Northern Lakes
COMMUNITY MENTAL HEALTH AUTHORITY

Grievance and Appeal Training

Purpose - To provide workforce members with the knowledge and understanding of persons served right to make grievances and to request appeals.

Objective – Workforce members are knowledgeable on providing persons served with:

A. The correct Notices/Adverse Benefit Determinations when service decisions are made that affect

1. new applicant's request for services
2. person's current service(s) or request for additional service(s)

B. Information on when and how persons served file a Grievance or an Appeal.

November 2019 rr

Grievance and Appeal rights are based on the law and policies

All NLCMHA persons served and applicants for services have the right to make a grievance and/or to request an appeal. The processes for Medicaid enrollees are slightly different from those persons served without Medicaid. The following mandates provide the legal basis for the processes and procedures that NLCMHA follows.

MEDICAID STANDARDS

- 42 CFR (Code of Federal Regulations)
- Medicaid Managed Specialty Supports & Services Concurrent 1915(b)/(c), Waiver Program Contract, Attachment P6.3.1.1 Grievance and Appeal Technical Requirement

  Attachment P4.4.1.1 Person Centered Planning Policy
- Healthy Michigan contract
- PIHP Grievance and Appeal Policy
- NLCMHA Grievance and Appeals Policy 106.106

NON-MEDICAID STANDARDS

- Michigan Mental Health Code, Act 258 of the Public Acts of 1974
- MDHHS/CMHSP Managed Mental Health Supports and Services Contract Attachment C6.3.2.1 - CMHSP Local Dispute Resolution Process

  Attachment C6.3.2.2 – CMHSP Family Support Subsidy Process
- NLCMHA Grievance and Appeal Policy 106.106

Definitions

- **Action**: Sometimes referred to as an adverse benefit determination (Medicaid term). A NLCMHA decision that impacts a person's served claim for services (new or existing): i.e. denial, reduction, suspension or termination of services, etc.

- **Adverse Benefit Determination:** A decision that adversely impacts a Medicaid Enrollee's claim for services. See page 11 for various decision types.
  - **Adequate Notice** – written statement advising the consumer or a decision to deny or limit authorization of services requested. Notice date is the **same date** as the effective date of the action.
  - **Advance Notice** – written statement advising the consumer of a decision to reduce, suspend or terminate services currently provided. Notice must be provided or mailed at **least 10 calendar days prior** to the effective date.

- **Appeal:** a request by a person served or their representative (with the person's served written permission) to review an "action" taken by a NLCMHA provider. A review at the local level by a PIHP/CMHSP of an action or adverse benefit determination. Medicaid also refers to as an **internal** appeal.

- **Consumer/Person Served**: Broad, inclusive reference to an individual requesting or receiving mental health services. May include parent(s) of minor child, guardian, or a new applicant to services. Medicaid also refers to as an **enrollee** or **member.**

Definitions (cont'd)

- **Grievance**: Person's expression of dissatisfaction about any matter other than an action/adverse benefit determination or a recipient rights complaint. Examples could include, but are not limited to quality of care or services provided, or interpersonal relationships between a provider and person served.

- **Individual Plan of Services (IPOS)** – "A written IPOS directed by the individual as required by the Mental Health Code. This may be referred to as a treatment plan or a support plan"*. Created by the person served and their provider using a person-centered planning process. [*Person-Centered Planning Guideline Attachment P4.4.1.1]

- **Provider:** An individual (i.e. case manager, outpatient therapist) directly <u>employed</u> by NLCMHA who provides services to a person served; **or** an individual or organization (i.e. psychiatrist, crisis residential services) <u>contracted</u> by NLCMHA to provide services to a NLCMHA person served. NLCMHA workforce members are referred to as providers in this training.

- **Service Authorization** – NLCMHA processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, scope, or duration of less than requested, all as required under applicable law.

Is the Person Served a Medicaid Beneficiary?

For purposes of Actions / Adverse Benefit Determination/ Notices / Appeals / Grievances, a person served who has any of the following, will answer this question with a "Yes".

