NORTH COUNTRY COMMUNITY MENTAL HEALTH
ADMINISTRATIVE MANUAL

CHAPTER: Five – Recipient Rights
PROCEDURE NAME: GRIEVANCE AND APPEAL PROCEDURE
EFFECTIVE DATE: August 1, 2009

PURPOSE

To establish a process for resolution of complaints over decisions regarding services and supports delivered by North Country Community Mental Health in compliance with federal and state law, DCH contractual requirements and Northern Affiliation protocols.

APPLICATION

North Country Community Mental Health provider operations.

DEFINITIONS

Action: A decision that adversely impact's a recipient's claim for services due to:

1. Denial or limited authorization of a requested Medicaid or non-Medicaid service, including the type or level of service.
2. Reduction, suspension, or termination of a previously authorized Medicaid or previously provided non-Medicaid covered service.
3. Denial, in whole or in part, of payment for a Medicaid or non-Medicaid covered service.
4. Failure to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service.
5. Failure to make an expedited authorization decision within 3 working days from the date of receipt of a request for expedited service authorization.
6. Failure to provide Medicaid or non-Medicaid services within 14 calendar days of the start date agreed upon during the person-centered planning and as authorized.
7. In regard to Medicaid covered services, failure of NCCMH to act within 45 calendar days from the date of a request for a standard appeal.
8. Failure of NCCMH to act within 3 working days from the date of a request for an expedited appeal.
9. Failure of NCCMH, to provide a disposition and notice of a local grievance/compliant within 60 calendar days of the date of request.
10. For a resident of a rural area with only one PIHP, the denial of a Medicaid enrollee's request to exercise his or her right to obtain services outside the network.

Adequate Notice of Hearing Rights: Written notice to recipient explaining their hearing rights at the same time an action takes effect or at the time of the signing of the individual plan of services/supports.

Advance Notice of Action: Written notice advising the recipient of a decision to reduce, suspend or terminate services currently provided. Notice is provided/mailed to the recipient at least 12 calendar days prior to the proposed date the action is to take effect.

Appeal: A request for a review of an action (defined above) relative to a Medicaid covered service or non-Medicaid covered service.

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

Expedited Appeal: Recipient may request an expedited appeal of an action if waiting the 45 days would jeopardize life, health or ability to attain, maintain or regain maximum function. If the recipient requests the expedited review, NCCMH determines if the request is warranted. If the recipient's provider makes the request, or supports the recipient's request, NCCMH must grant the request. The response must be

given no later than 3 business days after receipt. If recipient requests or agency can justify, the 3 business days can be extended up to 14 calendar days.

Fair Hearing: Impartial state level review of a Medicaid recipient's appeal of an action presided over by a DCH Administrative Law Judge. Also referred to as "Administrative Hearing."

Grievance: An expression of dissatisfaction about any matter relative to a Medicaid or non-Medicaid covered service, other than an action as defined above, which does not involve a rights complaint as defined below. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationship between a service provider and the consumer.

Grievance Process: Impartial local level review of a Medicaid recipient's grievance (expression of dissatisfaction) about NCCMH service issues other than an action.

Notice of Denial: Written statement advising the recipient of a decision to deny or limit authorization of Medicaid services requested. Notice is provided to the Medicaid recipient on the same date the action takes effect, or at the time of the signing of the individual plan of services/supports.

Local Appeal Process: Impartial local level NCCMH review of a Medicaid recipient's appeal of an action presided over by individuals not involved with the decision-making or previous level of review.

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

Recipient Rights Complaint: A written or verbal statement by a recipient or anyone acting on behalf of a recipient alleging a violation of a Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

PROCEDURE

Notification of Grievance and Appeal Processes

Applicants must be given notice of the processes for resolving grievances and for appeal at the time of the request for services or in advance of an adverse action whenever a Medicaid State Plan, waiver, or B3 is denied, reduced, suspended or terminated. The notice must be in writing and must be provided in the language format needed by the individual to understand the content.

Action	Time Frame for Notice
Denial of service request ……..	At time of decision
Plan of Service ……	At the time of the plan development
Increase in benefits ……..	At time of the action
Reduction, suspension, or termination of service currently being received ……	12 calendar days before action
*Standard authorization decision that denies or limits services requested ……..	Within 14 calendar days of request (may be extended up to another 14 days at the request of the recipient or provider)
*Expedited authorization decision that denies or limits services requested …….	Within 3 business days of request (may be extended up to another 14 days at the request of the recipient or provider)
Unreasonable delay of start of services ……	At time of the action

Note: If a consumer's physician makes a determination that a particular Medicaid State Plan or Waiver service is not medically necessary, no adverse action occurred. In these instances, an advance notice of adverse action is not required.

