# APPEAL AND GRIEVANCE RESOLUTION PROCESS

A Process for Handling Access and Clinical Care Concerns

HIAWATHA BEHAVIORAL HEALTH

TO ACCESS NOTICES IN ELMER, GO TO:

-CONSUMER CHART

-LEGAL/COURT ORDER/RELEASES

-ADVERSE BENEFIT DETERMINATION/CONSUMERS NOTICES

Meets requirement for- BBA, P 6.3.1.1 Grievance and Appeal TR

**Fulfills Topic Requirement:** Grievance & Appeals General Orientation

Updated 10/30/2024

# INTRODUCTION

Primary Funding Services are:

- Medicaid Benefits
- State General Fund Benefits
- Third Party or Private Pay
  - Majority of Consumers at HBH are Medicaid and/or General Funds
  - HBH, as an affiliate of the NorthCare Network, works in cooperation with NorthCare to manage the access to Medicaid and General Fund Benefits

# INTRODUCTION – CONT.

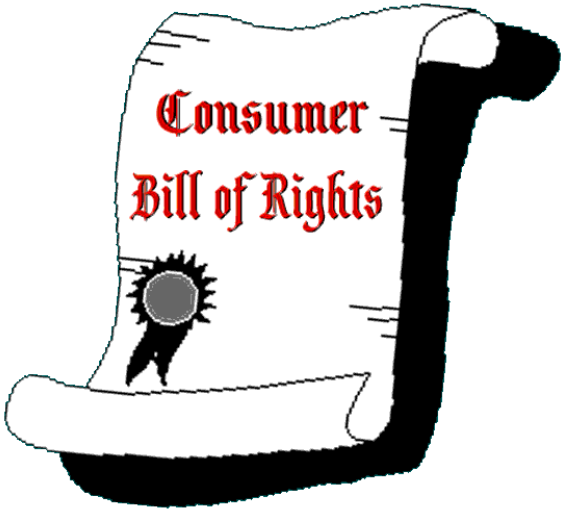
Consumer has limited choice of benefit managers

- HBH is the only manager for Specialty Behavioral Health (Mental Health Services) for persons with:
  - Severe Mental Illness
  - Serious Emotional Disturbance
  - Intellectual Disability

Therefore, if a consumer questions their services, it is mandated that a strong appeal – grievance – dispute resolution process be available to contest the denial.

# CONSUMER RIGHTS

- The consumers right to a strong appeal, grievance and dispute resolution process is included in:
  - Balanced Budget Act and Federal Medicaid Regulations.
  - MDHHS/NorthCare contracts for Medicaid and General Funds.
  - Michigan Mental Health Code
  - HBH Appeal/Grievance Policy
- Notice of these rights to the consumer is a critical responsibility of HBH.
  - HBH is responsible to notify consumers of their rights to the appeal, grievance and dispute resolution processes.
  - Notice is a critical contract responsibility of Hiawatha Behavioral Health and must be given in writing to consumers.



# CONSUMER RIGHTS – CONT.

Consumers have access to a number of avenues to file complaints. The avenues include:

- Appeal Process
- Request for Second Opinion
- Grievance Process (Consumer Complaint Process)
- Recipient Rights Complaint Process
- Informal Complaint Process

# APPEAL DEFINITION

- Appeal means a request for review of an action, as "action" is defined. The actions have specifically to do with receiving treatment services for all eligible (priority population) consumers – either for consumers eligible for Medicaid benefits or not eligible for Medicaid benefits.
- Medicaid consumers can appeal an action within **60 days** of the initiation of the action. Non-Medicaid Consumers have **30 days**.

# ACTION DEFINITIONS

Actions include the Following:

- Denials of service access – at screening or at intake;
- Denial of psychiatric hospitalization;
- Denial of services requested not previously addressed during treatment planning;
- Delay of the start of services past the previously agreed upon start date.
- Reduction, suspension, or termination of an approved service;
- Other situations as appropriate.