1. Medicaid (sometimes referred to as "fee-for-service" or "traditional" Medicaid)
2. All Medicaid Health Plans (MHP - i.e. Meridian, Molina, etc.)
3. Healthy Michigan Plan (Expanded Medicaid)
4. Medicaid Deductible/Spend-down (see **NOTE** below)
5. Michigan Medicaid Waiver Programs including:
   a. Habilitations Supports Waiver (HSW)
   b. Children's Waivers [does not include MI-Child]

NOTE: The Medicaid deductible (spend-down) must be met monthly in order for a person served to qualify for Medicaid. If the person served has **not** met their deductible/spend-down at the time you are providing a Notice, provide a **NON**-Medicaid Notice.

Grievances provide a way for persons served to express concerns

Grievances are expressions of dissatisfaction about any matter other than an action or a recipient rights complaint. Examples could include, but are not limited to quality of care or services provided, or interpersonal relationships between a provider and person served.

- If a provider of services is unable to provide a resolution to an issue or concern with a person served, the provider should notify the person served of their right to contact the provider's supervisor and/or Customer Services staff to consult with them and/or to file a grievance.
- Persons served (including parents of minors and guardians) may file a grievance at any time either orally or in writing with the Customer Services staff.
- The provider is expected to provide assistance to the person served in contacting Customer Services as necessary.
- Providers can also help persons served write a letter or use a Grievance form to express their grievance. Grievance forms are available in each office supply room and from Customer Services staff.

Grievances continued…

- Any person served may file a grievance at any time – there are no time limits
- Providers can only file a grievance on a person's behalf with the person's written permission.
- The Grievance and Appeal (G&A) Coordinator will submit the grievance to appropriate staff including the supervisor of the affected service and/or the Managed and Integrated Health Care Director, both who can request corrective action.
- The G&A Coordinator must provide a written acknowledgement to the person served within 5 business days notifying them that their grievance was received. After a resolution or other outcome has been reached, a disposition letter is sent to the person served; within 90 calendar days for Medicaid beneficiaries and within 60 calendar days for Non-Medicaid persons served.
- Supervisors should refer persons served to the G&A Coordinator when they are unable to reach a mutually agreeable resolution to a person's concern or when in their judgment it is preferable to have the G&A Coordinator involved.
- Customer Services staff will forward grievances that are allegations of Recipient Rights violations to the Office of Recipient Rights.

Actions and Service Decisions

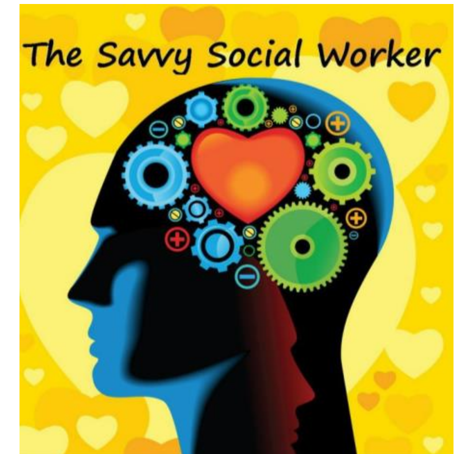
ACTIONS or Adverse Benefit Determinations (Medicaid term) are about **SERVICE** decisions.

- Service decisions are based on persons served meeting medical necessity criteria for community mental health service programs. See page 11 for the various types of service decisions that are made.

- A **Notice of Adverse Benefit Determination** about an action or service decision is required any time a new service decision is made. Decisions can include:
  - denying a request for a new service (including inpatient hospitalization)
  - denying or authorizing a change in service (i.e. amount, scope or duration).
  - authorizing or re-authorizing services on an IPOS or IPOS addendum.
  - reducing, suspending or terminating existing services.

Actions and Service Decisions

WHO makes decisions and provides Notices to persons served?