*When a standard or expedited authorization of services decision is extended, NCCMH must give the recipient written notice of the reason for the decision to extend the timeframe, and inform the recipient of the right to file an appeal if he or she disagrees with the decision.

At the initial Plan of Service (POS), when the POS is addended, and annually thereafter, applicants will be given a Notice of Hearing Rights that explains their options for appeal. An individual plan of service is developed through the person-centered process and describes those services that have been authorized to the recipient with the recipient's participation and agreement.

Denial of Access to CMHSP Services

1. If an applicant is denied access to services, a Notice of Denial is given. The applicant or his/her guardian or parent of a minor child, must be informed of his/her right to request a second opinion of the Executive Director and the request must be resolved within 5 business days. The Executive Director shall secure the second opinion from a physician, licensed psychologist, registered professional nurse, or master's level social worker, or master's level psychologist. This staff person would not have been involved in the original decision to deny services. If the individual providing the second opinion determines that the applicant has a serious mental illness, serious emotional disturbance, or developmental disability, or is experiencing an emergency situation or urgent situation, NCCMH shall direct services to the applicant.
2. If the applicant is Medicaid eligible, he/she may request a Fair Hearing before the Administrative Tribunal in addition to the local grievance and appeals process. Non-Medicaid applicants must first access the local appeal process. After receiving a written response, the non-Medicaid applicant has 5 business days to request an Alternative Dispute Resolution Process from the Department of Community Health. DCH shall complete the review within 15 business days of receipt and notify the applicant or guardian/parent in writing.
3. An applicant may not file a recipient rights complaint, as he/she does not have standing as a recipient. He/she may file a rights complaint if the request for a second opinion is denied.

Denial of Hospitalization

1. If the pre-admission screening or children's diagnostic and treatment service unit denies hospitalization, a Notice of Denial is given. The applicant or his/her guardian or his/her parent in the case of a minor child, may request a second opinion from the Executive Director. The Executive Director shall arrange for an additional evaluation by a psychiatrist, other physician, or licensed psychologist to be resolved in 5 business days after receiving the request. If the conclusion of the second opinion is different from the conclusion of the preadmission screening unit or children's diagnostic and treatment service unit, the Executive Director, in conjunction with the Medical Director, shall make a decision based on all clinical information available. The Executive Director's decision shall be confirmed in writing to the individual who requested the second opinion, and the confirming document shall include the signatures of the Executive Director and Medical Director or verification that the decision was made in conjunction with the Medical Director. If an individual is assessed and found not to be clinically suitable for hospitalization, the preadmission screening unit or children's diagnostic and treatment service unit shall provide appropriate referral services.

2. If the initial request for inpatient admission is denied and the individual is a current recipient of other NCCMH services, the individual or someone on his/her behalf may file a Chapter 7 complaint alleging a violation of his/her right to treatment suited to condition.
3. If a request for the second opinion is denied, the individual or someone on his/her behalf may file a recipient rights complaint under Chapter 7.
4. If the second opinion determines the individual is not clinically suitable for hospitalization and the individual is a current recipient of other NCCMH services and a recipient rights complaint has not been filed previously on behalf of the individual, the individual or someone on his/her behalf may file a complaint with the NCCMH Rights Office for processing under Chapter 7A.
5. The applicant may appeal the decision utilizing the Local Appeal process.
6. The applicant (Medicaid or non-Medicaid) may request an Expedited Local Appeal if waiting the standard 45 days would jeopardize life, health or ability to attain, maintain or regain maximum function.
7. Medicaid recipients may request a Fair Hearing on actions that impact Medicaid covered services within 90 days of denial. For non-Medicaid covered services, the MDCH Alternative Dispute Resolution process may be accessed and must be filed within 5 days from the date of the local appeal decision.

Suspension, Reduction or Termination of Existing Services

1. Whenever an existing service or support is to be suspended, terminated or reduced outside of the treatment planning meeting(s), the individual will be informed in writing at least 12 calendar days prior to the effective date of the action. The notice shall include:

    a. A statement of what action is being taken or intends to take;
    b. The date of the intended action;
    c. The reasons for the intended action;
    d. The procedures for exercising the various resolution options;
    e The recipient's right, if Medicaid, to have benefits continue pending resolution of the Fair Hearing decision and the circumstances under which the recipient may be required to pay for the cost of these services.
    f. The circumstances under which an expedited resolution is available and how to request it.

    Note: Notice must specify that if the recipient requests a MDCH Fair Hearing prior to the date of action (i.e. suspension, reduction, or termination of a Medicaid covered service), in most circumstances NCCMH may not reduce, suspend or terminate the service until a decision is rendered after the hearing.