# ACTION DEFINITIONS – CONT.

## ADVERSE BENEFIT DETERMINATION

- Must be given when services are delayed, reduced, suspended, or denied.
- Can be found in Elmer under Legal→Court Order/Releases→Adverse Benefit Determination/Consumer Notices

## Notice of Benefit Determination Legal References Table

| Action Taken | Reason for Action | Legal Reference |
|---|---|---|
| Adequate Notice: Denied | Eligibility: You do not meet the clinical eligibility for the requested service. | The legal basis for this decision is:<br>Michigan Mental Health Code (Act 258 of 1974), Sections 330.1100a (Definitions: A to E), 330.1100b (Definitions; F to N), 330.1100c (Definitions; P to R); 330.1100d (Definitions; S to W), and 330.1208<br>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 benefit. Managed Care Rule, 42 CFR 438.400 (b)(1).<br>MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A–D, Medical Necessity Criteria |
| Adequate Notice: Denied | Eligibility: You do not meet Medicaid eligibility criteria for services as a person with a serious.... | The legal basis for this decision is:<br>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 benefit. 42 CFR 438.400 (b)(1).<br>Michigan Mental Health Code (Act 258 of 1974), Sections 330.1100a, 330.1100b, 330.1100c, 330.1100d, and 330.1208<br>MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5.B Determination Criteria<br>MMHC 330.1498e Evaluation; second opinion; transfer; alternative program; applicability of section ; 330.1705 [for minors] Second opinion |
| Adequate Notice: Denied | Eligibility: You have other resources available for providing services... | The legal basis for this decision is:<br>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 benefit. 42 CFR 438.400 (b)(1).<br>MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and |

| Action Taken | Reason for Action | Legal Reference |
|---|---|---|
| | | Developmental Disability Supports and Services chapter, Section 2.5 A-D, Medical Necessity Criteria |
| Adequate Notice: Denied | Eligibility: You do not meet the clinical eligibility for the requested service. | The legal basis for this decision is:<br>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 benefit. Managed Care Rule, 42 CFR 438.400 (b)(1).<br>Michigan Mental Health Code (Act 258 of 1974), Sections 330.1100a-d MMHC 330.1498e Evaluation; second opinion; transfer; alternative program; applicability of section [for minors]; 330.1705 Second opinion.<br>MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 8.5.B - Inpatient Admission Criteria for Adults,<br>8.5.C is Admission Criteria for Children/Adolescents (through age 21), and 8.5.D covers Continuing Stay Criteria for Adults, Adolescents, and Children<br>MMHC 330.1498e Evaluation; second opinion; transfer; alternative program; applicability of section ; 330.1705 [for minors]Second opinion |
| Adequate Notice: Denied | Eligibility: Residency: you live outside of the <PIHP/CMHSP> service area... | The legal basis for this decision is:<br>Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2)<br>Michigan Mental Health Code (Act 258 of 1974), Section 330.1206 |
| Adequate Notice: Denied | Eligibility: You are currently residing in an institution in which <PIHP/CMHSP> cannot authorize... | The legal basis for this decision is:<br>MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter 2.3, Location of Services |

| Action Taken | Reason for Action | Legal Reference |
|---|---|---|
| Adequate Notice: Delayed more than 14 days | Delay: Your services were not provided within 14 calendar days of the start date... | The legal basis for this decision is:<br>Failure to provide services within 14 calendar days of the start date agreed upon during the person centered planning and as authorized by the PIHP. *Managed Care Rule* 42 CFR 438.400(b)(4) |
| Adequate Notice: Delayed more than 14 days | Delay: Your service authorization decision was delayed more than 14 days from the receipt.... | The legal basis for this decision is:<br>Failure to make a standard Service Authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service. *Managed Care Rule 42 CFR 438.210(d)(1).* |
| Adequate Notice: Delayed more than 14 days | Delay: Your expedited service authorization decision was delayed more than 72 hours after the receipt... | The legal basis for this decision is:<br>Failure to make an expedited Service Authorization decision within seventy-two (72) hours after receipt of a request for expedited Service Authorization. Managed Care Rule 42 CFR 438.210(d)(2) |
| Adequate Notice: Delayed more than 14 days | Delay: <PIHP/CMHSP> did not resolve your standard appeal request and provide notice within the agreed upon 30 calendar day | The legal basis for this decision is:<br>Failure of the PIHP/PIHP/CMHSP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2) |
| Adequate Notice: Delayed more than 14 days | Delay: <PIHP/CMHSP> did not resolve your extended standard appeal request and provide notice within the agreed upon 45 calendar day | The legal basis for this decision is:<br>Failure of the PIHP/PIHP/CMHSP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2) |
| Adequate Notice: Delayed more than 14 days | Delay: <PIHP/CMHSP> did not resolve your grievance request and provide notice within the agreed upon 90 calendar day | The legal basis for this decision is:<br>Failure of the PIHP to resolve grievances and provide notice within 90 calendar days of the date of the request. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1). |
| Advanced Notice: Reduced | Eligibility: You do not meet the clinical eligibility for service. You do not meet Medicaid criteria... | The legal basis for this decision is:<br>Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2)<br>MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A-D, Medical Necessity Criteria |