- **Access Unit** staff provide Notices to new applicants when a decision is made to deny their request for initial services with NLCMHA.
- Various work force members (i.e. Crisis Services Team, primary workers) provide Notices to persons served/community members requesting inpatient hospitalization.
- The person's primary worker/provider (i.e. case manager, therapist, RN, etc.) or a Utilization Management worker provides Notices to existing persons served when a decision is made, or an action is taken, that affects the person's existing services or request for additional services.

Actions and Service Decisions

The Notice serves to notify persons served of:

- A decision or action that was taken or about to be taken that will affect their current services or their request for new or additional services.

- Their right to file an appeal and how to do it, if they do not agree with the decision.

NLCMH Adequate & Advance Notice of Adverse Benefit Determination Requirements

Service Event	Action	Time frame for Notice	How Given
Denial or limited authorization of a requested service, including initial services and hospitalization. Includes determinations based on the type of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.	ADEQUATE NOTICE Denial or limited authorization of requested service	Within 14 days following receipt of the request for service	In person or mailed, as appropriate
IPOS developed or modified and authorized - Agreement to add, remove or change services, or to existing services changed in amount, scope, duration	ACTION NOTICE Provides Grievance and Appeal Rights for services authorized or not authorized	At the time of action	Attached to the Treatment Plan in NoIA.
Previously authorized services: • reduced in amount/scope/duration • suspended • terminated	**ADVANCE NOTICE** Reduction, suspension or termination of a previously authorized service	10 calendar days before action* 30 days for Non-Medicaid See "Exceptions to Advance Notice Rule – Medicaid Enrollees" on next page.	In person or mailed, as appropriate
Denial, in whole or in part, of a payment for a service.	ADEQUATE NOTICE Denial	At the time of action.	In person or mailed, as appropriate
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	ADEQUATE NOTICE Failure to make a standard decision with 14 days of request.	At the time that it is known that the 14 days timeframe will not be met.	In person or mailed, as appropriate
Failure to make an expedited Service Authorization decision **within 72 hours** after receipt of a request for expedited service authorization.	ADEQUATE NOTICE Failure to make an expedited decision within 72 hours.	At the time that it is known that the 72 hour timeframe will not be met.	In person or mailed, as appropriate
Failure to provide services **within 14 calendar days** of the start date agreed upon during the person-centered planning and as authorized the by the PIHP/CMHSP	ADEQUATE NOTICE Failure to provide services in 14 days	At the time that it is known that the services will be delayed more than 14 days from the agreed upon start date	In person or mailed, as appropriate
Failure of the PIHP/CMHSP to resolve standard appeals and provide notice **within 30 calendar** days from the date of a request for a standard appeal.	ADEQUATE NOTICE Failure to resolve an appeal request within 30 days.	At the time that it is known that the appeal will be delayed more than 30 calendar days from its receipt	In person or mailed, as appropriate
Failure of the PIHP/CMHSP to resolve expedited appeals and provide notice **within 72 hours** from the date of a request for an expedited appeal.	ADEQUATE NOTICE Failure to resolve an expedited appeal request within 72 hours	At the time that it is known that the expedited appeal will be delayed more than 72 hours from its receipt	In person or mailed, as appropriate
Failure of the PIHP/CMHSP to resolve grievances and provide notice **within 90 calendar days** of the date of the request.	ADEQUATE NOTICE Failure to resolve a Grievance within 90 days	At the time that it is known that the grievance will be delayed more than 90 calendar days from its receipt	In person or mailed, as appropriate
For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right to obtain services outside the network.	ADEQUATE NOTICE Denial to obtain services outside the network	At the time of the action	In person or mailed, as appropriate
Denial of a Medicaid Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles coinsurance and other Enrollee financial responsibility.	ADEQUATE NOTICE Denial of payment	At the time of action	In person or mailed, as appropriate

G&A notice requirements authority: 42CFR Part438 and MDHHS/CMHSP Managed Mental Health Supports and Service Contract P6.3.1.1 Oct 2018 revision 11/2019rr

