PATHWAYS CMH

POLICY TITLE: Grievance and Appeals	**CATEGORY:** Recipient Rights	
EFFECTIVE DATE: June 26, 2002	**BOARD APPROVAL DATE:** April 16, 2014	
REVIEW DATE: April 15, 2017	**REVISION(S) TO POLICY STATEMENT:** ☐ **Yes** ☒ **No**	**OTHER REVISION(S):** ☐ **Yes** ☒ **No**
RESPONSIBLE PARTY: Recipient Rights Supervisor or Designee	**CEO APPROVAL:** Mary J. Swift, CEO	

APPLIES TO:

Employees, volunteers, and contractual providers of Pathways CMH

POLICY:

It is the policy of Pathways that all consumers have the right to a fair and efficient process for resolving complaints regarding their services and supports managed and/or delivered by Pathways. A consumer of, or applicant for, public mental health services may access several options simultaneously to pursue the resolution of complaints. The goal is to create a mechanism for individuals to obtain basic information about their appeal and grievance rights and how they may achieve resolution of service delivery disputes.

PURPOSE:

The purpose of this policy is to define an easily accessible and responsible system to handle consumer appeals and grievances and to promote the resolution of consumer concerns with the goal of improving the quality of care.

DEFINITIONS:

Action for Medicaid Recipients:

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. Denial, in whole or in part, of payment of a service.
4. Failure to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for services.
5. Failure to make an expedited authorization decision within three (3) working days from the date of receipt of a request for expedited service authorization.
6. Failure to provide services within 14 calendar days of the start date agreed upon in the individual plan of service and following authorization by Pathways.
7. Failure of Pathways to act within 45 calendar days from the date of a request for an appeal.
8. Failure of Pathways to act within three (3) working days from the date of a request for an expedited appeal.
9. Failure of Pathways to provide written disposition of a local grievance/complaint within 60 calendar days of the date of the request. (Recipient Rights complaints follow the Michigan Mental Health Code requirements of Chapters 7 & 7A.) Timelines for resolution of grievances/complaints are set forth within this policy. Failure to meet the timelines becomes an action when there is no resolution within 60 days.

Action for a Non-Medicaid Recipient:
1. Initial Denial of access to services or inpatient hospitalization.
2. Reduction, suspension or termination of a previously authorized service.

Advance Notice of Action: Written statement advising the consumer of a decision to reduce, suspend, or terminate services currently provided. Notice to be provided/mailed to the consumer at least 12 calendar days prior to the proposed date the action will take effect.

Adequate Notice of Action: Written statement advising the consumer of a decision to deny or limit authorization of services requested. Notice is provided to the consumer on the same date the action takes effect, or at the time of the signing of the Individual Plan of Service.

Administrative Hearing (State Level): An evidentiary hearing conducted by an Administrative Law Judge with the MDHHS Administrative Hearing System regarding a decision by Pathways to deny, terminate, reduce or suspend a Medicaid covered service or a Habilitation Supports Waiver Service. Also referred to as "Fair Hearing".

Alternative Dispute Resolution Process (State Level): An impartial review, conducted by a MDHHS representative, regarding a decision by Pathways to deny, terminate, reduce or suspend a non-Medicaid covered service or an alternative service paid for by Medicaid Capitated funds but not required to be provided by the State of Michigan Master Contract.

Appeal: Request for a review of an "Action" as defined above.

Authorization of Services: Pathways process for initial and continuing service delivery.

Authorized Representative: The person the consumer selects to represent them during the Grievance and Appeals process.

Beneficiary: An individual who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid Services through NorthCare/Pathways.

Chief Executive Officer: CEO of Pathways.

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by Pathways, including Medicaid beneficiaries, and all other recipients of Pathways services.

Customer Services Complaint: Written or verbal statement by a consumer, or anyone acting on behalf of a consumer expressing dissatisfaction with service issues other than those addressed under Chapter 7 of the Michigan Mental Health Code. (See Customer Services Policy.)

Denial of Service: Denial of initial access to service or to inpatient hospitalization.

Expedited Appeal: The expeditious review of an Action, requested by a consumer or a beneficiary when the time necessary for the normal appeal review process could seriously jeopardize the consumer's life or health or ability to attain, maintain, or regain maximum function. If the consumer requests the expedited review, Pathways determines if the request is warranted.

Fair Hearing: Impartial state level review of a Medicaid beneficiary's appeal of an action presided over by a Department of Health and Human Services (DHHS) Administrative Law Judge. Also referred to as "Administrative Hearing".

Grievance: An expression of dissatisfaction about Pathways' services other than an Action.

Grievance Process: A Grievance may be either a Recipient Rights Complaint or a Customer Services Complaint.

Hearings Coordinator: Individual (or his/her designee) appointed by the CEO to coordinate the Fair Hearing/administrative hearing process.

