Grievance, Appeals, 2nd Opinions and Adverse Benefit Determinations

May 2024

What is Customer Service?

Customer Service is a series of activities designed to enhance the level of Customer satisfaction - that is conveying an atmosphere that is welcoming, helpful, and informative.

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

Who Are Our Customers?

- Individuals Receiving Services
  - Developmental Disabilities
  - Mental Illness
  - Severe Emotional Disturbances
  - Substance Use Disorder
- Parents/Family members
- Staff members
- Contracted Providers
- Community members/stakeholders
- Everyone who walks through the door

A Welcoming Environment

Webster's definition: wel·come *verb* \ˈwel-kəm\

: to greet (someone) in a warm and friendly manner

: to receive or accept (something) with happiness or pleasure

- Provide empathy and acceptance
- Being mindful of body language, attitude, and words
  - Pay attention to how you are saying things
  - Make eye contact and smile
  - Actively listen
  - Be present. Give them your full attention
- Being helpful

Grievance and Appeal System

Grievance System Overview

Grievance and Appeal System is the process SWMBH and CMHs implement to handle complaints and appeals of Adverse Benefit Determinations (ABDs). This also includes the processes to collect and track information about grievances and appeals.

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

Grievances and Appeals

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

- **Appeal** – complaint regarding an action taken regarding services based on an Adverse Benefit Determination (ABD) notice. Actions are denials, suspensions, reductions, or terminations. Appeals are directed to Customer Service.

- **Grievance** - complaint filed by customer regarding anything other than an Adverse Benefit Determination. Grievances are directed to Customer Service.

How do we inform Customers?

- At initiation/orientation to services
  - SWMBH Customer Handbook
  - Recipient Rights booklets
- Annually
  - Handbooks/brochures
  - As documented in Individual Plans of Service
- If a service action is taken
  - Adverse Benefit Determinations
- When requested of any staff
- When calling Customer Service or Recipient Rights offices
- Via posters in common areas of service sites

Grievance Examples

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

Grievance Process

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

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

Grievance Processing

Mental Health (CMH)

- Local CMH processes Grievances
- Assist customer with filing grievance
- Response is usually due within 90 days
- Ensure staff processing the grievance were not involved in the situation the grievance is about
- Customer Service will provide written resolution for each grievance
- Keep written records of grievances filed

SUD Providers (SWMBH)

- SWMBH processes Substance Use Disorder Grievances for:
  - CMHs who are not sub-capitated
  - Other contracted SUD providers
    - Outpatient
    - Residential
    - Recovery Houses
    - Medication Assisted Treatment (MAT) providers

Appeals

Reason for Appeals

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

Types of Appeals

- Local Appeal
- Administrative Fair Hearing (State)
- MDHHS Alternative Dispute Resolution Process (State)

Appeals and Timeframes

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

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

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

Filing an Appeal

- May be filed by customer, guardian, parent of a minor, or an authorized representative within 60 days of the Adverse Benefit Determination (ABD)
  - Providers can file on behalf only with written permission from the customer, guardian, or parent of a minor.
- An Appeal may be filed over the phone, in person, or in writing
- Filed locally at CMHSP or regionally through SWMBH, depending on who sent the original ABD.
- Customers may request an expedited appeal – 72 actual hours
- Contact Customer Service for State Fair Hearing Request Form

Continuation of Services

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

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

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

Appeals Processing

Mental Health (CMH)

- Local CMH processes appeals
- Assists Customer to file appeal
- Issues appeal resolution within 30 days (72 hours for expedited)
- Assures that the appeal reviewer was not involved in initial decision to take the Action, nor a subordinate of such individual
- Makes sure the clinical reviewer has the appropriate experience and credentials to make a decision about the service(s) in question
- Provides a copy of case file documents relevant to the appeal to the customer/representative.
- Provides written resolution for each appeal filed
- Keeps written records of appeals filed and resolved.

SUD Providers (SWMBH)

- SWMBH processes Substance Use Disorder Appeals for:
  - CMHs who are not sub-capitated
  - Other contracted SUD providers
    - Outpatient
    - Residential
    - Recovery Houses
    - Medication Assisted Treatment providers

Southwest Michigan
BEHAVIORAL HEALTH

SECOND OPINION RIGHTS

11/1/2023

What are Second Opinions?