Northern Lakes Adequate & Advance Notice Requirements

(cont'd Page 2)

Limited Exceptions to Medicaid Advance Notice Rule:

You may provide or mail a notice less than 10 days† before the effective date of action if:

1. You have factual information confirming the death of the consumer/enrollee.
2. You receive a clear written statement signed by the consumer or her legal representative that:
   a. She no longer wishes services; or
   b. Gives information that requires termination or reduction of services and indicates that she understands that this must be the result of supplying that information.
3. The enrollee has been admitted to an institution where she is ineligible under Medicaid for further services.
4. The individual's whereabouts are unknown and the post office returns agency mail directed to her indicating no forwarding address.
5. You establish the fact that the enrollee has been accepted for Medicaid services by another local jurisdiction (CMHSP/PIHP).
6. The individual's physician prescribes a change in the individual's level of medical care.
7. The Notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act.
8. The date of action will occur in less than 10 calendar days.
9. The period of Advance Notice may be shortened to five days before the date of action if you have facts indicating that the action should be taken because of probable fraud by the enrollee and these facts have been verified, if possible, through secondary sources.

† But not after the effective date of the action.

G&A notice requirements authority: 42CFR Part438 and MDHHS/CMHSP Managed Mental Health Supports and Service Contract Attachment P6.3.1.1 Oct 2018 revision 11/2019rr

Time Frames for Providing Notices

Adequate Notice

is handed or mailed to the persons served or applicant **at the time** an action decision is made or at the time that the IPOS has been finalized and authorized.

- Notice Date – the date the Notice is mailed or handed to the person served.
- Effective Date – the same date as the Notice Date.

There are no differences in Adequate Notice date requirements for persons served with Medicaid and Non-Medicaid

NOTE: Medicaid Adequate and Advance Notices are identified as a **"Notice of Adverse Benefit Determination"**

Time Frames for Providing Notices

Advance Notice

is handed or mailed to the person served **before** the action is due to take effect that will affect a person's existing services.

Notice Date – the date the Notice is mailed or handed to the person served.

Effective Date –

1. For **Medicaid** enrollees the Effective date is **10** calendar days after the Notice date

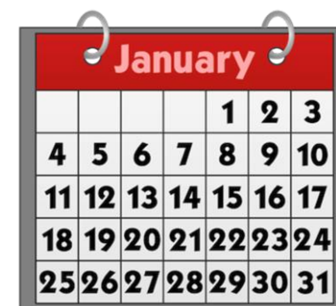
   Example: If the Notice date is January 1, then the Effective date is January 11.

2. For **NON-Medicaid** persons served the Effective date is **30** calendar days after the Notice date.

   Example: If the Notice date is January 1, then the Effective date is January 31.

The elapsed time between Notice date and Effective date allows the person served time to request an appeal:

1. before services are affected, and
2. to request that services continue during the appeal process, if they are a Medicaid enrollee.



Person Centered Planning and Adequate Notice

- When an **Individual Plan of Services** (IPOS) is due to expire, the person served is required to have a Person Centered Planning (PCP) meeting prior to the Plan's expiration date. The IPOS is also called a **Treatment Plan**.

- At the PCP meeting the person served and provider discuss whether the person served has satisfactorily met their goals. If additional services and goals are assessed as being needed and agreed to by both the person served and provider, a new IPOS is developed.

- An **Action Notice** is part of the authorized Treatment Plan. The Notice notifies the person served of their appeal rights if they are not satisfied with the IPOS as completed or revised.

- If a service(s) is not approved or is approved in an amount, scope or duration (level) that is different than what the person served is requesting, an **Adequate** Notice must be provided. The Notice identifies the new service(s) or the new level of an existing service that was requested, but is being denied.

- The IPOS must be clear as to which service(s) was requested but denied; or was authorized at a lesser (or greater) amount, scope or duration than what was requested.

Person Centered Planning and Advance Notice

- If the person served and provider meet and agree that the person's goals have been satisfactorily met, a "Discharge Summary" (in NoLa) is prepared to document this agreement. The Provider ensures that coordination of any necessary outside services takes place.