Local Appeals Process: Impartial local level review of a consumer's appeal of an Action presided over by individuals not involved with decision-making or previous level of review.

Local Dispute Resolution: Pathways process to respond to local Appeals and Grievances.

Medicaid Services: Services provided to a beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Support Waiver, and/or Section 1915 (b)(3) of the Social Security Act.

Recipient Rights Complaint: Written or verbal statement by a consumer, or anyone acting on behalf of the consumer, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

Resolution: Written statement, provided to a consumer, within established time frames relative to Pathways disposition of a Grievance or Appeal.

Second Opinion: The process to address a consumer request for review of denial of initial access to Pathways service or inpatient hospitalization per Chapters 4, 4A, & 7 of the Michigan Mental Health Code. Second opinions occur face to face or through teleconference.

Utilization Review: Pathways process in which established criteria are used to recommend or evaluate services provided in terms of cost-effectiveness, necessity and effective use of resources.

REFERENCES:

MCL 330.1100 et. seq
42 CRF Chapter IV, Subpart E, sections 431.200 *et. seq*
42 CFR Chapter IV, Subpart F, Sections 438.402 to 424
PIHP Grievance System for Medicaid Beneficiaries, Consultative Technical Advisory, July 2004
(Amendment #2 – Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)(c) Waiver Program; Contract Attachment P6.3.2.1
CMHSP Local Dispute Resolution Process (Amendment #1 MDCH/CMHSP Managed Mental Health Supports and Services FY03 through FY05: Contract Attachment C6.3.2.1)
NorthCare Network, Consumer Grievance & Appeal Process, Revised 2/21/05

HISTORY:

Dates Reviewed: May 2008; July 11, 2013; March 3, 2014; November 3, 2014; May 5, 2015; November 19, 2015; April 19, 2016; April 15, 2017
Dates Revised: May 2008; June 2011; July 11, 2013; November 3, 2014; November 19, 2015
Dates Approved: June 26, 2002; April 16, 2014

PROCEDURES:

I. Information Requirements

During the initial contact, the recipient shall be informed of the Grievance and Appeals process and the right to access the process (either orally or in writing), including the ability to express dissatisfaction at any point in services. Pathways staff shall assist individuals with grievances and/or appeals at any point in the process. Individuals will be given assistance in completing forms and taking procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

II. Right to a Chapter 4 and Chapter 7 Second Opinion

When an individual is denied *initial access to services*, or denied *access to inpatient psychiatric hospitalization,* the individual shall be informed of this denial. When inpatient hospitalization is denied, Notice must be given to the individual or his/her guardian or authorized representative at the time of the denial unless specific circumstances dictate otherwise and these circumstances are documented by the clinician. In this situation, the form must be mailed to the individual by the next business day. Pathways staff shall provide instructions on requesting a Second Opinion. If an individual is assessed and found not to be clinically suitable for hospitalization, the preadmission screening unit shall provide information regarding alternative services and the availability of those services, and make appropriate referrals.

A. Denial of Hospitalization

1. If Pathways preadmission screening unit or children's diagnostic and treatment service denies hospitalization, the individual, his/her guardian or his/her parent in the case of a minor child, may request a Second Opinion from the Pathways CEO.

2. The CEO or designee shall arrange for an additional evaluation by a psychiatrist, other physician, or licensed psychologist to be performed within three (3) days, excluding Sundays and legal holidays, after the CEO receives the request for the Second Opinion. If the conclusion of the Second Opinion is different from the conclusion of the preadmission screening unit, the CEO, in conjunction with the Medical Director, shall make a decision based on all clinical information available within one (1) business day.

3. The CEO's decision shall be confirmed in writing within three (3) business days to the individual who requested the Second Opinion. The confirming document shall include the signatures of the CEO and Medical Director or verification that the decision was made in conjunction with the Medical Director.

4. If the request for a Second Opinion is denied, the individual or someone on his/her behalf may file a Recipient Rights Complaint with Pathways Recipient Rights Office.

5. If the initial request for inpatient admission is denied and the individual is a current consumer of other CMHSP services, the individual or someone on his/her behalf is informed that they may file a Recipient Rights Complaint with the Recipient Rights Office alleging a violation of his/her right to treatment suited to condition.

6. If the Second Opinion determines the individual is not clinically suited for hospitalization and the individual is a current consumer of other Pathways services, and a recipient rights complaint has not been filed previously on behalf of the individual, the individual or someone on his/her behalf may file a complaint with the Recipient Rights Office.

7. In the event that a physician or licensed psychologist external to Pathways attests in writing that the individual (applicant or current recipient) meets the definition of an emergency situation as defined in Section 100a (23)(a) or (c) of the Michigan Mental Health Code, Pathways must assess the individual to determine if the individual meets the inpatient admission certification criteria, as defined in the MDCH Service Selection Guidelines. If psychiatric inpatient services are denied, the individual, his/her guardian, or parent in the case of a minor child, must be informed of their right to a Second Opinion.

