Section: Customer Services	Policy Name: **Medicare Member Adverse Benefit Determination Appeal**	Policy Number: **MHL 06.08**
Owner: **Customer Service Manager**	Reviewed By: **Sarah Ameter**	Total Pages: **18**
Required By: ☒ **BBA** ☒ **MDHHS** ☒ **NCQA** ☐ **Other (please specify):**	Final Approval By: Sarah Ameter	Date Approved: Aug 2, 2022
Application: ☒ **SWMBH Staff/Ops** ☐ **Participant CMHSPs** ☐ **SUD Providers** ☐ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☐ **Medicaid** ☐ **Other (please specify):** ☐ **Healthy Michigan** ☐ **SUD Block Grant** ☐ **SUD Medicaid** ☒ **MI Health Link**	Effective Date: **1/15/2015**

Policy: Southwest Michigan Behavioral Health (SWMBH) shall provide all staff with enrollee rights and protection training, including but not limited to, role specific training on member appeal rights and processes, from the initial denial at the time of coverage determination through the final adverse determination. All requests to appeal an Adverse Benefit Determination received at SWMBH, will be investigated and resolved in a consistent and timely manner, in accordance with the guidelines outlined in Section 42 of The Code of Federal Regulations, Part 422, Subpart M- Grievances, Organization Determinations and Appeals and Part 438, Subpart F: Grievance System and Appeal System. The appeals process meets all Centers for Medicare and Medicaid Services (CMS) guidelines, and National Committee of Quality Assurance (NCQA) standards. All appeals will be monitored, tracked and trended in a central database maintained by the Member Service Department.

Purpose: SWMBH is committed to ensuring that members can access all available appeal processes available to them, when disputing an adverse benefit determination of a benefit to which a member is, or is believed he/she is, entitled to.

Scope: Member Services and Utilization Management

Responsibilities: SWMBH Member Services staff will ensure that when an adverse benefit determination is made that the member is informed of the determination and appropriate appeal information is provided. All appeals received by members will be processed by Member Services staff and reviewed by appropriate, clinical staff for appeal determination. Member Services staff will secure all communications and coordination with member and all appeal level options.

Definitions:

A. Adverse Benefit Determination: (i) The 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 Service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner, as defined by the State; (v) the failure of the Integrated Care Organization (ICO) to act within the required timeframes for the standard resolution of Grievances and Appeals; (vi) for a resident of a rural area with only one ICO, the denial of an Enrollee's request to obtain services outside of the Network; or (vii) the denial of an Enrollee's request to dispute a financial liability.

B. Appeal: As defined in 42 CFR 438.400(b). A request for review of a ICO or Prepaid Inpatient Health Plan's (PIHP) decision that results in any of the following actions: (1)The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a properly authorized and covered service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of an Entity to act within the established timeframes for grievance and appeal disposition; (6) For a resident of a rural area with only one ICO Integrated Care Organization, the denial of a member's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network. Effective no later than January 1, 2018, a Medicaid-based Appeal is defined as a review by the ICO of an Adverse Benefit Determination.

C. Authorized Representative: An individual appointed by an enrollee or other party, or authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of an enrollee or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described at 42 CFR Part 405.

D. Grievance: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.

E. Grievance System: The system that provides the processes to handle appeals and grievances, as well as the processes used to collect and track information about grievances and appeals.

F. Quality of Care Issue: The extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people centered. A quality of care complaint may be filed through the Medicare health plan's complaint process and/or a Quality Improvement Organization (QIO). A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

G. Quality Improvement Organization (QIO): As set forth in Section 1152 of the Social Security Act and 42 CFR Part 476, an organization under contract with CMS to perform utilization and quality control peer

review in the Medicare program or an organization designated as QIO-like by CMS. The QIO or QIO-like entity provides quality assurance and utilization review.

H. Reconsideration: The first level in the appeals process which involves a review of an adverse organization determination by a Medicare health plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the Medicare health plan or CMS.

I. Independent Review Entity (IRE): An independent review entity contracted by CMS to review Medicare health plans' adverse reconsideration determinations. Reviews the case if SWMBH partially or fully denies coverage for an item/service that is covered by Medicare only or by Medicare and Medicaid upholding the original determination. SWMBH will automatically forward the case for review to the IRE.

