PATHWAYS CMH

POLICY TITLE: Grievance and Appeals	**CATEGORY:** Recipient Rights	
EFFECTIVE DATE: June 26, 2002	**BOARD APPROVAL DATE:** April 16, 2014	
REVIEW DATE: May 28, 2020	**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 recipients have the right to a fair and efficient process for resolving complaints regarding their services and supports managed and/or delivered by Pathways. A recipient 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 recipient appeals and grievances and to promote the resolution of recipient concerns with the goal of improving the quality of care.

DEFINITIONS:

Adverse Benefit Determination for Medicaid Recipients: A decision that adversely impacts Medicaid Enrollee's claim for services due to:

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 for 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 seventy- two (72) hours 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 30 calendar days from the date of a request for a Local Appeal.
8. Failure of Pathways to act within seventy- two (72) hours from the date of a request for an expedited Local Appeal.
9. Failure of Pathways to provide written disposition of a local grievance/complaint within 90 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 90 days.

10. For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network. 42 CFR 438.400(b)(6).
11. 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).

Adverse Benefit Determination for a Non-Medicaid Recipient:
1. Decision to deny initial access to services or inpatient hospitalization.
2. Decision to reduce, suspend, or terminate a previously authorized service.

Advance Notice of Adverse Benefit Determination: Written statement advising the recipient of a decision to reduce, suspend, or terminate services currently provided.
For Medicaid recipients: notice is to be provided/mailed to the recipient at least 10 calendar days prior to the proposed date the action will take effect.
For Non-Medicaid recipients: notice is to be provided/mailed at least 30 calendar days prior to the proposed day the action is to take place, with the exception of services authorized by a physician that no longer meet established medical necessity.

Adequate Notice of Adverse Benefit Determination: Written statement advising the recipient of a decision to deny or limit authorization of services requested. Notice is provided to the recipient on the same date the action takes effect, or at the time of the signing of the Individual Plan of Service or Amendment when a requested service has been denied, in whole or in part (amount, scope, or duration).

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 "Adverse Benefit Determination" as defined above.

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

Authorized Representative: The person the recipient 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 recipient, or anyone acting on behalf of a recipient expressing dissatisfaction with service issues other than those addressed under Chapter 7 of the Michigan Mental Health Code.

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

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by a recipient or a Medicaid Enrollee's provider when the time necessary for the normal appeal review process could seriously jeopardize the recipient's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the recipient requests the expedited review, Pathways determines if the request is warranted. If the Enrollee's provider makes the request, or supports the Enrollee's request, Pathways must grant the request.

Fair Hearing: Impartial state level review of a Medicaid beneficiary's appeal of an Adverse Benefit Determination 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 Adverse Benefit Determination.

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 recipient's appeal of an Adverse Benefit Determination 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.

Mediation: a confidential process in which a neutral third party facilitates communication between parties, assists in identifying issues, and helps explore solutions to promote a mutually acceptable resolution. A mediator does not have authoritative decision-making power.

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 recipient, or anyone acting on behalf of the recipient, 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 recipient, within established time frames relative to Pathways disposition of a Grievance or Appeal.

Second Opinion: The process to address a recipient's 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
Grievance and Appeals Technical Requirement PIHP Grievance and Appeal System for Medicaid for Medicaid Beneficiaries October 2017; MDHHS/CMHSP Managed Mental Health Supports and Services FY 17, Attachment C6.3.2.1, Amendment 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; May 31, 2018; July 6, 2018; May 3, 2020; May 28, 2020
Dates Revised: May 2008; June 2011; July 11, 2013; November 3, 2014; November 19, 2015; May 31, 2018; July 6, 2018; May 3, 2020 (procedures); May 28, 2020 (procedures)
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 recipient 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 recipient 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. Right to Request and Access Mediation

1. Persuant to Section 206a of the Michigan Mental Health Code, a recipient or his or her individual representative (recipient's legal guardian, minor recipient's parent, or other person authorized by law to represent the recipient in decision-making related to the recipient's services and supports) must be offered an opportunity to request mediation to resolve a dispute between the recipient or his or her individual representative and the community mental health services program or other service provider under contract with the community mental health services program related to planning and providing services or supports to the recipient. The community mental health services program or service provider must participate in mediation if mediation is requested.