B. Denial of Access to Community Mental Health Services Program

1. If an initial applicant for Pathways services is denied such services, an appropriate referral may be provided. In addition, the applicant or his/her guardian, or the applicant's parent in the case of a minor, must be informed of their right to request a Second Opinion of the CEO or designee. The request shall be processed in compliance with Section 705 of the Michigan Mental Health Code and must be resolved within five (5) business days.

2. The applicant may not file a Recipient Rights Complaint for denial of services suited to condition, as he/she does not have standing as a recipient of mental health services. He/she, may, however, file a Rights Complaint if the request for a Second Opinion is denied.

C. Denial or Termination of Family Support Subsidy

1. Pursuant to Section 159(3) of the Michigan Mental Health Code: If an application for Family Support Subsidy is denied or a Family Support Subsidy is terminated by Pathways, the parent or legal guardian of the affected eligible minor may demand, in writing, a hearing by Pathways. 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, and being Sections 24.271 to 24.287 of the Michigan Complied Laws.

2. Pursuant to the Administrative Rules: Copies of blank application forms, parent report forms, the forms for changed family circumstances, and appeal forms shall be available from Pathways (R330.1616 Availability of Forms) (NOTE: It is acceptable to ask families to write a letter to Pathways requesting an appeals hearing in lieu of a standardized form.)

3. Pathways shall review an application and promptly approve or deny the application and shall provide written notice to the applicant of its action and of the opportunity to administratively appeal the decision if the decision is to deny the application. If the denial is due to the insufficiency of the information on the application form or the required attachments, Pathways shall identify the insufficiency. (Rule 330.1641 Application Review).

4. If an application is denied or the subsidy terminated, a parent or legal guardian may file an appeal. The appeal shall be in writing and be presented to the community mental health service program within two months of the notice of denial or termination. (R330.1643 Appeal).

5. If an appeals hearing is held at the CMHSP and the presiding officer upholds the family's appeal in violation of Mental Health Code language, MDHHS shall require that the CMHSP reimburse MDHHS the disputed amount.

6. Families wishing to appeal the decision of the CMHSP hearings officer may do so through circuit court in their country of residence.

7. If a CMHSP approves an application in violation of Mental Health Code language or without full documentation proving eligibility, MDHHS shall require that the CMHSP reimburse MDHHS the disputed amount.

III. Dispute Resolution during the PCP Process

A. If the individual requests a specific mental health support or services for which appropriate alternatives for the individual exist that are of equal or greater effectiveness the staff should:

1. Identify and discuss the underlying reasons for the request/preference;
2. Identify and discuss alternatives with the individual; and
3. Negotiate toward a mutually acceptable support, service and/or treatment.

B. In the event that a mutually acceptable alternative cannot be reached, the staff should:

1. Document the individual's preference, the support, service and/or treatment offered and the reason for not accepting that preference;

2. Upon completion of the IPOS, Adequate Notice will be provided. Notice will include:

   a. What Action Pathways has taken or intends to take.
   b. The reason(s) for the Action.
   c. Basic legal authority for an action to place appropriate limits on service based on such criteria as medical necessity or on utilization control procedures.
   d. The right to file an Appeal and instructions for doing so.
   e. The circumstances under which expedited resolution can be requested and instructions for doing so.
   f. An explanation that the recipient may represent him or herself or use legal counsel, a relative, a friend or other spokesman.

IV. Pathways Grievance Process

A. Customer Services/Recipient Rights
A recipient, his/her legal representative may file a grievance either in writing or orally with the Pathways Recipient Rights Office and/or the Customer Service Office. No "Action" as defined in this procedure, on the part of Pathways is required before a recipient or his/her legal representative can file a grievance. Upon receipt of a local Grievance, the Recipient Rights Office/Customer Service Office shall:

1. Log receipt in the ELMER Recipient Rights Database or Customer Service Database;
2. Acknowledge receipt of complaint;
3. Process the Grievance within the Standards of Chapters 7 & 7A of the Michigan Mental Health Code and Pathways Recipient Rights policies if a mental health code-protected right is involved.
4. Process the Grievance through Customer Services for managing Consumer Grievances/Complaints that do not involve a mental health code-protected right. While not responsible for resolving the complaint, Customer Services is responsible for referring the complaint to the proper department (or person) and making sure the issue is resolved within 60 days.