Standards and Guidelines:

Federal regulations require that Southwest Michigan Behavioral Health, as an organization that serves Medicare beneficiaries, to establish meaningful complaint, grievance, and appeal procedures for members. SWMBH provides written information about grievance and appeal processes to members and/or their representatives, at the time of initial enrollment, upon involuntary disenrollment initiated by the ICO, upon denial of a member's request for expedited review of an organization determination or appeal, upon a member's request, and annually thereafter. Written information provided outlines the grievance and appeals procedures available to them, how to access them and the difference between appeals and grievances.

A. Distinguishing Between a Grievance and an Adverse Benefit Determination Appeal

1. If a member addresses two or more issues, then each issue should be processed separately and simultaneously (to the extent possible) under the proper procedure. At times both the grievance and appeal procedures may need to be utilized when there is both a grievance, as well as an appeal of an adverse benefit determination.
2. Upon receipt, the facts surrounding a complaint from a member or member's authorized representative, will determine whether the grievance or appeals process should be initiated. This review ensures routing to the appropriate process and facilitates timely processing.
3. If the complaint is solely about an adverse benefit determination it will be processed as an appeal and will be subject to this policy.
4. If the complaint is about dissatisfaction with anything other than an action or coverage it will be rerouted to the grievance process and be subject to Policy 6.7: Medicare Member Grievance Policy.

B. Member Authorized Representatives

1. Individuals who represent members may either be appointed or authorized to act on behalf of the member in filing a grievance, requesting an initial determination, or in dealing with any of the levels of the appeals process, as defined in the Medicare Managed Care Manual and 42 CFR, Part 422, Subpart M.
2. A member may appoint any individual (such as a relative, friend, advocate, an attorney, or any physician) to act as his or her representative.
3. Alternatively, a representative (surrogate) may be authorized by the court or act in accordance with State law to act on behalf of a member. A surrogate could include, but is not limited to, a court

appointed guardian, an individual who has Durable Power of Attorney, or a health care proxy, a person designated under a health care consent statute, or an executor of an estate.

4. To be appointed by a member, both the member making the appointment and the representative accepting the appointment (including attorneys) must sign, date, and complete a representative form (Form CMS-1696 Appointment of Representative or other equivalent written notice).
5. An "equivalent written notice" is one that:
    a. Includes the name, address, and telephone number of member and the individual being appointed;
    b. Includes the member's HICN [or Medicare Identifier, or plan (ID) Number];
    c. Includes the appointed representative's professional status or relationship to the party;
    d. Contains a statement that the member is authorizing the representative to act on his or her behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative;
    e. Is signed and dated by the member making the appointment; and
    f. Is signed and dated by the individual being appointed as representative and is accompanied by a statement that the individual accepts the appointment.
    g. Includes a written explanation of the purpose and scope of the representation
6. Due in part to the incapacitated or legally incompetent status of a member, a surrogate is not required to produce a representative form. Instead, he or she must produce other appropriate legal papers supporting his or her status as the member's authorized representative.
7. Either the signed representative form for a representative appointed by a member, or other appropriate legal papers supporting an authorized representative's status, must be included with each request for a grievance, determination, or an appeal.
8. A representative form is valid for one year from the date it has signatures for both the member and the representative, unless revoked. If the member would like the same individual to continue serving as a representative after one year, they must reappoint that person by submitting a new representative form. A form is valid for the life of a grievance, coverage request, or appeal if the grievance, coverage request, or appeal was received within one year of the date a representative form is signed by both the member and representative. If the representative form is maintained and accessible, a photocopy of the signed representative form is not required to be filed with future grievances, coverage requests, or appeals made on behalf of the member in order to continue representation. If the plan uses a representative form that is on file for requests, it must include a copy when sending a case file to higher level adjudicators, if applicable.
9. For grievances, requests for organization determinations, or adverse benefit determination appeals submitted either without a representative form or with a defective representative form – SWMBH will inform the member and purported representative, in writing, that the grievance, coverage determination, or appeal is not valid until documentation is provided. For expedited requests, SWMBH will ensure that expedited requests are not inappropriately delayed. When a request for a grievance, organization determination, or reconsideration of an adverse benefit determination is filed by a person claiming to be a representative, but the representative does not provide appropriate documentation upon SWMBH's request, SWMBH must make, and document, its reasonable efforts to secure the necessary documentation. SWMBH will not issue a decision

until or unless such documentation is obtained. SWMBH is not required to undertake a review until or unless such documentation is obtained but may choose to begin the review while continuing efforts to obtain the representative documentation. The time frame for acting on a grievance, organization determination, or appeal begins when the representative documentation is received.