Second Opinions Definition: The process for having a second qualified person (clinician, doctor) assess a case to determine if they agree with the opinion or recommendation of the original staff.

Where do Second Opinion Rights come from?

- Federal
  - Code of Federal Regulations
    - 42CFR 438.206 (b) (3)
- State
  - Michigan Mental Health Code
    - MCL 330.1705
    - MCL 330.1409
- Regional
  - SWMBH Policy 6.4 Customer Appeal System

Mental Health Code
Access Second Opinions

- If denied mental health services (front door/access denial)
- Second Opinion requests are filed by customer, guardian, or parent of a minor
- Second Opinion is completed by a “physician, licensed psychologist, registered professional nurse, or master’s level social work, or master’s level psychologist”
- If customer is found to have a serious mental illness, serious emotional disturbance, or a developmental disability, or is experiencing an emergency/urgent situation, the CMH agency will direct services to the customer.

Mental Health Code
IP Psych Hospital 2nd Opinions

- If denied Inpatient Psychiatric Hospital Admission
- Must be performed within 3 days of the request for second opinion (excluding Sundays and legal holidays)
- Completed by psychiatrist, other physician, or licensed psychologist.
- If second opinion differs from original denial:
  - Executive Director and Medical Director of the CMH agency will make a decision based on available clinical information.
  - Decision will be confirmed in writing to the customer.
    - Written decision must include signatures of executive director and medical director (or verified that medical director was consulted)
- If second opinion agrees with original denial, CMH agency will provide information to customer regarding alternative services and referrals.

Code of Federal Regulations

- Each PIHP/region must: Provide for a second opinion from a network provider or arrange for the customer to obtain one outside the network, at no cost to the customer.

- Regionally, these additional requests for a Second Opinion could include matters such as and may be connected to a filed grievance:
  - Diagnoses
  - Medications
  - Plan of care – such as type of therapy, treatment modalities, etc.

State Level Appeals

Administrative Fair Hearings

MDHHS Alternative Dispute Resolutions

Administrative Fair Hearing

- Impartial state level review of a local appeal denial, presided over by an Administrative Law Judge.
- Medicaid Customers
- Available after Local Appeal is Denied or not resolved timely.
- Customers must file within 120 days of the resolution letter.
- For continuation of services, file within 10 calendar days and request that services continue.
- Instructions for how to ask for this process are included with the Appeal Denial Letter.
  - Customers can name a formal representative for the hearing and submit evidence or testimony for review.
- ***Managed by SWMBH***

MDHHS Alternative Dispute Resolution Process

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

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

Customer Engagement

- How can we keep customers positively engaged?
  - Involve the customer in decisions about their services and supports
  - Discuss other support or service alternatives when services requested do not match the customer's assessed needs
  - Ask the customer regularly if they are satisfied with services and work with them to address areas of improvement
  - Review the Plan of Service with the customer to make sure the goals and objectives are appropriate and meet customer expectations
  - Encourage customers to speak with Customer Service staff so we can track any complaints they have and help to improve areas of concern.

Adverse Benefit Determinations (ABD)

ABD Definition

A decision that adversely impacts a Medicaid beneficiary's claim for services due to:

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning.
- Failure to make a standard authorization decision and provide notice within 14 calendar days from the date of receipt of a standard request for service.
  - Failure to make an expedited authorization decision within 72 hours from the date of receipt of a request for expedited authorization.
- Failure to act within 30 calendar days from the date of a request for a standard appeal.
  - Failure to act within 72 hours from the date of a request for an expedited appeal.

MDHHS G&A Technical Requirement and 42CFR 438.400, 438.210(d), 438.408 (b)

How are customers notified?

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

Timeframes

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

- Adequate Notice – provided at the time of the decision
  - For standard authorization denials or partial denials – within 14 calendar days of the initial request for authorization.
  - For expedited authorization denials or partial denials – within 72 hours of the expedited request for authorization.
  - For denial of payment – provided at the time of the decision to deny payment for a service.
  - Failure to meet timeframes for starting services, making an authorization decision, or completing appeals process.