B. Local Appeal Process for Persons *With* Medicaid

1. The beneficiary has 45 calendar days from the date of the Notice of Action to request a Local Appeal.
2. A request for a Local Appeal shall be made through the Office of Recipient Rights.
3. An oral request for a Local Appeal of an Action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the beneficiary requests an expedited appeal.
4. Pathways will give beneficiaries reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
5. Pathways must reinstate the Medicaid services until a disposition of the Appeal if the beneficiary or representative requests a Local Appeal not more than 12 calendar days from the date of the Advance Notice.
6. The Office of Recipient Rights shall:
    a. Log receipt of the Local Appeal request for reporting to NorthCare Recipient rights/Appeal Database and
    b. Send an acknowledgment letter within five (5) days of receipt of Local Appeal request;
    c. Submit the Local Appeal to the appropriate staff, including the administrator or designee with the authority to require corrective action, all of whom were not involved in the initial determination to deny, suspend, terminate, or reduce the service;
7. Pathways' Administrator will
    a. Provide the appellant a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. If the appellant has requested an expedited resolution, staff shall inform the appellant of the limited time available to present evidence.
    b. Provide the appellant or his/her representative opportunity, before and during the appeals process, to examine the appellant's case file including medical records, and any other documents and records considered during the appeals process.
    c. Facilitate resolution of the appeal within ten (10) calendar days of receipt; assure an expedited review of a local appeal involving an emergent situation where the standard ten (10) calendar day time frame would seriously jeopardize the health or life of the individual. Such a review shall be completed within three (3) working days of receipt of appeal.
8. If Pathways denies a request for an expedited resolution of an Appeal it must:
    a. Transfer the Appeal to the ten (10) calendar day time frame;
    b. Make reasonable efforts to give the beneficiary prompt oral notice of the denial, and
    c. Give the beneficiary follow up written notice within two (2) calendar days.
9. Within the three (3) working days or ten (10) calendar day time frame, Pathways administrator or designee will provide the individual, guardian, or parent of a minor child or his/her legal representative, a written resolution. For expedited Appeals, Pathways will make reasonable efforts to provide oral communication of the decision.
10. The written resolution shall include:
    a. The results of the Appeal and the date completed;
    b. An explanation of the individual, guardian, or parent of a minor child or his/her legal representative's rights to request a MDHHS administrative hearing and an offer of assistance in filing the request;
    c. For appeals resolved not wholly in favor of the recipient, the written resolution must include:
        i. The right to request a Fair Hearing and how to do so;
        ii. The right to request to receive benefits while the Fair Hearing is pending – this request must be made within twelve (12) days of the mailing of the written resolution.
        iii. Information on how to make the request;
        iv. Information that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds Pathways action.

v. For appeals resolved to the satisfaction of the recipient, an explanation and offer of assistance to withdraw any Fair Hearing request;
vi. Information on the individual, guardian, or parent of a minor child or his/her legal representative's right to file a Recipient Rights complaint with the Recipient Rights Office alleging a violation of the consumer's right to treatment suited to his/her condition.
vi. Pathways may extend time frames for the disposition of the local appeal by up to fourteen (14) days if:

1. The recipient requests the extension;
2. Pathways shows (to the satisfaction of MDHHS, upon its request) that there is need for additional information on how this is in the recipient's interest.

C. In handling beneficiary grievances and appeals, decision making shall include:

1. Individuals who were not involved in any previous level of review or decision making; and
2. If deciding any of the following, are health care professionals who have the appropriate clinical expertise, in treating the enrollee's condition or disease:

    a. An appeal of a denial that is based on lack of medical necessity.
    b. A grievance regarding denial or expedited resolution of an appeal.
    c. A grievance or appeal that involves clinical issues.

D. Local Appeal Process for Persons *Without* Medicaid

1. The individual, guardian, or parent of a minor child or his/her legal representative may dispute the determination to suspend, terminate, or reduce services by filing an oral and/or written request for a Local Appeal with the Pathways Recipient Rights Office within forty-five (45) days of receipt of Notice of Action (either Advance or Adequate).

2. The Recipient Rights Office shall then:

    a. Log receipt of the Local Appeal request in the NorthCare Recipient Rights/Appeals Database and send an acknowledgment letter to the appellant within five (5) days of receipt.

    b. Submit the Local Appeal to the appropriate administrator or designee with the authority to require corrective action, none of whom shall have been involved in the initial determination.

3. The Administrator shall:

    a. Facilitate resolution of the dispute within ten (10) calendar days of receipt.

    b. Assure an expedited review of the appeal involving an emergent situation where the standard ten (10) day time frame would seriously jeopardize the individual's health or safety; such a review shall be completed within three (3) business days of receipt of all necessary information by relevant Pathways services staff involved in the dispute resolution process.

4. The Administrator or designee shall provide the written resolution to the individual, guardian, or parent of a minor child.

5. The written resolution shall include:

a. Information regarding the individual, guardian, or parent of a minor child's ability to access the MDCH Alternative Dispute Resolution Process and an offer of assistance in doing this;

b. Information on the individual, guardian, or parent of a minor child or his/her legal representative's right to file a Recipient Rights complaint with the Recipient Rights Office alleging a violation of the consumer's right to treatment suited to his/her condition.

