Southwest Michigan
BEHAVIORAL HEALTH

Grievance, Appeals, and Notices

April 2020

What is Customer Service?

Customer Service is a series of activities designed to enhance the level of Customer satisfaction.

- Welcome and orient individuals to services, benefits available, and provider network
- Provide information on how to access mental health, primary health, and community services
- Provide information on how to access rights processes
- Assist individuals with problems and inquiries regarding benefits and services
- Assist customers and oversee local grievance and appeal processes
- Track and report patterns of problem areas for the organization

Who Are Our Customers?

- Individuals Receiving Services
  - I/DD – Persons with Intellectual and Developmental Disabilities
  - MIA – Adults with Mental Illness
  - SED – Youth with Severe Emotional Disturbances
  - SUD – Persons with Substance Use Disorders
- Parents/Family members
- Staff members
- Contracted Providers
- Community members/stakeholders
- Everyone who walks through the door

Grievance and Appeal System

Grievance System Overview

Grievance and Appeal System is the process SWMBH and CMHs implement to handle grievances and the appeals of adverse benefit determinations. This also includes the processes to collect and track information about grievances and appeals.

This is the system used when a customer is unhappy with their services or if they disagree with changes to their services.

Grievances and Appeals

- **Recipient Rights Complaint** - when a customer or someone who knows them feels their Michigan Mental Health Code or Public Health Code, PA 368 protected rights have been violated.
  - RR Complaints are covered in depth in other local trainings. RR Complaints are directed to your local Office of Recipient Rights.

- **Appeal** – complaint regarding an "Action" taken regarding services or a request for services. Actions are denials, suspensions, reductions, or terminations. Appeals are directed to Customer Service.

- **Grievance** - complaint filed by customer regarding the quality of their services. Issues here are not considered Rights or Actions. Grievances are directed to Customer Services.

How do we inform Customers?

- At initiation/orientation to services
  - In SWMBH Handbook
  - In Recipient Rights booklets/brochures
- Annually
  - Handbooks/brochures
  - As documented in Plans of Service
- When/As information need arises
  - On Adverse Benefit Determinations
- When requested by customer/authorized representative
  - At point of contact with Customer Services or Recipient Rights
- Via posters/flyer in common areas of service sites

Grievance Examples

- Requesting a change in provider
- Problems with hours of operation
- Appointment availability concerns
- Telephone accessibility
- Conflict with an employee/staff
- Unhappy with choice of providers
- Wait time for scheduled appointment
- Disagreement about prescribed medications
- Upset about getting billed by a provider

Grievance Process

- May be filed at any time by customer, guardian, parent of a minor, or an authorized representative
  - Providers can file on behalf only if there is written permission from the customer, guardian, or parent of a minor.
- May be filed by phone, in person, or in writing
- May be filed locally at CMHSP or regionally through SWMBH, depending on service type and insurance
- Person should be prepared to describe their situation and a recommendation for solution/what they would like to happen

*Note: even when "resolved" there may be times a grievance cannot be fully resolved to 100% satisfaction of the customer.

Grievance Processing

Mental Health for Medicaid or Healthy Michigan Plan (CMH)

- Local CMH will process and record Grievances
- Assist customer with filing grievance
- Response is due within 90 days or it can become an “action” which may be appealed.
- Ensure staff processing the grievance were not involved in the situation the grievance is about
- Customer Service will provide written resolution for each grievance
- Keep written records of grievances filed and resolved

MI Health Link (SWMBH)

- SWMBH processes and records all MI Health Link Grievances.
- Resolved within 30 days or it can become an “action” which may be appealed.

SUD Providers (SWMBH)

- SWMBH processes and records SUD Grievances for:
  - CMHs who are not sub-capitated
  - Other contracted SUD providers (Outpatient, Residential, Recovery Houses)

Appeals

Reason for Appeals

- Denial of requested service(s)
  - Current Customer
  - New Customer
- Limited authorization of requested service(s)
  - Less (in amount/scope/duration) than requested
- Reduction in current service(s)
- Suspension of current service(s)
- Termination of current service(s)
- Delay in providing authorized/approved service(s)
  - If over 14 calendar days from agreed upon start date
- Denied payment for a service NOT previously authorized
- Grievance or previous appeal not processed in the timeframe

Types of Appeals

- Second (2nd) Opinions
- Local Appeal
- Administrative Fair Hearing (State)
- MDHHS Alternative Dispute Resolution Process (State)

Second (2nd) Opinions

A Michigan Mental Health Code Right for:

(1) New customers who are denied access to CMH services (not eligible) based on initial screening/assessment.

