Section: **Customer Service**	Procedure Name: **Adverse Benefit Determination Appeal Procedure**	Procedure #: **MHL P06.08.01**
Overarching Policy: **MHL 06.08 Medicare Member Adverse Benefit Determination Appeal Policy**		
Owner: **Customer Services Manager**	Reviewed By: **Sarah Ameter**	Total Pages: **6**
Required By: ☒ **BBA** ☐ **MDHHS** ☐ **NCQA** ☒ **Other (please specify):** **_MHL 3-Way Contract___**	Final Approval By: Sarah Ameter	Date Approved: May 8, 2020
Application: ☒ **SWMBH Staff/Ops** ☐ **Participant CMHSPs** ☐ **SUD Providers** ☐ **MH/IDD Providers** ☐ **Other (please specify):** ________________________	Line of Business: ☐ **Medicaid** ☐ **Healthy Michigan** ☐ **SUD Block Grant** ☐ **SUD Medicaid** ☒ **MI Health Link** ☐ **Other (please specify):** ______________________	Effective Date: **1/1/20**

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: This procedure outlines the requirements of SWMBH staff to ensure complete, accurate, and timely communication, documentation and tracking of Appeals. This procedure promotes a high standard of clinical care and sharing of pertinent information for appeals. It also provides an accurate account of appeals filed in order to identify trends and improve care.

Scope: Member Services

Responsibilities: SWMBH Member Services department shall ensure compliance with this procedure related to the processing and record keeping of appeals.

Definitions:

A. <u>Adverse Benefit Determination:</u> (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 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. <u>Appeal:</u> As defined in 42 CFR 438.400(b). A request for review of a ICO or PIHP's 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. <u>Authorized Representative:</u> 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.

Procedure:

A. <u>Member or member's authorized representative will contact SWMBH orally or in writing to request an appeal of an adverse benefit determination.</u>
   1. If the request is received orally for a standard appeal, it must be confirmed in writing. This requirement is waived for expedited appeal requests.
   2. If a member wishes to name a representative for an appeal, Member Services will send an appointment of representative form for the member to complete and return.

B. <u>Appeals will be addressed by the Member Services Department.</u>

C. <u>Member Services will listen, support, and help problem-solve when a member and/or authorized representative requests an appeal. SWMBH staff will ask questions to determine the member's desired resolution/outcome related to the appeal.</u>
   1. If the nature of the complaint is not about an adverse benefit determination, and/or if no adverse action has been made, the concern will be addressed by the grievance process.

D. <u>Member Services will determine if the appeal was received in a timely manner. Appeals must be submitted verbally or in writing to SWMBH no more than 60 calendar days from the date on the</u>

Notice of Adverse Benefit Determination when services are denied, reduced, suspended, or terminated.

1. If the appeal was filed within 10 calendar days or effective date (whichever is later) of an adverse action to reduce, suspend, or terminate services, Member Services will determine if the member is eligible for continuation of benefits during the appeal. If deemed eligible, Member Services will notify the appropriate agency to continue services during the appeal.

E. Member services will offer and facilitate language assistance or interpreter services, auxiliary aides, or other support to help the member or authorized representative understand and complete the appeal process.

F. Member services will inform the member or authorized representative of the right to review the case file and to present information or evidence orally or in writing related to the appeal. SWMBH will inform them of the limited time available for presenting evidence based on the timeframe of the appeal.

G. Member services will determine if the appeal will be filed using the standard process, or if the request is clinically urgent and needing an expedited resolution timeframe as defined in Policy 6.8: Medicare Member Adverse Benefit Determination Appeal Policy.

H. Member Services will document the appeal. Appeal documentation will be kept separate from the member's clinical record in order to protect their privacy during the investigation.

1. Member Services will enter known information into the following fields under the "Appeal" record:
   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. Complainant's Name and Address if not Member
   j. Staff Involved in Initial Decision
   k. Explain Issue
   l. Additional Information

I. Member Services will acknowledge receipt of the appeal in writing, unless the appeal is processed under the expedited timeframe. If expedited, Member Services may acknowledge receipt of the appeal orally or in writing.

1. If acknowledging in writing, the Appeal Acknowledgment will include:
   a. Name of the member for whom the appeal was filed.
   b. The date the appeal was received.
   c. A summary description of the appeal.
   d. The date the appeal must be resolved by.
   e. Information about the member's appeal rights.

2. If acknowledged orally, Member Services will verbally summarize the request back to the caller to ensure that their request and desired outcome is documented correctly. Member Services will document any verbal acknowledgement in the appeal record.

J. Member Services will determine the appropriate appeal reviewer. Clinical appeals are reviewed by health professionals who:
  1. Are clinical peers;
  2. Hold and active, unrestricted license to practice in a health profession;
  3. Are board-certified, if applicable;
  4. Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate; and
  5. 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.
  6. 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 information to the identified clinical staff for appeal review. Information may include information from SWMBH's electronic record, provider agency records, and any information provided to SWMBH from the member or authorized representative.

L. Member Services will enter any additional information (including date/time of contacts) in the "Additional Information" field in the Appeal record.

M. Member Services will notify the member or authorized representative in writing if there is an extension of the appeal timeframe, including the anticipated date of resolution within the extension timeframe if:
  1. The member or authorized representative asks for an extension of the timeframe; or
  2. Member Services can justify the need for additional information and how a delay is in the member's best interest.

N. Upon resolution of the investigation, Member Services will complete the following steps to finalize the appeal.
  1. Contact the member to verbally inform them of the resolution/results of the investigation.
  2. Complete the remaining fields in the Appeal record:
     a. Date Resolved
     b. Resolution
     c. Comment
     d. Status
     e. Staff Involved in Appeal Decision
  3. Member Services will mail a written notice Appeal Resolution to the member or authorized representative. It will be written in easy to understand language following Policy 6.4 Limited English Proficiency Policy It 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 Independent Review Entity

(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.

4. Member services will upload written acknowledgments and resolutions to the appeal record.

Effectiveness Criteria: Effectiveness of this procedure will be measured by complete documentation and timely processing of member appeals.

References: None

Attachments: None

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
1	6/3/17	SWMBH		
2	10/23/17	SWMBH		Kim Rychener
3	1/1/20	Definitions, Procedure: A, C1, D-F, H-I, K-M, N3-4	New format, appeal process updates	Heather Woods

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Final Audit Report 2020-05-08

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