2. Exceptions to advance notification include: NCCMH may mail a notice not later than the date of action if:

    a. It has factual information confirming death of the consumer.
    b. The consumer or his/her legal representative has provided a written statement that he/she no longer wish services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying the information.
    c. The recipient has been admitted to an institution where he/she is ineligible under Medicaid for further services.
    d. The recipient's whereabouts are unknown and the post office returns mail directed with no forwarding address.
    e. It establishes the fact that the recipient has been accepted for Medicaid services by another PIHP.
    f. A change in the level of medical care is prescribed by the recipient's physician.

g. NCCMH may shorten the period of advance notice to 5 days before the date of action if it has facts indicating that the action should be taken because of probable fraud and these facts have been verified, if possible, through secondary sources.

3. Maintaining Medicaid-covered services and supports:

a. If NCCMH mails the advance notice of action impacting Medicaid covered services as required above and the Medicaid recipient or his/her legal representative requests a MDCH Fair Hearing before the date of action in lieu of, or in addition, to filing an appeal, NCCMH may not terminate or reduce services until a decision is rendered after the hearing unless:
    - It is determined at the hearing that the sole issue is one of federal or state law; AND
    - NCCMH promptly (i.e. in the advance notice) informs the recipient that services are to be terminated or reduced pending the MDCH hearing decision.

b. If NCCMH's action is sustained by the Fair Hearing Decision, NCCMH may seek reimbursement from the recipient for the cost of any services provided the recipient during this period of time, up to the individual's ability to pay as determined by the Code.

4. Reinstatement of Medicaid Covered Services:

a. NCCMH must reinstate Medicaid covered services if a recipient or his/her legal representative requests a MDCH Fair Hearing not more than 12 calendar days after the date of the action.
b. The reinstated Medicaid covered services must continue until the hearing decision unless, at the hearing, it is determined that the sole issue is one of federal or state law or policy.
c. NCCMH must reinstate and continue Medicaid covered services until a hearing decision, if:
    - Action was taken without the required advance notice; AND
    - The recipient or his/her legal representative requests a hearing within 12 calendar days of the mailing of the notice of action; AND
    - NCCMH determines that the action resulted from factors other than the application of federal or state law or policy.
d. If a recipient's whereabouts are unknown as indicated by return of non-forwardable mail from NCCMH, any discontinued Medicaid State Plan or Waiver services must be reinstated if his/her whereabouts become known during the time he/she is eligible for services.

<u>State Fair Hearing Appeal Process</u>

Federal regulations provide a Medicaid recipient the right to an impartial review (fair hearing) by a state level administrative law judge, of a decision (action) made by NCCMH.

1. A Medicaid recipient has the right to request a fair hearing when NCCMH or its contractor takes an "action," or grievance request is not acted upon within 60 calendar days. The recipient does not have to exhaust local appeals before he/she can request a fair hearing.
2. NCCMH must issue a written notice of action to the affected recipient.
3. NCCMH may not limit or interfere with the recipient's freedom to make a request for a fair hearing.
4. Recipients are given 90 calendar days from the date of the notice to file a request for a fair hearing.

5. If the recipient or representative requests a fair hearing not more than 12 calendar days from the date of the notice of action, NCCMH must reinstate the Medicaid services until disposition of the hearing by the administrative law judge.
6. If the recipient's services were reduced, terminated or suspended without advance notice, NCCMH must reinstate services to the level before the action.
7. The parties to the state fair hearing include NCCMH, the recipient and his or her representative, or the representative of a deceased recipient's estate.
8. Expedited hearings are available.

Local Appeal Process

Special requirements for appeals must:

1. Provide that oral requests for appeal of an action are treated as appeals (to establish the earliest possible filing date for the appeal), but must be confirmed in writing unless the recipient requests expedited resolution.
2. Give reasonable assistance in completing forms and taking other steps to complete the appeals process. This assistance includes, but is not limited to, interpreter services, and toll free numbers with TTY/TDD and interpreter capability.
3. Give recipient a reasonable opportunity to present oral or written evidence and allegation of fact or law in person as well as in writing. NCCMH must inform the recipient of the limited time available for this in the case of an expedited resolution.
4. Give recipient, guardian or parent of a minor child the opportunity, before or after the appeal process, to examine the clinical record and any other documents considered during the appeal process.
5. Allow parties in the appeal process to include the recipient and his/her representative or the legal representative of a deceased consumer's estate.