1. Pathways shall provide notice to a recipient, or his or her individual representative, of the right to request and access mediation at the time services or supports are initiated and at least annually after that. When a local dispute resolution process, local appeals process, or state Medicaid fair hearing is requested, notification of the right to request mediation must also be provided to the recipient or his or her individual representative.

2. A mediator must be an individual trained in effective mediation technique and mediator standard of conduct. A mediator must be knowledgeable in the laws, regulations, and administrative practices relating to providing behavioral health services and supports. The mediator must not be involved in any manner with the dispute or with providing services or supports to the recipient.

3. A request for mediation must be recorded by a mediation organization after a request for mediation has been made by a recipient or his or her individual representative or received by Pathways or a service provider under contract with Pathways. Mediation must begin within 10 business days after the recording. Mediation does not prevent a recipient or his or her individual representative from using another available dispute resolution option, including, but not limited to local dispute resolution process, the local appeals process, the state Medicaid fair hearing, or filing a recipient rights complaint. A mediation organization shall ascertain if an alternative dispute resolution process is currently ongoing and notify the process administrator of the request for mediation. The parties may agree to voluntarily suspend other dispute resolution processes, unless prohibited by law or precluded by a report of an apparent or suspected violation of rights delineated in chapter 7.

4. Mediation must be completed within 30 days after the date the mediation was recorded unless the parties agree in writing to extend the mediation period for up to an additional 30 days. The mediation process must not exceed 60 days.

5. If the dispute is resolved through the mediation process, the mediator shall prepare a legally binding document that includes the terms of the agreement. The document must be signed by the recipient or individual representative and a party with the authority to bind the service provider according to the terms of the agreement. The mediator must provide a copy of the signed document to all parties within 10 business days after the end of the mediation process. The signed document is enforceable in any court of competent jurisdiction in this state.

6. If the dispute is not resolved through the mediation process, the mediator must prepare a document that indicates the dispute could not be resolved. The mediator shall provide a copy of the document to all parties within 10 business days after the end of the mediation process.

7. A contracted mediation organization must provide a report with aggregate data and a summary of outcomes to the department every 6 months, or as the department considers appropriate, to review and evaluate the effectiveness and efficiency of mediation in resolving disputes relating to planning and providing services and supports by the community mental health services program and its service providers.

IV. 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 of Adverse Benefit Determination will be provided if a service requested by the recipient has been denied, in whole or in part (amount, scope, or duration). Notice will include:
   a. What Action Pathways has taken or intends to take.
   b. The reason(s) for the Action.
   c. Basic legal authority used in making the determination
   d. The right to request 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.

V. 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 "Adverse Benefit Determination" as defined in this policy 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 90 days.

B. Local Appeal Process for Persons *With* Medicaid

1. The beneficiary has 60 calendar days from the date of the Notice of Adverse Benefit Determination 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 Adverse Benefit Determination 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 Enrollees 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 files a request for a Local Appeal and for continuation of benefits not more than 10 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) business days of receipt; assure an expedited review of a local appeal involving an emergent situation where the standard ten (10) business day time frame would seriously jeopardize the health or life of the individual. Such a review shall be completed within seventy-two (72) hours 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) business 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 seventy-two (72) hours or ten (10) business 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 ten (10) calendar 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 the Adverse Benefit Determination made by Pathways.
        v. 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 recipient'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) calendar 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 sixty (60) days of receipt of Notice of Adverse Benefit Determination (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) business days of receipt.

b. Assure an expedited review of the appeal involving an emergent situation where the standard ten (10) business day time frame would seriously jeopardize the individual's health or safety; such a review shall be completed within 72 hours 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 MDHHS 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 recipient's right to treatment suited to his/her condition.

VI. 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 MDHHS 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 recipient, 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.