V. MDHHS Alternative Dispute Resolution Process

A. In the event that the individual utilizes the Local Dispute Resolution Process or the second opinion processes, Pathways must communicate in writing the outcome of that process to the individual. That communication must include notification to the individual of their ability to request access to the MDCH Alternative Dispute Resolution Process by sending such request to:

Michigan Department of Health and Human Services
Division of Program Development, Consultation and Contracts
Bureau of Community Mental Health Services
ATTN: Request for DHHS Level Dispute Resolution
Lewis Cass Building – 5th Floor
320 Walnut St.
Lansing, MI 48913

B. The individual has 10 days from the written notice of the Local Dispute Resolution Process outcome to request access to the MDHHS Alternative Dispute Resolution Process.

C. MDCH shall review all requests within two business days after receipt. An MDHHS representative shall attempt to resolve the issue with the individual and the CMHSP within 15 business days.

D. Requests may be received in any written form, but must include the following information:

1. Name of the consumer;
2. Name of guardian legally empowered to make treatment decisions or a parent of a minor child.
3. Daytime phone number where the consumer, legal guardian, or parent of a minor child may be reached.
4. Name of the CMHSP where services have been denied, suspended, reduced or terminated;
5. Description of the service being denied, suspended, reduced or terminated;
6. Description of the adverse impact on the consumer caused by the denial, suspension, reduction or termination of service.
7. If the recipient requests assistance with filing, Pathways Office of Recipient Rights will:
   a. Provide information about the process for filing;
   b. Offer to assist the individual with filing;
   c. On the day the request for Alternative Dispute Resolution is received:
      i. Date stamp the request.
      ii. Fax the request to MDHHS
      iii. Mail the request to MDHHS
      iv. Log the request in the NorthCare/Pathways Recipient Rights/Appeals Database;
      v. Forward a copy of the request to the Pathways Hearing Coordinator.

VI. Medicaid Consumer Right to Administrative Hearing

A. All Medicaid beneficiaries are told of their right to an Administrative Hearing if they are dissatisfied at any point with the mental health services or supports they are receiving. Pathways may not limit or interfere with a beneficiary's freedom to make a request for a Fair Hearing.

B. MDHHS Administrative Hearing

After receiving Notice of An Action (see definition of Action), or if the consumer disagrees with the Individual Plan of Service, a Medicaid consumer or his/her authorized representative may:

1. Submit a Request for Administrative Hearing (Fair Hearing) within ninety (90) calendar days from the date of the Notice with the MDHHS and/or;

2. Request a Local Appeal within forty-five (45) calendar days from the date of the Notice of Action and/or;

3. File a Complaint with either the Office of Recipient Rights or Customer Services.

    a. The Office of Recipient Rights will:

        i. Provide information about the process for filing, the time frames, the circumstances where services will be continued until a hearing decision is rendered, and the process for withdrawing a hearing request;

        ii. Offer to assist the individual with filing a hearing request;

        iii. On the day the hearing request is made or received:

            a. Date the request;
            b. Fax the request to MDHHS
            c. Mail the request to MDHHS;
            d. Forward a copy of the request to the Hearings Coordinator
            e. Forward a copy to the responsible Administrator
            f. Log the request in the NorthCare Recipient Rights Appeal Database;

        iv. Maintain an accurate, secure record system for Requests for Administrative Hearings (NorthCare Recipient Rights Appeals Database);

        v. Notify the appropriate Administrator that services must be continued for twelve (12) calendar days from the date of the Advance Notice of the Action;

        vi. Notify the appropriate Office Manager that a room and appropriate equipment for the hearing must be scheduled.

B. The Hearing Coordinator will:
    i. Offer a pre-hearing conference to the consumer to see if the issues can be resolved;
    ii. Prepare a Hearing Summary and documents to be used as evidence during the hearing and submit this to MDHHS.

C. Maintaining Services and Supports
Pathways must continue Medicaid services previously authorized while the Local Appeal and/or Fair Hearing are pending if:

1. The beneficiary specifically requests to have the services continued, and
2. The Appeal is filed within 12 calendar days; and
3. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, and
4. The original period covered by the original authorization has not expired.

D. When Pathways continues or reinstates the Medicaid services while an appeal is pending, the services must be continued until one of the following occurs:
   1. The Beneficiary withdraws the appeal;
   2. Twelve (12) calendar days pass after Pathways mails the written resolution of a Local Appeal, unless the beneficiary, within the twelve (12) day time frame, has requested a Fair Hearing.
   3. The Michigan Administrative Hearing System issues a Fair Hearing decision adverse to the Beneficiary.

E. If Pathways or the MDHHS Fair Hearing Administrative Law Judge reverses a decision to deny authorization of services, and the Beneficiary received the disputed services while the Appeal was pending, Pathways or the State must pay for those services in accordance with State policy and regulations.

F. If Pathways or the MDHHS Fair Hearing Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, Pathways must authorize or provide the disputed services promptly, and as expeditiously as the Beneficiary's health condition requires.