10. For reconsiderations/appeals, if SWMBH does not receive the documentation by the conclusion of the Appeal time frame, plus extension, SWMBH may dismiss the appeal on the grounds that a valid request was not received. SWMBH will notify the member and the person asserting representative status of the dismissal in writing. The dismissal notice should explain that reason(s) for the dismissal, how the invalid request can be cured, and that the request will be processed if the enrollee or representative submits a properly executed form. The notice should explain the right to request IRE review of the dismissal within 60-calendar days after receipt of the written notice of dismissal. The notice may also explain that if the representative documentation is submitted after the 60-day filing deadline for requesting an appeal has expired, a good cause statement explaining why the form was not filed timely should be included with the request for an IRE review.
11. A provider, physician, or supplier may not charge a member for representation in filing a grievance, organization determination, or appeal. Administrative costs incurred by a representative during the appeals process are not reasonable costs for Medicare reimbursement purposes.
12. Unless otherwise stated in the rules described in 42 CFR, Subpart M of part 422, the representative has all the rights and responsibilities of a member in filing a grievance, obtaining an organization determination, or in dealing with any of the levels of the appeals process.
13. All notices or other correspondence intended for the member shall be sent to the member's representative instead of to the member. SWMBH may send notices or correspondence to both the representative and the member but is not required to do so.

C. <u>Parties to the Benefit Determination for Purposes of an Appeal</u>

1. The parties to an organization determination for purposes of an appeal include:
   a. The member (including his or her representative);
   b. An assignee of the member (i.e., a physician or other provider who has furnished a service to the member and formally agrees to waive any right to payment from the member for that service);
   c. The legal representative of a deceased member's estate; or
   d. Any other provider or entity (other than the Medicare health plan) determined to have an appealable interest in the proceeding.

D. <u>Member Rights for Appeal Process</u>

1. Medicare Members have the following rights regarding the appeal process, including not limited to, the right:
   a. To a reconsideration of an adverse benefit determination, and the right to request an expedited redetermination.
   b. To request and receive appeal data from SWMBH
   c. To submit written comments, documents or other information related to the appeal.
   d. To have an authorized representative act on their behalf throughout the appeals process.

e. To continued coverage of a benefit denial, reduction, or termination of coverage for an ongoing course of treatment for which coverage was previously approved, as outlined in Section V, Continuation of Benefits of this policy.

f. Assistance from the Ombudsman's office at any time throughout the appeal process and information on how to do so.

g. To an automatic reconsideration determination made by an Independent Review Entity (IRE) contracted by CMS, in the event the result of the initial reconsideration by SWMBH is upheld in whole or part.

h. To receive notice when an appeal is forwarded to the IRE.

i. To a hearing before an Administrative Law Judge if the independent review entity upholds the original adverse determination in whole or in part and the remaining amount in controversy is meets the appropriate threshold as defined in 422.600.

j. To request a Quality Improvement Organization (QIO) review of a termination of coverage of inpatient hospital care. If a member receives immediate QIO review of a determination of non-coverage of inpatient hospital care, the above rights are limited. In this case, the member is not entitled to the additional review of the issue by SWMBH. The QIO review decision is subject to a Medicare Administrative Law Judge (ALJ) hearing if the amount in controversy meets the appropriate threshold, and review of an ALJ hearing decision or dismissal by the Medicare Appeals Council (MAC). Members may submit requests for QIO review of determinations of non-coverage of inpatient hospital care in accordance with the procedures set forth in the Medicare Parts C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

k. To request and be given timely access to the member's case file and a copy of that case subject to federal and state law regarding confidentiality of patient information. SWMBH shall have the right to charge the enrollee a reasonable amount, for example, the costs of mailing and/or an amount comparable to the charges established by a QIO for duplicating the case file material. At the time the request for case file material is made, SWMBH shall inform the enrollee of the per page duplicating cost. Based on the extent of the case file material requested, SWMBH shall provide an estimate of the total duplicating cost for which the member will be responsible. SWMBH may also charge the member the cost of mailing the material to the address specified.

l. To challenge local and national coverage determinations. Under §1869(f)(5) of the Act, as added by §522 of the Benefits Improvement and Protection Act (BIPA), certain individuals ("aggrieved parties") may file a complaint to initiate a review of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). Challenges concerning NCDs are to be reviewed by the DAB of the Department of Health and Human Services. Challenges concerning LCDs are to be reviewed by ALJs. The new coverage challenge process is available to both beneficiaries with original Medicare and those enrolled in Medicare health plans.