VII. State Fair Hearing Appeal Process for Medicaid Recipients

A. Federal regulations provide an Enrollee the right to an impartial review by a state level administrative law judge in certain circumstances:

   1. After receiving notice that, as resolution of a Local Appeal, Pathways is upholding an Adverse Benefit Determination. Enrollees are given 120 calendar days from the date of the resolution notice to file a request for a State Fair Hearing.

   2. When Pathways fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals.

B. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the Enrollee, free to the Enrollee, independent of the State and Pathways, and not extend any timeframes or disrupt continuation of benefits).

C. Pathways may not limit or interfere with an Enrollee's freedom to make a request for a State Fair Hearing.

D. If the Enrollee's services were reduced, terminated, or suspended without Advance notice, Pathways must reinstate services to the level before the effective date of the Adverse Benefit Determination.

E. The Parties to the State Fair Hearing include Pathways, the enrollee and his or her representative, or the representative of a deceased Enrollee's estate. A Recipient Rights Coordinator shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.

F. Expedited hearings are available.

G. The Office of Recipient Rights or Customer Services 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 Office Manager that a room and appropriate equipment for the hearing must be scheduled.

H. 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.

VIII. Continuing or Reinstating Medicaid Services

A. Pathways must continue Medicaid services previously authorized to a Medicaid Enrollee while the Appeal is pending if:
   1. The beneficiary specifically requests to have the services continued, and
   2. The request for a Local Appeal and for continuation of benefits is filed within 10 calendar days from the date of the notice; 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.

B. 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 Enrollee withdraws the appeal;
   2. The Enrollee fails to request a State Fair Hearing and continuation of services within 10 calendar days from the date of the written resolution of the Local Appeal;
   3. The Michigan Administrative Hearing System issues a Fair Hearing decision adverse to the Beneficiary.

C. If the final resolution of the Appeal or State Fair Hearing upholds Pathways' decision to reduce, suspend, or terminate a service, Pathways may recover the cost of services furnished to the Enrollee while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements. 42 CFR 438.420(d).

D. If the Enrollee's services were reduced, terminated or suspended without an advance notice, Pathways must reinstate services to the level before the effective date of the action of the Adverse Benefit Determination.

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 Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

IX. 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 and the policy/authority relied upon in making the determination;
   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. Provide notification of the individual's right to request a Local Appeal and how to access it;
   6. Provide notification that after exhausting the local appeal process, the person has the right to request a state level hearing (for Medicaid Enrollees, a State Fair Hearing; for persons without Medicaid, the MDHHS Alternative Dispute Resolution Process).
   7. Description of the circumstances under which an appeal can be expedited, and how to request an expedited appeal.
   8. 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 Adverse Benefit Determination to the affected recipient.

   2. For Persons *without* Medicaid, Advance Notice is to be provided/mailed **at least 30 calendar days prior** to the proposed day the action is to take place, with the exception of services authorized by a physician that no longer meet established medical necessity. For Persons with Medicaid, Advance Notice is to be provided/mailed at least **ten (10) calendar days** prior to the proposed effective date of the Action (except as permitted under the "exception" section).

   Advance Notice of Adverse Benefit Determination must include the following:
      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 request an appeal, including information on exhausting the local appeal process, and the right to request a state level appeal (for Medicaid Enrollees, a State Fair Hearing; for persons without Medicaid, the MDHHS Alternative Dispute Resolution Process) thereafter, 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 consumer may represent him/herself or use legal counsel, a relative, a friend or other spokesperson,
g. For Medicaid Enrollees, notification of the person's right to have benefits continue pending resolution of the appeal, instructions on how to request benefit continuation, and a description of the circumstances under which the Enrollee may be required to pay the costs of the continued services.

3. Exceptions to the provision of Advance Notice of Adverse Benefit Determination:
Pathways may mail an Adequate Notice, no later than date of action if:
a. Pathways has factual information confirming the death of the recipient.
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 Enrollee has been admitted to an institution where he/she is ineligible under Medicaid for further services.
d. The Enrollee'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 Enrollee 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 Enrollee's physician.
g. The date of the action will occur in less than ten (10) calendar days.
h. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act.
i. Pathways has facts (preferably verified through secondary sources) indicating that action should be taken because of possible fraud by the Enrollee (in this case, Pathways may shorten the period of advance notice to 5 days before the date of action).