- If the person served has not participated in a closing meeting, an Advance notice must be mailed to the person served notifying them that their services have been terminated regardless if the IPOS has expired or not and regardless if they made a request to be closed by phone.

- If the person served does not agree to having a service(s) reduced, suspended or terminated, during a PCP/IPOS Meeting, an Advance Notice must be created to provide the person served their Appeal rights. The Notice identifies which existing service(s) the person served does not agree to have reduced, suspended or terminated and the effective date of the action.

- The Effective date should be 10 days (30 days for Non-Medicaid) after the Notice date of the service action. Medicaid beneficiaries can only ask for continuation of their services during an appeal if they request them before the latter of: 1) 10 calendar days from the Notice date; or 2) the intended effective date of the proposed action/Adverse Benefit determination. (See page 25 for more information on continuing services during appeals).

- Medicaid enrollees have 60 calendar days from the date of the Notice to request an appeal. For persons served without Medicaid it is 30 calendar days.

- Notices must be mailed or handed to the person served on the Notice Date.

Before Providing Advance Notice

Before the provider sends out an Advance Notice notifying a person served that their current service(s) will be terminated, they need to ensure that the NLCMHA medical records clearly document and identify why services are being terminated. Some examples may include:

- ❑ Lack of medical necessity for the service as determined by an assessment of the person's needs by a qualified professional.
- ❑ Current institutional residence that prohibits NLCMHA authorization for services.
- ❑ The person served is not participating in services as authorized in their IPOS.
- ❑ The person served has not responded to outreach contacts.
- ❑ Attempts were made to assist with and encourage the person served to follow the goals and receive the services which they requested and were authorized.

NOTE: When a person served is provided notice that their services are being terminated, their case can be closed after the effective date on the Advance Notice, unless they have asked to appeal the termination decision.

Notices: Required Information, Signatures and Dates

There is various information, signatures, and dates required on the Notice of Adverse Benefit Determination:

- **“Name”:** Consumer/enrollee name
- **“Member ID”:** Consumer identification number is required.
- **“Beneficiary ID”:** (if Medicaid enrollee)
- **Notice has been Provided to** information is the name of the person who the notice is given to: person served, guardian, or parent (if minor children).
- **Notice Date** is the date the Notice is provided (handed to or mailed out) to the person served. This date cannot be pre- or post-dated.
- **Mail or Provided** documents how the provider provided notice to the person served.

Note: Only Access staff use the “Denied at Screening” option. Inpatient Hospitalization denials should use the “Denied Inpatient” decision.

Notices: Information (cont'd)

- **Action/decision** (i.e. denied, IPOS completed, terminated etc.) – choose the correct action/decision that has or will occur.

- **Name of Services –** Identify the service(s) and service code for which notice is being given.

- **Effective Date** is the date the action takes place.
  1) On an Adequate Notice the Notice date and Effective date is the same date.
  2) On an Advance Notice the Effective date is 10 calendar days after the Notice date for Medicaid enrollees; thirty (30) calendar days for Non-Medicaid.

- **Reason** is the reason for the action. Use language that is clear and understandable to the person served. Do not use acronyms (i.e. SMI, IPOS, SED, LOCUS)

Note: The Notice must have all fields filled in. Do not send out a Notice that has an "error/NULL" message in it. Re-do the Notice if an "error/NULL" appears.

Notices: Required Information (cont'd)

The **notice of Adverse Benefit Determination (Medicaid)** must meet the following requirements:

1. Enrollee notice must be in writing, and must meet the requirements of 42 CFR 438.10 (i.e., "…manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency);
2. Notification that 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 on utilization control procedures;
3. Description of Adverse Benefit Determination [the service decision made];
4. The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;
5. Notification of the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee's Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);
6. Notification of the Enrollee's right to request an Appeal, including information on exhausting the PIHP's single local appeal process, and the right to request a State Fair Hearing thereafter;
7. Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal;
8. Notification of the Enrollee's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the Enrollee may be required to pay the costs of the continued services (only required when providing "Advance Notice of Adverse Benefit Determination");
9. Description of the procedures that the Enrollee is required to follow in order to exercise any of these rights; and
10. An explanation that the enrollee may represent himself or use legal counsel, a relative, a friend or other spokesperson.