(2) Current customers who are denied access to Psychiatric Inpatient Hospitalization.

2nd Opinions are managed by the CMH

- A 2nd Opinion involves a review of the denial by a credentialed clinician NOT previously involved in the denial.
- 2nd Opinions are resolved within 3 days for hospitalization denials and according to appeal timeframes for access (front door) denials of eligibility.

**Note: This does not apply to SUD Services.

Appeals and Timeframes

- Appeals for the denial, termination, suspension, or reduction of services can be accessed after a notice of action is issued.
  - Treatment Plan/Addendum
  - Adverse Benefit Determination

- An Appeal must be filed no later than 60 calendar days from the date of the notice.

- If they want services to continue during the appeal without the proposed action happening, customers must file their appeal within 10 calendar days of (1) the date of the notice or (2) the effective date of the action, whichever is later.
  - Continuation of services does not apply to the denial of a new service.

Continuation of Services

Medicaid services that were previously authorized, must continue when a local level appeal and/or the State Fair Hearing are pending if:

- The member specifically requests to have the services continued; **and**
- The request is made within 10 calendar days of (1) the date of the notice or (2) the effective date of the change, whichever is later; **and**
- The appeal involves the termination, suspension, or reduction, of the previously authorized course of treatment; **and**
- The services were ordered by an authorized provider; **and**
- The original period covered by the original authorization has not expired

If continued, services would remain in place until (1) the customer withdraws the appeal, (2) the customer fails to request a State Fair Hearing within 10 days of the appeal resolution, or (3) the State Fair Hearing office issues an adverse hearing decision.

Filing an Appeal

- An Appeal may be filed by the Customer, Legal guardian, Parent of a Minor or an Authorized Representative
  - An Authorized Representative is an individual given written permission to act on behalf of the Customer
  - Provider can file if they have status of Authorized Representative
- An Appeal may be filed over the phone, in person, or in writing
  - Oral Appeal must be followed by a written/signed request unless it is expedited.
- Customers may request an expedited appeal – 72 actual hours

Appeals Processing

Mental Health for Medicaid or Healthy Michigan Plan (CMH)

- Local CMH will process and record appeals
- Assist Customer to file appeal
- Issue appeal resolution within 30 days (72 hours for expedited)
- Assure that the appeal reviewer was not involved in initial decision to take the Action, nor a subordinate of such individual
- Assure that the clinical reviewer has the appropriate experience/ credentials to make a determination about the service(s) in question
- Provide written resolution for each appeal filed
- Keep written records of appeals filed and resolved.

MI Health Link

- SWMBH processes and records all MI Health Link Appeals.

SUD Providers

- SWMBH processes and records SUD Appeals for:
  - CMHs who are not sub-capitated
  - Other contracted SUD providers (Outpatient, Residential, Recovery Houses)

State Level Appeals

Administrative Fair Hearings

MDHHS Alternative Dispute Resolutions

Administrative Fair Hearing

- Impartial state level review of a local appeal denial, presided over by an Administrative Law Judge.
- Medicaid Customers
- Only available after Local Appeal.
- Customers must file within 120 days of the resolution letter.
- For continuation of services, file within 10 calendar days.
- Instructions for how to ask for this process will be included with the Appeal Resolution.
  - Customers can name a formal representative for the hearing and submit evidence or testimony for review.
- ***Managed by SWMBH***

MDHHS Alternative Dispute Resolution Process

- Impartial state level review of a local appeal denial, presided over by MDHHS staff.
- Non-Medicaid Customers
- Only available after Local Appeal.
- File within 10 days of the mailing date of the Appeal resolution
- Instructions for how to ask for this process will be included with the Appeal Resolution.
  - Customers can send written evidence or testimony.

Managed by CMH or SWMBH, depending on who processed the local level appeal.

Avoiding Grievances/Appeals

- How can our region work to keep customers positively engaged and help to avoid or limit the number of Grievances/Appeals or RR complaints filed by customers …?
  - Involve the customer in decisions about their treatment
  - Negotiate for other medically necessary service alternatives when services requested by a customer do not match their needs
  - Ask the customer regularly whether they are satisfied with services and work with them to address areas of improvement
  - Review the Plan of Service with the customer to make sure the goals and objectives are appropriate and meet customer expectations

Adverse Benefit Determinations (ABD)

How are customers notified?