| Action Taken | Reason for Action | Legal Reference |
|---|---|---|
| Advanced Notice: Reduced | Other: <PIHP/CMHSP> does not having provider capacity to provide the service(s). | The legal basis for this decision is:<br>Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2) |
| Advanced Notice: Reduced | Medical Necessity: You have not attended or participated in your authorized services since.... | The legal basis for this decision is:<br>Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2)<br>MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A-D, Medical Necessity Criteria |
| Advanced Notice: Reduced | Other: You have requested to change your current service(s). | The legal basis for this decision is:<br>Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2) |
| Advanced Notice: Suspended | Other: <PIHP/CMHSP> does not having provider capacity to provide the service(s). | The legal basis for this decision is:<br>Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2) |
| Advanced Notice: Suspended | Medical Necessity: You have not attended or participated in your authorized services since.... | The legal basis for this decision is:<br>Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2)<br>MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A-D, Medical Necessity Criteria |
| Advanced Notice: Suspended | Other: You have requested to change your current service(s). | The legal basis for this decision is:<br>Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2) |
| Advanced Notice: Terminated | Eligibility: You do not meet the clinical eligibility for service. You do not meet Medicaid criteria... | The legal basis for this decision is:<br>Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2)<br>MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and |

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|---|---|---|
| | | Developmental Disability Supports and Services chapter, Section 2.5 A–D, Medical Necessity Criteria |
| Advanced Notice: Terminated | Eligibility: Residency: you live outside of the <PIHP/CMHSP> service area... | The legal basis for this decision is:<br>Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2)<br>Michigan Mental Health Code (Act 258 of 1974), Section 330.1206 |
| Advanced Notice: Terminated | Medical Necessity: You have not attended or participated in your authorized services since.... | The legal basis for this decision is:<br>Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2)<br>MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A–D, Medical Necessity Criteria |
| Advanced Notice: Terminated | Medical Necessity: You have not attended or participated in your authorized services since.... | The legal basis for this decision is:<br>Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2) |
| Adequate Notice: Denied | Other: Payment for a service, in whole or in part | Denial, in whole or in part, of payment for a service. 42 CFR 438.400(b)(3)<br>MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Section 2.5 A–D, Medical Necessity Criteria |
| Adequate Notice: Denied | Other: Request to dispute a financial liability | Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. 42 CFR 438.400(b)(7) |
| Adequate Notice: Denied | Other: Suspended due to not following clubhouse rules | Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2)<br>MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, Section 5.2, Clubhouse Psychosocial Rehabilitation Programs; Target Population |

# GRIEVANCE DEFINITION

Grievance means an expression of dissatisfaction about any matter other than an action

- Grievances are collected through the consumer complaint process
- Examples:
  - My worker was rude to me
  - My worker never sees me on time
  - My doctor ignores what I say
  - The reception area is cold and cluttered