Appeal Process

Notices are mandated documents, notifying persons served of their right to “appeal” an NLCMHA “action” or decision that will affect their current services or request for new or additional services.

Due Process: refers to **legal** protection or rights given to individuals under the law. Due process for persons served includes providing:

1) prior written **notice** of the Action
2) **different levels of appeal** before an impartial decision maker
3) **continued benefits (Medicaid)** pending a final decision
4) a **timely** decision

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Local/Internal Appeals Process – Medicaid

- The first level of appeal for persons served is at the local CMHSP level. Medicaid regulations refers to these as "internal" appeals. Persons served must use the local level process before asking for a state Fair Hearing, also called an Administrative Hearing.
- Persons served have **60** calendar days from the "Notice Date" to request a Medicaid Local Appeal.
- Oral requests for appeals will be accepted and will act as the date the appeal request is officially received. However, the oral request must be followed up in writing with a Request for Local Appeal.
- Appeals are coordinated by the Grievance and Appeal Coordinator in the Customer Services Office.
- Staff can provide persons served with a "Request for Local Appeal" or the Grievance and Appeal (G&A) Coordinator will mail one to them after verbal contact with the person served.

Local/Internal Appeals Process – Medicaid (cont'd)

- The G&A Coordinator will notify the appropriate staff (Supervisor, Operations Manager or Chief Population Officer of the services involved) who will assign a qualified staff person to provide the local appeal review, who
    1. has the appropriate clinical expertise, and
    2. was not part of the original decision process.
- NLCMHA has **30** calendar days from the date the local appeal request was received to provide the person served with a written Notice of Local/Internal Appeal Resolution.
- Requests for expedited appeals will be honored if waiting for a standard time would seriously jeopardize the person's life or ability to attain, maintain or regain maximum function. Expedited appeals, if approved, must be resolved within 72 business hours.
- Persons served can also file a rights complaint in response to actions taken by NLCMHA.
- Applicants to new NLCMHA services do not have rights as recipients to use the Rights process, but they can request a local appeal or second opinion (discussed later).

Fair Hearings - Medicaid

- Persons served with Medicaid have the right to request a Fair Hearing only after utilizing the Internal Appeal process first.
- Persons served can ask for a fair hearing within **120** calendar days from the date of the NLCMHA Notice of Internal Appeal Resolution.
- The NLCMHA Fair Hearing Officer will create a Hearing Summary to submit to the Administrative Tribunal/Administrative Law Judge and to the person served prior to the Hearing.
- The Hearing Summary is based primarily on documentation in the person's NLCMHA medical record.
- Providers may be asked to attend hearings to provide oral testimony.
- Fair Hearings are also referred to as Administrative Hearings and are handled by the Michigan Office of Administrative Hearings & Rules (MOAHR).

Continuation of Services when Advance Notice is given - Medicaid

- If a person served with Medicaid requests an internal appeal on or before the latter of: 1)10 calendar days from the date of the Advance notice, or 2) the intended effective date of the Notice, they may request to continue their services until a decision is provided.

- The person served must be advised at the time the request is made that if the appeal decision is not in their favor, they may be required to pay for those services received during the appeal process.

- If the service(s) is due to expire during the time of the appeal/hearing process, they are not entitled to receive those services beyond the expiration date. This is one reason, an existing IPOS must be reviewed and re-authorization planned (through Person Centered Planning) well in advance of the current IPOS expiring.

- If the services continued during the local appeal process and the person served requests a Fair Hearing, they may ask for the services to continue during the Fair Hearing process as well, if they make the request within 10 days of the date on the Notice of Local/Internal Appeal Resolution.