E. Assistance for Appeals Process

1. Members shall receive reasonable assistance in completing any forms or other procedural steps, including interpreter services and toll-free numbers with TTY/TDD and interpreter capability. This also includes assistance that includes auxiliary aides and services upon request.
2. Written materials shall be in an easily understood language and format, and members shall be notified that written materials are available to them in alternative formats, including prevalent languages other than English, and oral interpretation is also available. Documentation shall also include how to access such assistance.
3. Written materials, including notices, shall be translated for members who speak prevalent languages.
4. Language services will be provided to members requesting assistance through bilingual staff or interpreter services, face-to face or telephonically, including but not limited to:
    a. Filing an appeal
    b. Notification and/or correspondence regarding the appeal
5. All steps in the appeals processes shall be provided within the scope of, and maintain compliance with, SWMBH's MI Health Link Policy 6.4: Limited English Proficiency

F. Handling Misclassified Grievances

1. All coverage determinations are subject to appeal procedures. Sometimes complaints do not appear to involve coverage determinations and are misclassified as grievances exclusively.
2. Upon discovery of such an error, SWMBH must notify the member in writing that the case was misclassified and will be handled through the appeals process. The time frame for processing the appeal begins on the date the appeal is received by SWMBH; as opposed to the date the plan discovers its error.

G. Time Frames for Filing an Appeal of an Adverse Benefit Determination

1. Oral inquiries seeking to appeal are treated as appeals (to establish the earliest possible filing date for the appeal) and will be confirmed in writing, unless the member or the provider requests expedited resolution. If a standard appeal request is filed, it must be confirmed with a written request, or SWMBH may dismiss the appeal. SWMBH may, but is not required, to accept web/internet requests.
2. The Member, or a member's authorized representative, including a provider acting on behalf of the member, must file an appeal no later than sixty calendar days (60 days) from the date on the Notice of Adverse Benefit Determination for items/services, per CMS/Michigan Department of Health and Human Services (MDHHS)/ICO Contract and the Medicare Managed Care Manual. The expiration date to file an appeal is included in the Notice of Adverse Benefit Determination. The request should include: the member's name, information to identify which denial is being appealed., and contact information for the member or their authorized representative, if proof of appointment is provided.
3. If a member or their authorized representative shows good cause in writing, SWMBH may extend the time frame for filing an appeal.
4. The member or their authorized representative must request the appeal in writing and include the reason for good cause. The circumstances considered when making the decision to extend the timeframe to appeal include but are not limited to:
    a. The member did not receive the adverse determination notice, or received it late;

b. The member was seriously ill, which prevented a timely appeal;
c. There was a death or serious illness in the member's immediate family;
d. An accident caused important records to be destroyed;
e. Documentation was difficult to locate within the time limits;
f. The member had incorrect or incomplete information concerning the appeal process; or
g. The member lacked capacity to understand the time frame for filing an appeal
h. The member sent the request to an incorrect address, in good faith, within the time limit and the request did not reach SWMBH until after the time period had expired.
i. The delay is a result of additional time needed to produce member documents in an accessible format.

5. If SWMBH denies a members request for a good cause extension the member has a right to file a grievance with SWMBH.

H. Withdrawing an Appeal Request

1. A member or their representative may withdraw a request for appeal in writing at any time before an appeal decision is mailed by SWMBH.
2. If the withdrawal is received after SWMBH has forwarded the appeal to an IRE, then SWMBH must also forward the withdrawal to the IRE for processing.

I. How to File an Appeal Request

1. Members or their representative may file an appeal either verbally by contacting the Member Services Department at 1-800-676-5814 or by submitting a request in writing.
2. All oral requests shall be recorded in the member's record in the member's own words, repeated back to them for accuracy, and placed into the Grievance and Appeal Tracking system.
3. All written requests are submitted to Southwest Michigan Behavioral Health at the following mailing address or faxed to the following fax number:

Southwest Michigan Behavioral Health
Member Services Department
5250 Lovers Lane
Portage, MI 49002
Phone: 1-800-676-5814 Fax: 269-883-6670

J. Adverse Benefit Determination Appeal Levels

1. There are five levels of member appeals:
   a. Level 1 – SWMBH Standard Appeal, SWMBH Expedited Appeal
   b. Level 2 – Medicare Independent Review Entity (IRE)
   c. Level 3 – Medicare Administrative Law Judge (ALJ) Hearing
   d. Level 4 – Medicare Appeals Council (MAC) Review
   e. Level 5 – Medicare Judicial Review
2. Upon SWMBH upholding the denial of coverage in whole or in part of an item/service that is covered by Medicare only the case will be automatically forwarded to the IRE for review and pending that review decision and the dollar amount of the item/service appealed members have the right to the following appeal options in successive order; ALJ, MAC and Judicial Review.