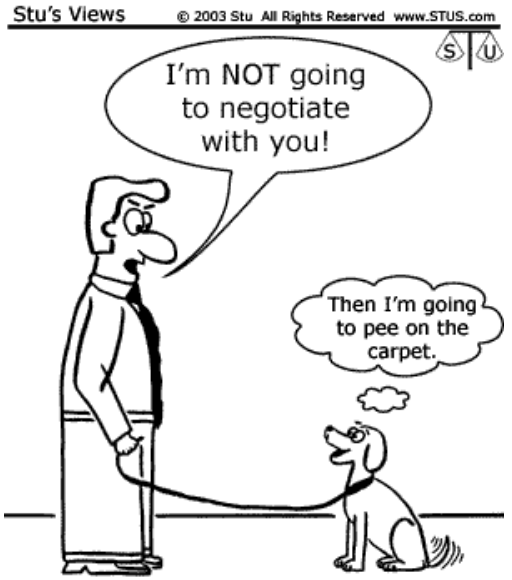
# COMPLAINT

Recipient Rights complaint alleging a violation of the consumer mental health code protected rights

- Examples:
  - I requested a second opinion on my denial to services and it was ignored;
  - My worker is not following my treatment plan;
  - The program supervisor told me, in a rude manner, that I was ignorant;
  - A copy of my treatment plan was sent to the school without my signed permission.

# INFORMAL COMPLAINT PROCESS OR INFORMAL DISPUTE RESOLUTION

- Negotiation process to resolve any disputes. Negotiation is usually between program staff and the consumer
- During the treatment planning process, the consumer must be informed of the informal complaint / informal dispute resolution process. Documentation of informing the consumer of the informal complaint and dispute resolution process is located on the Notice given to every consumer.
- Examples:
  - I want a different case manager
  - I would like to be in a different group at Connections/Options
  - The parking lot is icy/slippery.



# INFORMAL DISPUTE RESOLUTION PROCESS – CONT.

- Consumers must be notified of the informal dispute resolution process during the intake and the ongoing planning process;
- The informal process should always be attempted before going to the more formal process;
- Even when a request for a fair hearing is made by a consumer, attempts should be made to resolve the dispute at the informal level;
- Mediation is part of the informal process.

# SERVICES

- The treatment plan that is approved is a contract that specifically names the service(s) that will be delivered to the consumer;
- Many services are available and some of the primary services are case management, supports coordination, psychiatric, skill building, community living supports, individual and group counseling, respite, Home Based and many more;
- Along with naming the services, the treatment plan must also describe the amount, scope and duration of services;
- Consumers must be informed of their right to dispute, grieve or appeal any part of their treatment plan including the denial of any service or the amount, scope and duration of services.

# APPEAL

Consumers must be informed of their right to dispute, grieve or appeal any part of their treatment plan including the:

- Delay/Denial of any eligible service
- Or the…
  - Amount
  - Duration
  - Scope of any service

# AMOUNT

- The number of units (E.G. 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided;
- The amount is documented during the treatment plan process in the sections: "Description of Services " and "Authorizations".

# DURATION

- The length of time (E.G. three weeks, six months, etc.). It is expected that a service identified in the treatment plan will be provided. The completion data should also be included.
- The duration is documented during the treatment plan process in the sections: "Description of Services" and "Authorizations".

# SCOPE

The parameters within which the service will be provided, including:

- Who (E.G. Professional, Para-professional, Aide Supervised by professional – Name the position, not the individual as individual can change)
- How (E.G. Face to Face, Telephone, Taxi/Bus, Group or Individual
- Where (E.G. Community setting, Office, Beneficiary's home)

The Scope is documented during the treatment plan process in the sections: "Description of Services" and "Authorizations".

# APPEAL NOTICE

- Giving notice of appeal rights is mandatory and is the responsibility of the assigned clinician;
- Separate information is given to Medicaid and Non-Medicaid consumers because each group has different appeal processes of action and hearing rights.

| | | | | |
|---|---|---|---|---|
| Denial of service request at intake; hospitalization review; consumer or guardian/parent request for new service | Yes | **Adequate Notice** of Adverse Benefit (Second opinion can also be requested) | At the time of the denial | 60 calendar days from date of notice – usually immediate request & expedited review |

## GRIEVANCE / APPEAL DEFINITIONS

**Appeal –** A challenge to an action and it can be requested as a local appeal or State Tribunal appeal. Consumers must first request local appeal before requesting a state level appeal.