C. Person Responsible for the Provision of Notice:
Notice of a decision to limit or deny a requested service or to suspend, reduce, or terminate a currently authorized service, shall be provided by the appropriately credentialed staff person responsible for the decision. Persons responsible for the provision of notice shall be as follows:

Adverse Benefit Determination:	**Notice Provided By:**
Denial of Initial Service Request	Intake Clinician
Denial of Hospitalization	ES Clinician
Denial of a requested service, in whole or in part (amount, scope, or duration), at the time the IPOS/Amendment is developed.	Clinician
Denial of Medical Services Referral	Medical Director
Denial of Medication Adherence Program	Nursing Supervisor
Denial of Behavior Management Services	Behavior Psychology Services Supervisor

Authorization decision that denies or limits services	Utilization Manager
Suspension, reduction, or termination of services based on a Utilization Review	Utilization Manager
Denial of Specialty Support services (Speech Therapy, Dietary, Occupational Therapy, Physical Therapy)	DDA Supervisor-Marquette

D. Table: Type of Notice and Timeframe for Notice

Adverse Benefit Determination	Type of Notice	Time Frame for Notice
Denial of Initial Service Request	Adequate	At the time of denial
Denial of a requested service, in whole or in part (amount, scope, or duration), at the time the IPOS/Amendment is developed.	Adequate	At the time of authorization
Reduction, suspension or termination of service currently authorized	Advance	**Medicaid Recipients:** 10 calendar days before action **Non-Medicaid Recipients:** 30 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 72 hours 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.

X. 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.

XI. MI Health Link Enrollees

MI Health Link is a program that allows individuals who have both full Medicare and full Medicaid to receive coordinated care. Individuals who have MI Health Link have the right of choose any provider that is an approved MI Health Link provider through The Upper Peninsula Health Plan (UPHP).

- MI Health Link Enrollees who do not meet criteria for Specialized Mental Health Services can request outpatient mental health services at Pathways within the Mild/Moderate benefit package. The Mild/Moderate mental health benefit is managed by NorthCare. All authorization for services are approved/denied by NorthCare. Only Electroconvulsive Therapy (ECT) requires prior authorization. If NorthCare denies payment for a service, NorthCare will provide the individual a MI Health Link Notice of Denial of Medical Coverage. Pathways does not provide notices to those being served within the Mild/Moderate benefit.

- For MI Health Link Enrollees who meet criteria for Specialized Mental Health Services, all prior authorization decisions are approved/denied by Pathways. When an adverse benefit determination is made involving a Medicaid covered service (including services covered by both Medicaid and Medicare), Pathways will provide the enrollee a standard Medicaid notice. Enrollees have the right to appeal an adverse benefit determination by accessing the appeal processes available to Medicaid recipients. MI Health Link notices or Medicare notices are not generated by Pathways.

Non- Medicaid Notices and Appeals

Advance Notice of Adverse Benefit Determination: Provided/mailed to recipient at least 30 calendar days prior to proposed date of action, with the exception of services authorized by a physician that no longer meet established medical necessity.

Adequate Notice of Adverse Benefit Determination: Provided on the same date the action takes effect (for denial of access to services or denial of hospitalization, the person can also request a Second Opinion).

Within 60 days

Request a Local Appeal

Pathways has 10 business days to complete the appeal (72-hours for an expedited appeal). Written resolution of the appeal will be sent to the recipient.

Resolved wholly in favor of the recipient

Resolved not wholly in favor of the recipient

Within 10 days

Access MDHHS Alternative Dispute Resolution:

MDHHS will attempt to resolve within 15 business days.

Medicaid Notices and Appeals

Advance Notice of Adverse Benefit Determination: Provided/mailed to recipient at least 10 calendar days prior to proposed date of action. *For services to continue pending appeal, the person must file a Local Appeal and request continuation of services within 10 days from the date of the notice.

Adequate Notice of Adverse Benefit Determination: Provided on the same date the action takes effect (for denial of access to services or denial of hospitalization, the person can also request a Second Opinion).