K. Appeal Reviewer

1. SWMBH will ensure that the individuals who make decision on appeals are individuals who were not involved in any previous level of review or decision-making nor a subordinate of any such individual; and, if deciding any of the following are health care professionals who have the appropriate clinical expertise, in treating the member's condition or disease:
    a. An appeal of a denial that is based on lack of medical necessity
    b. An appeal that involves clinical issues.
2. 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
3. All same specialty review recommendations are presented to the appropriate person, persons or department as part of the appeal investigation.

L. Documentation and Investigation of Appeal Requests

1. The appeals process will include, as parties to the appeal, the member and his or her representative or the legal representative of a deceased member's estate
2. The member and his or her representative are provided with an opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process. This shall be processed in compliance with all federal and state laws regarding confidentiality, and disclosure of mental health records, medical records, or other health information. The member's case file must be provided sufficiently in advance of the resolution timeframe.
3. The member and his or her representative are provided a reasonable opportunity to present supporting documentation, evidence and allegations of fact or law, in person as well as in writing. SWMBH will inform the member of their right to request a 14-day extension if they feel more time is needed to submit evidence.
4. 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.
5. SWMBH takes all information into account during the appeals process without regard to whether the information was submitted or considered in the initial consideration of the case; and implements the decision of appeal if it overturns the initial denial.
6. SWMBH will assure that appeal request and all supporting documentation are presented to the appropriate person/persons or department
7. An investigation of the appeal will take place and will be documented. The documentation will include but is not limited to:
    a. Type of appeal, standard or expedite.
    b. The substance of the appeal request, including any aspects of clinical care involved and the member's reason for appealing.
    c. Dated summary of the issues.

d. Name of the appellant
e. Name of the provider or facility (if applicable).
f. Date of appeal.
g. Date of decision, and the resolution.
h. The initial adverse action notes and records.
i. Additional clinical information and documentation submitted by the member, member's representative, and/or member's provider as applicable.
j. All aspects of clinical care involved.
k. Same specialty reviewer's (same specialty reviewer not involved in the initial determination and not a subordinate of any person involved in the initial determination) comments.

M. Acknowledgement of Standard Appeal Request

1. Upon receipt of an appeal request, SWMBH logs and tracks all complaint types in the Grievance and Appeals Database. The content will be available to the Department of Health and Human Services (DHHS) or CMS in electronic format upon request.
2. Member Services will send an acknowledgement letter to the member or authorized member representative and/or the member's provider as applicable
3. SWMBH will acknowledge the receipt of all appeals in writing
   a. The letter will provide information about their appeal rights.
   b. It will include a request for any additional clinical documentation that could support the services requested.
4. SWMBH will proactively include information and reminders about the availability of the Ombudsman's Office and will refer the member to the Ombudsman's Office. The referral may include direct outreach to the Ombudsman's office, warm transfer to the Ombudsman's office and will include full collaboration with the Ombudsman's office.

N. Standard Appeal Decision Timeframes

1. SWMBH will resolve each standard appeal and make reasonable effort to provide oral notice and will provide written notice of the appeal resolution, as expeditiously as the member's health condition requires.
   a. For pre-service appeals, notice of resolution will be sent within thirty (30) calendar days from the date the appeal is received.
   b. For post-service appeals, notice of resolution will be sent within sixty (60) calendar days from the date the appeal is received (Medicare only).
2. SWMBH may extend the timeframe for a standard resolution of the appeal by up to fourteen (14) calendar days, and provide the member written notice of the delay, if:
   a. The member requests or agrees to the extension;
   b. SWMBH demonstrates that there is need for additional information and how the delay is in the member's interest.
3. When SWMBH extends the time frame, it must notify the member in writing (within 2 days) of the reasons for the delay, and inform the enrollee of the right to file an expedited grievance if he or she disagrees with SWMBH's decision to grant itself an extension. When extensions are used, SWMBH shall issue and effectuate its determination as expeditiously as the enrollee's health condition requires, but no later than upon the expiration date of the extension.