- Advanced Adverse Benefit Determination
  - Reduction
  - Suspension
  - Termination
- Adequate Adverse Benefit Determination
  - Denial or Partial Denial of service/authorization
  - Denial of Payment
  - Delay in providing authorized services
- Notice of 2nd Opinion Rights
  - Front-Door denial of eligibility for CMH services
  - Denial of Inpatient Psychiatric Hospitalization
- Treatment Plan/Addendum

Timeframes

- Advanced Notice – provided at least 10 calendar days before the effective date of the intended action.
  - For termination, reduction, or suspension of current services

- Adequate Notice – provided at the time of the decision
  - For standard authorization/service denials – within 14 calendar days of the initial request for authorization.
  - For expedited authorization/service denials – within 72 hours of the expedited request for authorization.
  - For denial of payment – provided at the time of the decision to deny payment for a service.

Exceptions to Advanced Notice

- Factual information confirming customer death
- Clear, written and signed statement that customer no longer wishes to receive service(s)
- Customer was admitted to an institution such as jail/prison, State hospital or extended care facility where they are ineligible for service
- Customers whereabouts are unknown and the post office returns mail with no indication of a forwarding address
- Customer has moved out of the service coverage area
- Change in level of medical care is prescribed by customer's physician
- Notice involves adverse determination made regarding preadmission screening requirements
- Date of Action will occur in less than 10 calendar days.
- Facts (preferably verified by 2nd source) indicating possible fraud by the enrollee and that action should be taken (Advanced Notice may be 5 days)

Check Your Funding Source

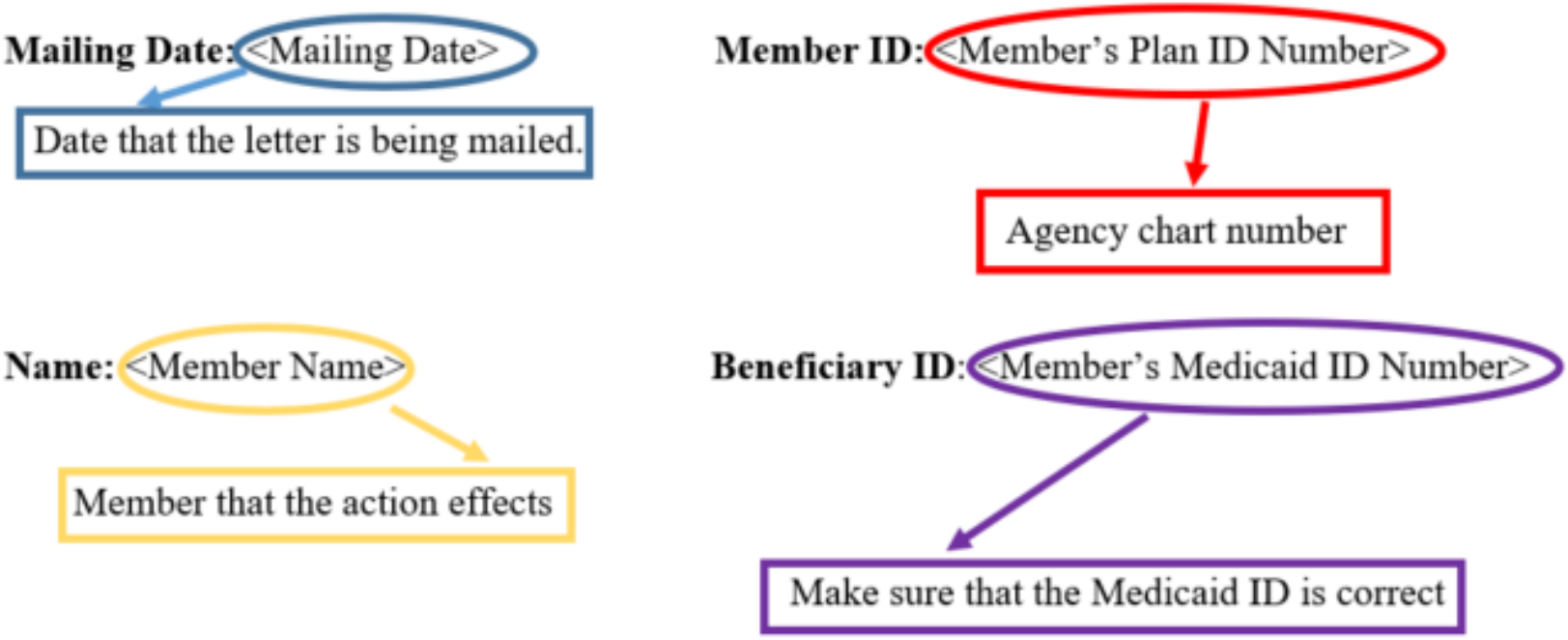
- Before filling out a notice, always check the funding source. Funding sources may have different templates for notices.
  - Medicaid, Healthy Michigan Plan, Medicaid Health Plans, Medicaid Spend Down
    - *Adverse Benefit Determination (covered in this training)*
  - MI Health Link (duals program)
    - MHL Meridian
    - MHL Aetna
  - General Fund/Block Grant

Adverse Benefit Determination

- Must be easily understood by the customer
  - 4th Grade Reading Level – simple language
  - Spell out all Acronyms (do not assume they know)
  - Use short sentences

- The clinician name and credentials listed on the notice should be the person making the decision.
  - If part of a Utilization Review process, enter the name of the reviewer on the notice, not the case manager.