**Second Opinion –** A challenge of access denial to mental health services (admission); new service (already receiving some services) or denial of hospitalization. Second opinion must be completed by a professional who was not involved in the initial denial decision.

**Rights Complaint** – A challenge / complaint regarding alleged violation of rights as a consumer of services. Abuse; Neglect; Confidentiality; etc. would be examples and the investigations are conducted by Recipient Rights Office.

**Grievance –** Other types of complaints not covered above such as long waiting time in reception area; reception area dirty and noisy; no parking; etc. Complaints are usually reviewed by Customer Services program. Grievances that are not resolved can become an appeal process.

**Corporate Compliance Complaint** – Alleged violation of law, rule, regulation and would include suspected fraud / misuse of funds; appropriate licensing / credential of perform duty; etc. Investigation usually conducted by Corporate Compliance Officer.

(Source material: Attachment P.6.3.1. PIHP Contract; Attachment C6.3.2.1 State Contract)

# FORM SIGNATURE/DISTRIBUTION

Clinicians should print and give Adverse Benefit Determination to the consumer/guardian at time of action. If a clinician is unable to give Adverse Benefit Determination to the consumer in person, they will have to request mailing by medical records through the 'release' functionality in Elmer. Medical records will be expected to mail out within 2 calendar days of receiving the release request in their queue. Clinicians should plan on giving 12 calendar days for the Adverse Benefit Determination for Medicaid consumers, and 30 days Advance Notice for consumers without Medicaid.

# ADVERSE BENEFIT DETERMINATION DISTRIBUTION

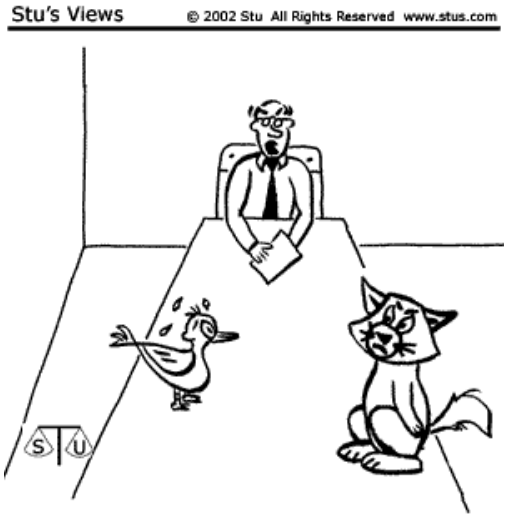
- You should also send a copy to client or guardian or verify that you have hand delivered them a copy. To do this, choose "Send External" and use the look up function to enter "Con". This will pull generic consumer address. You will choose either "Consumer Hand Delivered" or "Consumer Home Address" for the county of residence depending on if Medical Records should mail them the form or if you will be giving them a copy directly.
- Click "Save and Continue to Signatures"
- Sign with Password.

# ADMINISTRATIVE FAIR HEARING PROCESS

- Available for all consumers who have Medicaid and are receiving state plan services;
- Consumer must first use the local appeal process and receive a decision on their appeal. If still not satisfied, the consumer can then request the state tribunal administrative fair hearing process.
- Recipient Rights Office assists in processing the filing and establishing the hearing event. The Recipient Rights Officer will also assist the consumer in filing for the hearing.

# STATE TRIBUNAL ADMINISTRATIVE FAIR HEARING PROCESS

- Corporate Compliance Officer and program manager prepare the required material and represent the agency at the hearing
- Hearing is presided over by an administrative law judge who may be there in person or conducts the hearing over the telephone
- Notice of hearing results is provided in writing to the agency and the consumer



# MDHHS ALTERNATIVE DISPUTE RESOLUTION

- At the state level and available for all Non-Medicaid consumers;
- Consumers must first appeal the issue at the local CMH level;
- Consumer must file within 14 calendar days of receiving Adverse Benefit Determination