4. When complete documentation for a reconsideration request has not been submitted, SWMBH shall make reasonable and diligent efforts to obtain all necessary medical records and other pertinent information within the required time limits. If SWMBH cannot obtain all relevant documentation, a decision will be made based on the material available.

O. Expedited Appeal Requests

1. An expedited review process for appeals will be utilized if it is determined by SWMBH, or if the provider indicates (in making the request on the member's behalf or in support of the member's request) that taking the time for standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function
2. Expedited review will be granted to all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.
3. Post-service appeals are not eligible for expedited processing.
4. May be submitted orally and do not require written confirmation or the member's written consent to have the provider act on the member's behalf.
5. Members will be informed of the limited time available to the member to present evidence and allegations of fact or law in person or in writing.
6. SWMBH will ensure that punitive action is not taken in retaliation against a member who requests an appeal or a provider who requests an expedited resolution or supports a member's appeal.
7. SWMBH medical director, or contracted physician when applicable, reviews the expedited appeal request, together with any support documentation submitted, as expeditiously as the member's health requires upon receipt of the request to determine if the case meets expedited urgency or need.
8. If a member's request for expedited resolution is denied, the appeal will be transferred to the timeframes for a Standard Appeal request and SWMBH will make reasonable efforts to give the member prompt verbal notice of the denial and follow up within two (2) calendar days with a written notice that the appeal will be handled through the Standard Appeal process. This notice must also include the member's right to file an expedited grievance if they disagree with the decision not to expedite the appeal process.

P. Expedited Appeal Decision Timeframes

1. In cases where SWMBH determines a member's request meets expedited urgency or a practitioner supports the member's request, SWMBH notifies the party filing the appeal, as soon as possible, but in no event more than twenty-four (24) hours after the submission of the appeal, of all information that the plan requires to evaluate the appeal.
2. SWMBH's medical director, or contracted physician when applicable, renders a decision as expeditiously as the member's health requires, but no later seventy-two (72) hours from the receipt of the request.
3. For notice of an expedited resolution, SWMBH will make reasonable effort to provide oral notice to all parties to the appeal, as expeditiously as the member's health requires, but no later than seventy-two (72) hours from the expedited appeal request and shall provide written or electronic notification of its decision no later than three (3) calendar days after the oral notification.

4. SWMBH may extend the timeframe for an expedited resolution of the appeal by up to fourteen (14) calendar days, and provide the member with written notice of the reason for the delay, if:
    a. The member requests the extension;
    b. SWMBH demonstrates that there is need for additional information and how the delay is in the member's interest.
5. When SWMBH extends the time frame, it must notify the member in writing (within 2 days) of the reasons for the delay and inform the enrollee of the right to file an expedited grievance if he or she disagrees with SWMBH's decision to grant itself an extension. When extensions are used, SWMBH shall issue and effectuate its determination as expeditiously as the enrollee's health condition requires, but no later than upon the expiration date of the extension.

Q. Notification of Appeal Determination/Rights

1. Members will receive a written notice of appeal decision that is specific to the item or service being appealed in easy to understand language and does not include abbreviations or acronyms that are not defined, or procedure codes that are not explained, and is in compliance with SWMBH MHL Policy 06.04: Limited English Proficiency.
2. 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.

R. Failure of SWMBH to Meet Timeframes

1. If SWMBH fails to notify the member/member representative within the required time frames set forth in this policy for either a standard or expedited appeal, this constitutes an adverse decision.

2. SWMBH must then submit the complete file to the independent review entity according to the process and timeframes outlined in the Medicare Managed Care Manual.