VII. Notice Requirements and Table

   A. Adequate Notice Requirements:
      1. Must be mailed not later than the date of the Action;
      2. State what Action the agency intends to take;
      3. State the reasons for the intended Action;
      4. For denial of services, explain the primary reasons why the requested service is not medically necessary. State that, upon request, the specific reasons why a denial was issued (clinical rational) will be provided in writing;
      5. Give an explanation of the individual's right to request a Fair Hearing and how to access it;
      6. Give an explanation of the individual's right to request a Local Appeal and how to access it, and;
      7. State that the individual may represent him/herself or use legal counsel, a relative, a friend or other spokesperson.

B. Advance Notice Requirements:
   1. Whenever services are suspended, reduced, or terminated as a result of the Utilization Review function or outside of a negotiated Individual Plan of Service, Pathways will issue an Advance Notice of Action to the affected consumer.

   2. Advance Notice will be mailed at least twelve (12) calendar days before the date of the Action (except as permitted under the "exception" section) and must include:
      a. What Action Pathways has taken or intends to take.
      b. The reason(s) for the Action,
      c. 42CFR 440.230(d) is the basic legal authority for an action to place appropriate limits on a Medicaid service based on such criteria as medical necessity or on utilization control procedures,

d. The consumer's right to file a Local Appeal, and instructions for doing so;
e. The Beneficiary's right to request a State Fair Hearing, and instructions for doing so,
f. The circumstances under which expedited resolution can be requested, and instructions for doing so,
g. An explanation that the consumer may represent himself or use legal counsel, a relative, a friend or other spokesperson,
h. The circumstances under which the Beneficiary may be required to pay the costs of these services.

3. Exceptions to the provision of Advance Notice of Action – Pathways may mail an Adequate Notice, no later than date of Action if:
   a. Pathways has factual information confirming the death of the consumer.
   b. Pathways receives a clear written statement signed by the recipient that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she is ineligible under Medicaid for further services
   c. The Beneficiary has been admitted to an institution where he/she is ineligible under Medicaid for further services.
   d. The Beneficiary's whereabouts are unknown and the Post Office returns Pathways mail directed to him/her indicating no forwarding address.
   e. Pathways establishes the fact that the Beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
   f. A change in the level of medical care is prescribed by the Beneficiary's physician.
   g. The date of the Action will occur in less than ten (10) calendar days.

C. Table

Action	Type of Notice	Time Frame for Notice
Denial of Initial Service Request	Adequate	At the time of denial
IPOS developed	Adequate	At the time of authorization
Increase in Benefits	Adequate	At the time of the action
Reduction, suspension or termination of service currently being received	Advance	12 Calendar days before action
Standard authorization decision that denies or limits services	Adequate	Within 14 calendar days of request*
Expedited authorization decision that denies or limits services requested	Adequate	Within 3 working days of request*

*If Pathways is unable to complete either a standard or expedited service authorization to deny or limit services within the time frame requirement, the time frame may be extended up to an additional fourteen (14) calendar days.

If Pathways extends the time frame, it must:

Give the Beneficiary written notice, no later than the date the current time frame expires, of the reason for the decision to extend the time frame and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision; and

Issue and carry out its determination as expeditiously as the Beneficiary's health condition requires, and no later than the date the extension expires.

VIII. Record Keeping and Reporting Requirements
Pathways must maintain a record of appeals and grievances and their disposition that is available for review by state officials and must report all occurrences to appropriate NorthCare and Pathways Committees.

IX. MI Health Link Enrollees
MI Health Link is a program that joins Medicare and Medicaid benefits, rules, and payments into one coordinated delivery system. For MI Health Link enrollees, all existing Medicare and Medicaid grievance and appeal rights are available. Michigan Department of Health and Human Services (MDHHS) and Centers for Medicare and Medicaid Services (CMS) developed a process that gives enrollees protections from both the Medicare and Medicaid programs.

The MI Health Link Ombudsman Program is an available resource for MI Health Link enrollees. The program provides advocacy for enrollees needing assistance with access to services, billing issues, quality of supports and services and other issues by working with the MI Health Link health plans, the Pre-paid Inpatient Health Plans for behavioral health services, and MDHHS for problem resolution. Enrollees can contact the MI Health Link Ombudsman Program by calling 888-746-6456. Inquires may also be directed to: http://mhlo.org/

Notices:
When a required Medicare service(s), including those services covered by Medicare and Medicaid is denied, in whole or in part, the enrollee must be provided a Notice of Denial of Medical Coverage (Attachment A). This notice must also be provided to the enrollee when a previously authorized service(s) is reduced or terminated.

When an enrollee requests a Medicare service(s) and a coverage decision is not made within the required time frame for standard or expedited requests, the enrollee must be provided with a Notice of Our Failure to Make a Coverage Decision, (Attachment B).