Completing the ABD document



The following action has been taken:

This is where you describe what has changed. Include:

- Name of service or services that the action effects
- Type of action (denial/partial denial, reduction, suspension, or termination)
- Identify the date of the action or intended action
- Name and Credentials of the person who made the decision

*Example: Your Community Living Support (CLS) services are being reduced from 20 hours a week to 16 hours a week. This change will happen on May 10, 2020. This decision was made by Cindy Smith, LBSW, QIDP from Southwest Michigan Behavioral Health.

**Example: Your request for Substance Use Disorder (SUD) Outpatient services was denied on April 30, 2020. This decision was made by John Smith, LPC, CAADC from Southwest Michigan Behavioral Health.

Action is based on the following:

- Must include the reason for the decision and the criteria used

- If Medical Necessity, must also reference:
  - 42CFR 440.230(d) as the legal authority for the agency to place appropriate limits on a service based on criteria such as medical necessity or utilization control procedures.

- If the suspension, reduction, or termination of a current service, must also notify the customer that they may need to repay the cost of services continued during an appeal if they chose “continuation of benefits” and if the action is still affirmed.

Action is based on the following:

***Example**: You were authorized for 20 hours a week of CLS, but records show that you only use 16 hours a week. As we told you when we met yesterday (April 29), we are going to reduce your services to the level you are using. Based on our review, 16 hours a week seems to be enough to meet your needs. We plan to authorize 16 hours a week starting May 10 through the end of your treatment plan.

Reason

The Medicaid Provider Manual allows us to use methods, such as utilization reviews, to help decide the correct amount, scope and duration of services (Section 2.5 D).

Criteria

The Code of Federal Regulations (42 CFR 440.230 (d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or utilization control procedures.

42CFR Reference

If you file an appeal and choose to continue benefits while the appeal is processed, you may have to repay the cost of those services given if the appeal decision is not in your favor. See “Continuation of services during an Internal Appeal” for more information.

Repayment Risk

Action is based on the following:

**Example: Based on the information you shared, you do not meet American Society of Addiction Medicine (ASAM) medical necessity criteria for (level 1.0) outpatient services.

Criteria

You do not meet criteria because: you have no withdrawal risk (Dimension 1). You report no medical or mental health concerns (Dimensions 2-3). You report alcohol is not a problem for you (Dimension 4). You report drinking 4 (12 oz) beers on February 20th and have not had alcohol since then (Dimension 5). You report legal charges for driving under the influence in February. This is your first legal charge for substance use. You have safe housing and family support. (Dimension 6).

Reason

We recommend that you use community support groups (Alcoholics Anonymous) to stay sober.

The Code of Federal Regulations (42 CFR 440.230 (d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or utilization control procedures.

42CFR Reference

Provide Notice of Adverse Benefit Determination

- All Adverse Benefit Determinations should be addressed/written to:
  - The Customer
  - Customer's Legal Guardian (if applicable)
  - Customer's parent (if a minor child)

- Whenever mailed, Notice should be sent to the last known address on file for the Customer, Legal Guardian or Parent (whoever has legal authority to make treatment decisions)

For more information

- MDHHS/PIHP Contract for the current fiscal year
- Michigan Mental Health Code
- SWMBH policies for Grievance/Appeals
- SWMBH Customer Handbook
- Call your local customer service representative or SWMBH

Customer Service Contacts

- Barry
  - Tina Williams
  - 269-948-8041
- Berrien/Riverwood
  - Charity Burton
  - 866-729-8716
- Branch/Pines
  - Kammy Ladd
  - 866-877-4636
- Calhoun/Summit Pointe
  - Dawn Nichols
  - 877-275-5887
- Cass/Woodlands
  - Ann Hart
  - 800-323-0335
- Kalamazoo
  - Teresa Lewis
  - 877-553-7160
- St. Joseph
  - Jessica Singer
  - 855-203-1730
- Van Buren
  - Sandy Thompson
  - 269-657-5574

Southwest Michigan
BEHAVIORAL HEALTH

Thank-you

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