Local Appeal/Dispute and Alternative Dispute Resolutions
Non-Medicaid

LOCAL APPEAL/DISPUTE RESOLUTION – NLCMHA

- This resolution process is provided for persons served **without Medicaid**
- The persons served must ask for a Local Appeal Resolution before they can request a state-level Alternative Dispute Resolution with MDDHS
- A person served must request a Local Appeal Resolution within **30** days of the Notice date on the Adequate or Advance notice.
- The person served can make an oral request for a Local Appeal Resolution but they must confirm it in writing unless an expedited review is requested and approved.

Local Appeal and Alternative Dispute Resolutions
Non-Medicaid (cont'd)

LOCAL APPEAL RESOLUTION (continued)

- As with Medicaid appeals, the appropriate management staff will assign a qualified staff person to provide the Non-Medicaid local appeal review, who
    1. has the appropriate clinical expertise, and
    2. was not part of the original decision process
- NLCMHA has **45 days** to provide a written response/resolution to the person served based on the findings of the staff doing the Local Appeal review.
- If NLCMHA does not recommend hospitalization and/or an alternative services requested by the person served/guardian, NLCMHA must notify the person served or guardian of the Local Dispute Resolution Process. The Decision from that process must be reached within **3 business days. (C6.3.2.1)**
- Current persons served with or without Medicaid can always file a rights complaint in response to actions taken by NLCMHA. Applicants to new services cannot file a rights complaint.

Local Appeal and Alternative Dispute Resolutions
Non-Medicaid (cont'd)

ALTERNATIVE DISPUTE RESOLUTION –

Michigan Department of Health & Human Services / State-level

- If the person served is not satisfied with the resolution or response to the local appeal, they may ask for a state-level Alternative Dispute Resolution. A local appeal resolution must be requested before requesting the MDHHS Alternative Dispute Resolution.
- The person served has 10 days from receiving NLCMHA's written notice of the Local Dispute Resolution process outcome to request access to the MDHHS Alternative Dispute Resolution process.
- Persons served must make a written request to MDHHS. Instructions on how to access this level of appeal is included on the Non-Medicaid Notices.

Local Appeal and Family Support Subsidy

Recipients (Medicaid or Non-Medicaid) of the **Family Support Subsidy (FSS)** can use the NLCMHA Local Appeal process to appeal FSS decisions (i.e. denial, payback requests, and termination of FSS)

1. Requests must be received within two months (60 calendar days) of the date on the NLCMHA notification letter.
2. The NLCMHA Family Support Subsidy Coordinator notifies the Grievance and Appeal Coordinator when a family requests a local appeal.
3. The NLCMHA Fair Hearing Officer oversees the Local Appeal/Hearing process. The hearing shall be conducted in the same manner as provided for contested case hearings under Chapter 4 of the Administrative Procedures Act of 1969, Act No. 306 of the Public Acts of 1969, being Sections 24.271 to 24.287 of the Michigan Compiled Laws.
4. This is the highest level of appeal/hearing resolution offered to Recipients of FSS. FSS Recipients can go to the Circuit Court in their county of residence if they are not satisfied with the local appeal resolution decision.

Please refer the parent or guardian to the **NLCMHA FSS Coordinator** for any questions. The parent / guardian must notify the FSS Coordinator of any changes in the family's status (i.e. income) or changes in the child's educational status.

