Grievance and Appeal)
County	Interlocal Agreement of December 1992 Section IX(j)
CARF	CARF 2023 Behavioral Health Standards
Other	Board By-Laws