S. External Appeals Options/Levels

1. Independent Review Entity (IRE)
   a. For items/services that are covered by Medicare only or by Medicare and Medicaid, if SWMBH upholds the coverage decision in whole or in part it will complete and submit a written case summary to the Independent Review Entity (IRE) according to the IRE defined timeframes and processes.
   b. Standard requests will be forwarded to the IRE within 30 days of the decision.
   c. Expedited requests will be forwarded to the IRE within twenty-four (24) hours of the decision, and no later than 60 days for requests for payment.
   d. SWMBH will notify the member that it has forwarded the case to the IRE for review.
   e. The IRE will conduct the review as expeditiously as the member's health condition requires and render a decision within 30 days for standard external appeals, 72 hours for expedited external appeals, and 60 days for payment requests. The IRE may extend these timeframes up to 14 calendar days.
   f. The IRE will notify all parties of the determination.
   g. If the IRE reverses SWMBH's decision, SWMBH will authorize the service under dispute no later than 72 hours from the date SWMBH receives the notice reversing the decision.
   h. The notice will include the right to an ALJ hearing and the procedure to request one if the total dollar amount of the items/services being appealed meets or exceeds the AIS threshold.
2. Adjudicated Law Judge (ALJ) Hearing
   a. In order for a case to be reviewed at an ALJ Hearing it must meet the AIC (amount in controversy) threshold.
   b. The member or their authorized representative must file a request for an ALJ hearing in writing within sixty (60) days of the IRE notice of determination with the entity specified in the IRE's reconsideration notice.
   c. If SWMBH receives a written request for an ALJ hearing from the member, SWMBH must immediately forward the member's request to the IRE. The IRE is responsible for compiling the reconsideration file and forwarding it to the appropriate ALJ hearing office.
3. Medicare Appeal Council (MAC) Review
   a. Members or their authorized representative must request a MAC review in writing through a letter to the MAC within 60 days of the ALJ decision. The request should be submitted directly to the MAC at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, DC 20201

4. Judicial Review

a. Any party may not obtain judicial review unless the MAC has acted on the case- either in response to a request for review or on its own motion and the cost of the items/services meets or exceeds the AIC threshold.
b. The party may combine claims to meet the amount in controversy requirement. To meet the requirement:
    i. All claims must belong to the same member.
    ii. The MAC must have acted on all the claims.
    iii. The member must meet the 60-day filing limit for all claims.
    iv. The request must identify all claims.
c. To file a Judicial Review any party must file a civil action in the district court of the United States in accordance with procedures outlined in 42 CFR 422.612 and 405.1136 except that escalation does not apply.
d. The action should be initiated in the judicial district in which the member lives or where SWMBH has its principal office.

5. Final Decisions by Other Review Entities
    a. If the organization determination is reversed in whole or in part by the IRE, ALJ, the Medicare Appeals Council (MAC), or Judicial Review:
        i. SWMBH must pay for, authorize, or provide the service under dispute as expeditiously as the member's health condition requires, but no later than 60 calendar days from the date it receives notice reversing the initial organization determination.
        ii. However, if SWMBH requests MAC review of an ALJ decision, the plan may await the outcome of the review before paying for, authorizing or providing the service under dispute.
        iii. If SWMBH files an appeal with the MAC, it must concurrently send a copy of the appeal request and any accompanying documents to the member and must notify the IRE that it has requested a MAC review.
        iv. Whenever SWMBH imposes a decision, it must inform the IRE.

T. <u>Second Opinions</u>

1. Members have the right to a Second Opinion review under the authority of the State of Michigan Mental Health Code. The Second Opinion review process may be requested for denial of inpatient hospitalization and for denial of initial services under sections 409 and 705 of the Michigan Mental Health Code.
2. For each denial of inpatient care or eligibility for services, at the time of the denial, Southwest Michigan Behavioral Health is required to provide the member with written notice of the rights to a Second Opinion Process. The notice must indicate that the beneficiary is entitled to request a Second Opinion and the process for doing so.
    a. For the denial of inpatient care under Section 409 of the Michigan Mental Health Code, the individual 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 performed within 3 days, excluding Sundays and legal holidays, after the executive director receives the request. If the conclusion of the second opinion is different from the conclusion of the preadmission screening 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 shall provide appropriate referral services.

b. For the denial of eligibility under Section 705 of the Michigan Mental Health Code, If an applicant for community mental health services has been denied mental health services, the applicant, his or her guardian if one has been appointed, or the applicant's parent or parents if the applicant is a minor may request a second opinion of the executive director. 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. The process should follow standard or expedited appeal process timeframes, as outlined in this policy, as the circumstances warrant.

3. Second Opinions are made available at no cost to beneficiaries, from a qualified health professional within the network or outside the network if a qualified health professional is not available within the network.