Time Frames for Requests and Resolutions of Grievances and Appeals

TYPE of REQUEST	TIMEFRAME for Consumers' Requests	TIMEFRAME for CMH / MAHS/ MDHHS to provide a resolution
MEDICAID		
Grievance P6.3.1.1* (p. 13)	Any time	Within 90 calendar days from receipt of the grievance (orally or in writing) - CMH
Local Appeal P6.3.1.1 (p. 9)	"60 calendar days from the date of the Notice"	Within 30 calendar days from receipt of appeal request (orally or in writing) - CMH
Fair Hearing with the Administrative Tribunal - MAHS P6.3.1.1 (p.15, 26)	"120 calendar days from the date of the applicable [CMH written] notice of [Local Appeal] resolution."	Within 90 calendar days from receipt of hearing request –MOAHR
To request that existing services continue during the Local Appeal/Fair Hearing Process P6.3.1.1 (p. 8)	Local Appeal - on or before the latter of: 1)10 calendar days from the date of the Advance notice /Adverse Benefit Determination , or 2) the intended effective date of the Notice/ABD. Fair Hearing - Within 10 calendar days after CMH sends Notice of Local Appeal Resolution	
NON-MEDICAID		
Grievance C6.3.2.1**	Any time	Within 60 calendar days from receipt of the grievance (orally or in writing) - CMH
Local Appeal / Dispute Resolution C6.3.2.1	"30 days from the time Notice is received."	Within 45 calendar days from receipt of appeal request (orally or in writing) - CMH
Alternative Dispute Resolution with MDHHS C6.3.2.1	"10 days from the [CMH] written notice of the Local Dispute Resolution Process outcome."	"Within 15 business days" from receipt of consumer's written Alternative Dispute Resolution request for review - MDHHS

*P6.3.1.1 – MDHHS Grievance and Appeal Technical Requirement (Medicaid) Oct.2018 Revision
**C6.3.2.1 – MDHHS CMSHP Local Dispute Resolution Process (General Fund/Non-Medicaid)

1/19/18 NLCMH rr

MOAHR – Michigan Office of Administrative Hearings & Rules MDHHS – Michigan Dept. of Health & Human Services

2nd Opinion Rights

The Grievance and Appeals process is required by law for Medicaid enrollees and by contract with MDHHS for persons served without Medicaid. In addition, the Michigan Mental Health Code provides persons served who are denied services in two specific situations the option of requesting a second opinion, which must be:

- Offered orally and in writing at the time of denial of:
    1) An applicant's initial request for CMH services
    2) Request for in-patient hospitalization

- Provided within **5** business days of the person's request; within **3** business days for inpatient hospitalization. Expedited requests must be considered (see next page).

- Completed by a qualified person other than the person who originally denied services. Depending on the service request denied, the person providing the second opinion will be a physician, licensed psychologist, registered professional nurse, master's level social worker or master's level psychologist. Most second opinions for inpatient (hospitalization) service denials are provided by the NLCMHA Medical Director.

Second Opinions (cont'd)

- The decision must be provided both orally and in writing to the person served and must be documented and placed in the person's medical record.
- Requests for expedited reviews (3 business days for services, 24 hours for inpatient hospitalization) will be approved and completed **IF** it is determined that the standard time for resolution could seriously jeopardize the individual's life health or safety, or ability to attain, maintain or regain maximum function.
- A second opinion does not replace the right to file a Local Appeal (Medicaid or non-Medicaid).

NOTE: If a person served/applicant is denied their right to a 2nd opinion, they may file a recipient rights complaint.

Second Opinion rights are based on the following legal requirements:

- Michigan Mental Health Code Act 258 of the Public Acts of 1974 MCL330.1409(4), 1498e(4), 1705
- MDHHS/CMHSP Managed Health Supports and Services Contract, C6.3.2.1
- Northern Lakes CMH Policies 106.106, 106.1001,106.1017, 106.201

Record Keeping

- Fill Notices out completely.
- Make a copy of the Adequate/ABD notice for the medical record if you are providing a Notice that is not created in NoLA (i.e. crisis services contacts).
- The medical record must contain copies of all Notices.
- Record, document, write down and keep accurate and clear records. The records you keep may be used as evidence in an appeal or hearing.
- Error on the side of caution when sending out Notices to consumers - **when in doubt, send it out.**

Where to go for Assistance

- Coordinating Grievances and Appeals is a Customer Services function.

- Your Grievance and Appeals Coordinator is available to help you and to answer your questions.

(231) 876-3246 or toll free (800) 337-8598