Appeal Process:

1. An appeal shall be filed on the Request for Local Appeal form and submitted to the Fair Hearings Coordinator of NCCMH within 45 calendar days of receipt of notice of an action.
2. The Fair Hearings Coordinator will:
    a. Log receipt of the appeal and acknowledge receipt to the recipient.
    b. For Medicaid recipient disputing an action that impacts a Medicaid covered service, advise the individual, guardian, or in the case of a minor, the parent, that he/she may file a request for a MDCH Fair Hearing in lieu of, or in addition to, the appeal. Information shall include the process for the filing the request for a hearing, an offer of assistance in filing the request and an explanation of time frames and circumstances under which Medicaid services will be continued pending the hearing decision.
    c. Submit the appeal to the appropriate Program Director to assign review by staff that was not involved in the original decision to deny, suspend or terminate services. Review will be conducted by the Program Director (or alternate if the Program Director was involved in the original decision) and a staff with appropriate clinical expertise in treating the recipient's condition. The Medical Director will be involved as appropriate.
    d. Facilitate resolution of the appeal within 45 calendar days of receipt of the appeal. Ensure an expedited review of an appeal involving an emergent situation where the standard 45-day time frame would seriously jeopardize the health or life of the individual. Such a review shall be completed within 3 business days of receipt of the appeal.
    e. Send the notice of disposition to the appellant containing an explanation of the results of the resolution and the date it was completed.
    f. If a request for expedited resolution of an appeal is denied, reasonable effort will be made to give recipient prompt oral notice of the denial with follow-up written notice within 2 calendar days.

Grievance Process

1. The consumer, guardian or parent of a minor child may file a grievance orally or in writing at any time regarding dissatisfaction with any aspect of service provision other than an adverse action as defined in this procedure or an allegation of a recipient rights violation. The recipient will be given reasonable assistance in completing the Grievance form. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability. The grievance will be filed with the NCCMH Customer Services.
2. Customer Services will:
   a. Log receipt of the verbal or written grievance for reporting to NCCMH's Quality Improvement Council.
   b. Determine whether the grievance is more appropriately a rights complaint and, if so, refer the grievance, with the recipient's permission, to the Office of Recipient Rights.
   c. Acknowledge receipt of the grievance to the recipient.
   d. Submit the written grievance to the appropriate staff, including an NCCMH administrator with the authority to require corrective action, none of who have been involved in the initial determination.
   e. For grievances regarding denial of expedited resolution of an appeal and for a grievance that involves clinical issues, the grievance is reviewed by health care professionals who have the appropriate clinical expertise in treating the recipient's condition or disease.
   f. Facilitate resolution of the grievance as expeditiously as the recipient's health condition requires but no later than 60 days.
   g. Medicaid grievances may access the State Fair Hearings process if NCCMH fails to respond to the grievance within 60 calendar days. This constitutes an action and can be appeals for fair hearing to the DCH Administrative Tribunal.
   h. A written notification of the outcome will be provided to the consumer, guardian, or parent of a minor child within 60 calendar days of a decision. The notice shall include the results of the grievance process, the date the grievance process was concluded, the right to request a fair hearing as stated above and the process to access the fair hearing.

MDCH Alternative Dispute Resolution Process

1. Within 5 business days of receipt of the decision on the local dispute (appeal or grievance), the consumer, his/her guardian or parent of a minor recipient, may file a request for a MDCH level dispute resolution to: Department of Community Health; Division of Program Development, Consultation & Contacts; Bureau of Community Mental Health Services; Attention: Request for DCH Level Dispute Resolution; Lewis Cass Building – 6th Floor; Lansing, MI 48913.
2. If the DCH representative using a "reasonable person" standard, believes that the denial, suspension, termination or reduction of the services and/or supports will pose an immediate and adverse impact upon the consumer's health and safety, the issue is to be referred within one business day to the Bureau of Community Mental Health Services for contractual action consistent with applicable provisions of the MDCH/CMHSP contract. In other cases, DCH shall complete its review of the dispute within 15 business days of receipt. Written notice of the resolution shall be submitted to the recipient, his/her guardian or parent of a minor recipient.

Monitoring and Quality Assurance

Quarterly reports of grievances and appeals will be reported to the Risk Management Committee and to the PIHP Customer Services department. Grievance and appeal records will be available to MDCH for review upon request. An Annual Report will be given to the governing Board.

NCCMH FORMS: Adequate Notice of Hearing Rights; Notice of Denial; Request for Second Opinion; Advance Notice of Service Reduction, Termination, or Suspension; Request for Local Appeal; Grievance

REFERENCE: 42 CFR 431.200-250; 42 CFR 438.400;
MDCH PIHP Specialty Services Contract;
Northern Affiliation Grievance and Appeal, Fair Hearing Protocol;
MDCH/CMHSP Managed Mental Health Supports and Services Contract FY09 Attachment C6.3.2.1;
Michigan Mental Health Code, Chapter 7 and Chapter 4;
Balanced Budget Act of 1997

REVISED: 3/19/07; July 6, 2009

APPROVED BY SIGNATURE:

Alexis Kaczynski	*7/16/09*
Director	Date
Karen Oliverius	*7/15/09*
Recipient Rights Officer	Date