Subject: Medicare Member Adverse Benefit Determination Appeal Procedure	**Accountability:** Member Services	**Effective Date:** 6/3/17	**Pages:** 4
Overarching Policy: 6.8 Medicare Member Adverse Benefit Determination Appeal Policy		**Last Reviewed Date:** 10/23/17	**Past Reviewed Dates:** 6/3/17
LINE OF BUSINESS: ☐ Specialty Waiver (B/C) ☐ 1115 Waiver ☐ Healthy Michigan ☐ SUD Medicaid ☐ SUD Block Grant ☒ MI Health Link ☐ OTHER: _____	**APPLICATION:** ☒ SWMBH Staff and Ops ☐ Participant CMHSPs ☐ SUD Providers ☐ MH / DD providers ☐ Other:_____	**Last Revised Date:**	**Past Revised Dates:**
Approved : _____ Date: 11/10/17		**Required Reviewer:** Chief Clinical Officer Director of UM & ME Manager of UM & Call Center	

I. Purpose

This procedure outlines the requirements of Southwest Michigan Behavioral Health (SWMBH) staff to ensure professional, complete, accurate and timely communication, documentation and tracking of appeals filed regarding an adverse benefit determinations. Appropriate communication and documentation promotes a high standard of clinical care, improved communication, and dissemination of information between and across providers, as well as an accurate account of appeals filed in order to identify trends and improve care.

II. Scope

Provides staff with guidelines for documenting the appeal process for each appeal filed, including investigation, and communication with members, providers, and stakeholders, as well as outcomes/determinations of the appeal request, in SWMBH's Managed Care Information System (MCIS), as it relates to member adverse benefit determination appeals.

III. Procedural Steps

A. Member or Member's authorized representative may contact Southwest Michigan Behavioral Health orally or through writing to express their complaints or request to appeal an adverse benefit determination.

B. All oral requests will be recorded in the member's own words, repeated back to him/her for accuracy and placed in the grievance and appeal (G&A) tracking system.

C. Requests for appeals will be addressed by the Member Services Department.

D. Member Services will provide empathic listening and problem solving techniques to gather to appropriate, necessary documentation relevant to the appeal request.

E. Member Services will determine timeliness of the appeal request. All Medicare appeals must be submitted verbally or in writing to SWMBH no more than sixty days from the date on the *Notice of Adverse Benefit Determination* for items/services terminated, reduced, suspended, or denied.

F. Member services will offer and/or facilitate assistance needed, for members requesting bilingual staff or interpreter services, auxiliary aides, and/or additional support to understand and complete the grievance and complaint process.

G. Member Services will determine if the request will be subject to the standard process, or if the request is clinically urgent and will be processed through the timeframes for an expedited appeal resolution, as defined in Policy 6.8: Medicare Member Adverse Benefit Determination Appeal Policy.

H. Member Services will document the nature of the appeal and enter the information into the SWMBH MCIS Grievance & Appeals banner as well as enter a "Contact Note" into the Member's Master Record

I. Member Services will work with the Member to determine if the appeal is of an expeditious nature, or whether it can be handled in the standard timeframe allotted

1. The initial "Contact Note" will outline the nature of the Member's appeal and the proposed next steps Member Services will conduct in order to investigate the appeal
2. Member Services will enter information into the following fields under the "Appeals" tab:
    a. Relation to Client
    b. Date Received
    c. Expedited Appeal
    d. Request Received in Writing
    e. Action Being Appealed
    f. Appeal Type
    g. Reason for Original Action
    h. Received Via
    i. Member's demographic information
    j. Complainant's Name and Address if *not* Member
    k. Staff Involved in Initial Decision
    l. Explain Issue
    m. Additional Information
    n. Was the Member Informed of the right to a state fair hearing?
    o. Did the member choose a state fair hearing?
    p. Was the appeal received within 12 days of notice being sent?

J. Member Services will determine the appropriate appeal reviewer.

1. Clinical appeal considerations are conducted by health professionals who:
    a. Are clinical peers;
    b. Hold an active, unrestricted license to practice in a health profession
    c. Are board-certified, if applicable;
    d. Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate; and
    e. Are neither the individual who was involved in the initial review and/or made the original non-certification/denial, nor the subordinate of such an individual
    f. All same specialty review recommendations are presented to the appropriate person, persons or department as part of the appeal investigation.

K. Member Services will supply all relevant, appropriate documentation to the appeal reviewer for review. This includes information included in SWMBH's MCIS, as well as all information provided to SWMBH from the member or his/her authorized representative. SWMBH will inform the member of the limited time available for presenting evidence and allegations of fact or law, in person as well as in writing in the case of expedited resolution.

L. Member Services will send an acknowledgment letter to the member or his/her authorized representative and/or the member's provider as applicable SWMBH will acknowledge the receipt of all appeals in writing within three (3) business days after receiving an appeal request either orally or in writing
    1. The letter will provide information about their appeal rights.
    2. It will include a request for any additional clinical documentation that could support the services requested.

M. In the event the member or authorized representative requests an extension, or SWMBH staff involved in the appeal resolution process can justify the need for additional information or documents and how a delay will be in the member's best interest, Member Services will immediately notify the member/representative of the delay in writing including the anticipated date of resolution within the timeframes allowed.

N. Upon resolution of the Appeals investigation, Member Services will complete the following procedural steps:
    1. Contact the Member to verbally detail the investigation/resolution
    2. Complete a "Contact Note" in the Member's master record indicating that the appeal has been resolved, including date/time of resolution
    3. Member Services will supply members with a written notice of the appeal decision that is specific to the item or service being appealed in an easy to understand language, and in compliance with Policy 6.4: Limited English Proficiency.
    4. The written notice of the appeal resolution will include:
        a. A description of the item/service being appealed.
        b. The results of the appeal request and the date it was completed.
        c. For items/services covered by Medicare that were not resolved wholly in the favor of the member the information that the case has been forwarded to the IRE for review, including contact information for the IRE and the member's right to submit additional evidence that may be relevant to the case direct to the IRE.
        d. Specific reasons for the determination and in cases where the determination has a clinical basis the clinical rationale for the determination.
        e. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
        f. Notification that the member can obtain, upon request, a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request
        g. Notification that the member is entitled to receive, upon request and at no cost to the member, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents or record relied upon and document and records submitted in the course of making the appeal decision.
        h. A list of the titles and qualifications of each individual participating in the appeal review, including specialty, as appropriate.
        i. An explanation of the member's further appeal rights, as applicable and any relevant written procedures on how to pursue those options.
        j. Complete the remaining fields in the Appeals Tab in SWMBH MCIS under RESOLUTION:
            i. Date Resolved
            ii. Resolution
            iii. Comment
            iv. Status

v. Staff involved in Appeal Decision

k. Member Services will upload both the acknowledgment and resolution disposition letters to the Appeals Tab under "LETTER LIST"

IV. Definitions

A. Adverse Benefit Determination: A determination by or on behalf of a member that the treatment does not meet SWMBH's or Medicare's requirements for medical necessity appropriateness, heath care setting, level of care or coverage denial determination based on an exclusion.

B. Grievance: Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare Health Plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. A member or their representative may file the grievance, either orally or in writing, to a Medicare Health Plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame. A grievance includes complaints regarding concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to members, the claims regarding the right of the member to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the member believes he or she is entitled. Additionally, any appeal of a decision that is not about coverage of a benefit and does not meet the definition of an adverse benefit determination, is categorized under this definition of grievance.

V. References

A. None

VI. Attachments

A. None