When an Action is being taken on a service(s) covered only by Medicaid, Pathways will issue the standard notice (Adequate Notice/Advanced Notice) to the affected consumer (See Section VII. Notice Requirements and Table).

Appeal Rights:
An enrollee has **60 calendar days** from the date of the Notice of Denial of Medical Coverage/Notice of Our Failure to Make a Coverage Decision to request a local level appeal or Internal Appeal. A request for an appeal must include the following information in writing:

- Consumer's name

- Address
- MCO Number
- Reasons for Appealing
- Any evidence that the consumer wants reviewed as part of the appeal such as medical records, doctors' letters, or other information that explains why the consumer needs the item(s) or service(s).

A Pathways Administrator or Designee, who was not involved in the initial authorization decision will provide the enrollee a written decision (Notice of Appeal Decision) on an appeal within **30 calendar days** after receiving the request. An expedited appeal can be requested by the enrollee if the consumer's health could be seriously harmed by waiting the standard 30 calendar days for a decision. Expedited appeals will be completed within **72 hours**. Before or during the appeal, an enrollee can ask to see the medical records and other documents that Pathways used to make their decision. If the enrollee's appeal is denied, or partially denied, the reason(s) for the denial will be provided.

When Internal Appeals for **Medicare** covered services are resolved not wholly in favor of the consumer, the appeal will automatically be sent to the Medicare Independent Review Entity (IRE) for an External Appeal. The IRE will respond to the appeal within 30 calendar days.

When Internal Appeals for service(s) covered by **both Medicare and Medicaid** are resolved not wholly in favor of the consumer, the appeal will automatically be sent to the IRE for an External Appeal. In addition, the enrollee can request a Medicaid Fair Hearing with the Michigan Administrative Hearing System (See Section VI. Medicaid Consumer Right to Administrative Hearing). This must be done within 90 days from the date of the initial notice.

For appeals requested on a service(s) covered only by Medicaid, Pathways will follow the standard Medicaid appeal process (See Section IV. Pathways Grievance Process)

Continuation of Services:
When an enrollee's previously authorized service(s) covered by Medicare, including those services covered by Medicare and Medicaid is terminated or reduced, the service will continue during the appeals process as long as the appeal is filed within 12 calendar days from the date of the notice. The service(s) will continue until on one of the following occurs:

1. The enrollee withdraws the appeal
2. All of the entities that received the appeal respond with a decision to uphold the initial authorization decision
3. The authorization period for the service(s) expires

For continuation of an authorized service(s) covered only by Medicaid, see Section VI. C, Maintaining Services and Supports.

Notice of Denial of Medical Coverage

{Replace *Denial of Medical Coverage* with *Denial of Payment*, if applicable}

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Mailing Date: <Mailing Date>

Member/Beneficiary ID: <Member's Medicaid ID Number>

Name: <Member's Name>

Type of Service Subject to Notice: ☐ **Medicare** ☐ **Medicaid** ☐ **Medicare/Medicaid Overlap Service**

Your request was denied

We [*Insert appropriate term:* denied, stopped, reduced, suspended] the {*payment of*} medical services/items listed below requested by you or your doctor {*provider*}:

Why did we deny your request?

We [*Insert appropriate term:* denied, stopped, reduced, suspended] the {*payment of*} services/items listed above because: [*Include citations with descriptions that are understandable to the member, of applicable State and Federal rule, law, and regulation that support the action. Plans may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.*]

You have the right to appeal our decision

You have the right to ask NorthCare Network MI Health Link to review our decision by asking us for an internal appeal. You may also request a Fair Hearing regarding a Medicaid covered service before, during, after, or instead of filing an internal appeal with us. The process is described later in this notice.

Internal Appeal: Ask NorthCare Network MI Health Link for an internal appeal within **60 calendar days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

> *If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed.* ***If you want the service to continue while your case is under review, you must ask for an appeal within 12 calendar days*** *of the date of this notice or before the service is stopped or reduced, whichever is later.*

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-888-333-8030 to learn how to name your representative. TTY users call 711. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us.

Important Information About Your Appeal Rights

There are 2 kinds of internal appeals

Standard Appeal – We'll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 calendar days**.

Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 calendar days for a decision.

We'll automatically give you a fast appeal if a doctor asks for one for you or supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 calendar days.

How to ask for an internal appeal with NorthCare Network MI Health Link

Step 1: You, your representative, or your doctor {*provider*} must ask us for an internal appeal. Your request must include:

- Your name
- Address
- Member number

- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal.

For a Standard Appeal: Address: 200 West Spring Street, Suite 2, Marquette, MI 49855
Fax: 1-906-225-5149

For a Fast Appeal: Phone: 1-888-333-8030 Fax: 906-225-5149

What happens next?

If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we'll send you a written decision. The letter will tell you if the service or item is usually covered by Medicare and/or Medicaid.