U. Quality Improvement Organization (QIO)

1. Members will be provided written information at the time of initial enrollment and annually thereafter, of the “Quality of Care” complaint process available under QIO process as described in §1154(a)(14) of the Social Security Act.
2. All appeals that are determined to be regarding quality of care, must be responded to in writing and include a description of the member’s rights to file a grievance with the QIO, including contact information for the appropriate QIO to which the member may submit his or her quality of care grievance.
3. Under section 1154(a)(14) of the Social Security Act, the QIO must review beneficiaries' written complaints about the quality of services they have received under the Medicare program. This process is separate and distinct from SWMBH’s Complaint/Grievance and Appeal procedures.
4. For quality of care issues, an enrollee may file a complaint with SWMBH; file a written complaint with the QIO, or both.
5. SWMBH will cooperate in resolving any complaint submitted to the QIO.

V. Continuation of Benefits

1. A member may continue to receive services during the appeals process under the following circumstances:
2. As used in this section, “timely” filing means filing in writing on or before the later of the following:
    a. Within ten (10) calendar days of the mailing of the notice of adverse benefit determination.
    b. The intended effective date of the proposed action.
3. The member’s benefits will be continued if the member or the provider files the appeal timely; the appeal involves the termination, suspension, or reduction of a previously authorized course

of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the member requests extension of the benefits.

a. For items/services that are covered by Medicare only benefits will continue through the health plan appeal process as long as the appeal is filed timely within ten (10) calendar days from Notice of Adverse Benefit Determination.

b. For items/services that are covered by Medicaid only and by both Medicaid and Medicare benefits will continue through the State Fair Hearing process if each subsequent appeal is filed within ten (10) calendar days of the prior Notice of Adverse Benefit Determination or Appeal Resolution letter.

4. If the member requests benefits to be continued or reinstated while the appeal is pending, the benefits will continue until one of the following occurs:
   a. The member withdraws the appeal or request for External Review or State Fair Hearing
   b. The member fails to request an External Review or State Fair Hearing within ten (10) calendar days of the notice of appeal resolution.
   c. An External Reviewer or the State Fair Hearing officer issues a hearing decision adverse to the member.
   d. The time period or service limits of a previously authorized service has been met.
5. If the final resolution of the appeal is adverse to the member, that is, upholds SWMBH's action, the services will be terminated upon the intended effective date of the action or if that date has passed, services will be terminated within 10 business days of the decision.

W. Record Keeping

1. SWMBH tracks and maintains records of all appeals received and will ensure documentation of the following information, at minimum:
   a. A general description of the reason for the Appeal;
   b. The date received;
   c. The date of each review, or if applicable, the review meeting;
   d. The resolution at each level of the Appeal, if applicable;
   e. The date of the resolution at each level, if applicable;
   f. Name of the covered person for whom the Appeal was filed.
2. SWMBH maintains hard copy and/or electronic images of the complete appeal records in accordance with applicable record retention policies. Full documentation of the appeal will include all components of the investigation as well as any actions taken.
3. The content of the Appeals Database will be made accessible to CMS and MDHHS upon request. SWMBH will retain a copy of the database for ten (10) years.
4. SWMBH will maintain the privacy of all appeals records at all times, including the transmittal of medical records, if applicable.

X. Tracking and Reporting Appeals

1. SWMBH's Member Services Department shall report appeals received regarding behavioral health, substance use disorders and intellectual/developmental disabilities, to:
   a. The SWMBH MI Health Link Committee and Quality Assurance and Performance Improvement (QAPI) Department on a quarterly basis.

b. Each contracted ICO as required in each ICO/PIHP contract, via SWMBH's QAPI department.
c. Other parties as required through contractual obligations and/or regulatory requirements

References:

A. SWMBH MI Health Link Policy 6.4: Limited English Proficiency
B. SWMBH MI Health Link Policy 6.7: Medicare Member Grievance Policy
C. Code of Federal Regulations: 42CFR 438: Subpart F, 42CFR 422: Subpart M, 42CFR 405
D. Medicare Managed Care Parts C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
E. MI Health Link 3-Way Contract: 2.11 Enrollee Appeals
F. NCQA Standard: UM8 Policies for Appeals; UM9 Appropriate Handling of Appeals; RR2 Policies and Procedures for Complaints and Appeals

Attachments: None

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
3	4/10/19	SWMBH	Updated per Medicare Managed Care guidelines	Heather Woods
4	1/1/20	SWMBH	Update per guidelines	Heather Woods
5	8/20/21	Standards and Guidelines: D1j, E2	Edit wording to clarify language assistance and in-text reference.	Heather Woods
6	7/15/22	Annual Review	No Changes	Heather Woods

MHL 06.08 Medicare Member Adverse Benefit Determination Appeal

Final Audit Report 2022-08-02

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