- If the service is covered by Medicare, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, you will receive a written decision that will explain if you have additional appeal rights.
- If the service is covered by Medicaid, you can ask for a Fair Hearing if you haven't already done so. Your written decision will give you instructions on how to request a Fair Hearing. Information about the Fair Hearing process is also below.
- If the service could be covered by both Medicare and Medicaid, we will automatically send your case to an independent reviewer. You can also ask for a Fair Hearing.

How to ask for a Medicaid Fair Hearing

You do not have to file an internal appeal with the plan before requesting a Fair Hearing. You can request a Fair Hearing at the same time as you file an internal appeal, after filing an internal appeal, or instead of filing an internal appeal.

You have 90 calendar days from date of this notice to request the hearing. **If you want the service to continue while your case is under review, you must ask for a Fair Hearing within 12 calendar days** of the date of this notice or before the service is stopped or reduced, whichever is later.

A Request for Hearing form is included with this letter. It also has instructions that you should review.

Step 1: You, your representative, or your doctor {*provider*} must ask for a Fair Hearing. Your written

request must include:

- Your name
- Address
- Member number
- Reasons for requesting a Fair Hearing
- Any evidence you want the Administrative Law Judge to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Step 2: Send your request to: Address: Michigan Administrative Hearing System (MAHS)
PO Box 30763
Lansing, MI 48909

Phone: 1-877-833-0870 Fax: 517-373-4147

What happens next?

The Michigan Administrative Hearing System (MAHS) will schedule a hearing. You will receive a written "Notice of Hearing" telling you the date and time. Most hearings are held by telephone, but you can request to have a hearing in person. During the hearing, you'll be asked to tell an Administrative Law Judge why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision within 90 calendar days from the date your Request for Hearing was received by MAHS. The written decision will explain if you have additional appeal rights.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for an expedited (fast) Fair Hearing. Your request must be in writing and clearly state that you are asking for a fast Fair Hearing. Your request can be mailed or faxed to MAHS at 517-373-4147. If you qualify for an expedited Fair Hearing, MAHS must give you an answer within 72 hours. However, if MAHS needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions about the Fair Hearings process, including the expedited (fast) Fair Hearing, you can call MAHS at 1-877-833-0870.

{A copy of this notice has been sent to:}

Get help & more information

- NorthCare Network MI Health Link Toll Free: 1-888-333-8030 TTY users call: 711
  Monday through Friday 8:00 a.m. – 5:00 p.m. Eastern Time
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116
- MI Health Link Ombudsman Program: 1-877-349-9324 (TTY 711)

- Michigan Medicare/Medicaid Assistance Program (MMAP): 1-800-803-7174
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

NorthCare Network is a behavioral health plan that subcontracts with the Upper Peninsula Health Plan, which is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.

You can speak with someone about getting this information in other languages. Call 1-888-33-8030 (TTY: 711). The call is free.

Usted puede hablar con alguien acerca de cómo obtener esta información en otros idiomas. Llame 1-888-333-8030 (TTY 711). La llamada es gratuita.

يمكنك التحدث إلى أحد ما بشأن الحصول على هذه المعلومات بلغات أخرى. اتصل بـ 1-888-333-8030 (مستخدمي أجهزة الهواتف النصية (TTY): 711). إن المكالمة مجانية.

This information is available for free in other languages and formats like Braille or audio CD.

Notice of Our Failure to Make a Coverage Decision
NorthCare Network MI Health Link

Important: We did not respond to your request for coverage within the required time period. This notice explains your right to appeal our failure to respond. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Mailing Date: <Mailing Date> **Member/Beneficiary ID:** <Member's Medicaid ID Number>

Name: <Member's Name>

Type of Service Subject to Notice: ☐ **Medicare** ☐ **Medicaid** ☐ **Medicare/Medicaid Overlap Service**

We did not make a decision on your request

NorthCare Network MI Health Link received your request for coverage on <enter date received>. As of the date of this notice, we have not made a decision on the services/items listed below requested by you or your doctor {*provider*}:

You have the right to appeal our failure to decide

According to federal regulations, we must make a coverage decision within 14 calendar days for standard requests and 72 hours for expedited requests (with a possible 14 calendar day extension). Our failure to make a timely decision is considered a denial of coverage. You have the right to appeal this denial by asking us for an internal appeal. You may also request a Fair Hearing regarding a Medicaid covered service before, during, after, or instead of filing an internal appeal with us. The process is described later in this notice.

Internal Appeal: Ask NorthCare Network MI Health Link for an internal appeal within **60 calendar days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-888-333-8030 to learn how to name your representative. TTY users call 711. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us.

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- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

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- If the service is covered by Medicare, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, you will receive a written decision that will explain if you have additional appeal rights.
- If the service is covered by Medicaid, you can ask for a Fair Hearing if you haven't already done so. Your written decision will give you instructions on how to request a Fair Hearing. Information about the Fair Hearing process is also below.
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