Exceptions to Advanced Notice

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

Adequate Notice (Denials)

- When is expedited appropriate?
  - For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

42 CFR 438.210(d)(2)

Denial Timeframe Extension

- SWMBH/CMHs may be able to extend the standard (14 calendar day) or expedited (72 hour) Service Authorization timeframes for up to an additional 14 calendar days if:
  - The member requests the extension, or
  - If SWMBH/CMH can show that there is a need for additional information and the extension is in the member's best interest

If SWMBH/CMHs extend the time NOT at the request of the Enrollee, we must:

- Make reasonable efforts to give the member prompt oral notice of the delay
- Within 2 calendar days, provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he/she disagrees with that decision; and
- Issue and carry out the determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

MDHHS G&A Technical Requirement
42CFR 438.210 (d) and 438.404 (c) (4).

Check Your Funding Source

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

Medical Necessity Decision Makers

- Who can make full/partial authorization denials?
  - Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.
- Document the Decision Maker(s) in your electronic record.

42CFR 438.210 (b) (3)

Medical Necessity Criteria

- Medicaid Provider Manual
  - Provides specific guidance for approval of services such as ACT, Respite, CLS, Case Management, ABA, Waivers (HSW, SEDW)
- Michigan Mental Health Code
- MIChild Provider Manual
- MDHHS Administrative Rules: non-Medicaid
- Michigan Public Health Code: non-Medicaid
- American Society of Addiction Medicine (ASAM)
- Milliman Care Guidelines (MCG)
- Level of Care Utilization System (LOCUS)
- Agency Policies for multiple no-shows

MDHHS Access Standards (Standard IV)
ASAM, MCG, LOCUS

THE ABD TEMPLATE

ABD Static Template Content

- Notification of the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits).
- Notification of the Enrollee's right to request an Appeal, including information on exhausting the PIHPs Appeal process, and the right to request a State Fair Hearing thereafter.
- Description of the circumstances under which an Appeal can be expedited, and how to request an expedited Appeal.
- Notification of the Enrollee's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation (liability of cost language may need to be added separately)
- Description of the procedures that the Enrollee is required to follow to exercise any of these rights.
- An explanation that the Enrollee may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman.

G&A Technical Requirement and 42CFR 438.404 (a)-(b)

Required Content

- Description of Adverse Benefit Determination.
  - What is happening? When will it happen?
  - What service is affected?
    - Use Medicaid service type on ABD, not local program name
- The reason(s) for the Adverse Benefit Determination
  - Why is this happening?
- Policy/authority relied upon in making the determination.

Also, if applicable:

- Notification that 42 CFR 440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. (*only added for medical necessity decisions*).
- Notice that the member may be required to pay the cost of continued services if requested during an appeal (*only for Advanced ABDs where the member is currently receiving services*)

MDHHS G&A Technical Requirement and 42CFR 438.404 (a)-(b)

Required Format

- The Enrollee notice must be in writing and must meet the requirements of 42 CFR 438.10 (i.e., "…manner and format that may be easily understood and is readily accessible by such Enrollees and potential Enrollees" and meets the needs of those with limited English proficiency and/or limited reading proficiency).

- Hints:
  - Letters must be professional, grammatically correct, free of errors, and fully completed
  - Use consistent font type and size
  - Have abbreviations spelled out with first use
  - Written to the member ("you", "your")
  - Align with MDHHS template
  - 6.9 grade reading level for narrative content (excluding service types and clinical terms necessary)

MDHHS Contract General Requirements: M2; MDHHS G&A Technical Requirement and 42CFR 438.404 (a)-(b)

6.9 Grade Level

Simple words

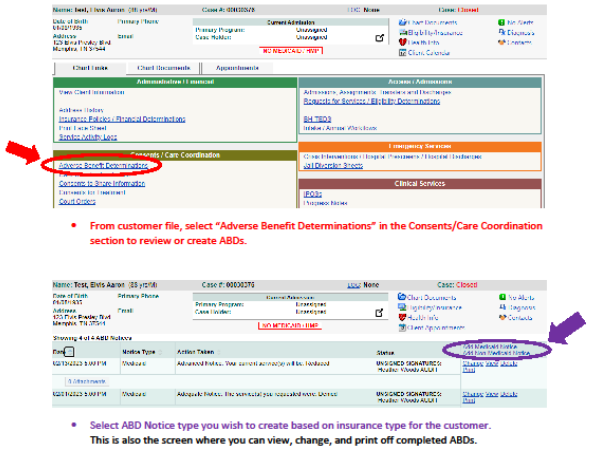
Instead of Terminate, Suspend, and Reduce

- We are **ending** your case management services.
- We are **pausing** your community living support services.
- We are **lowering** your outpatient therapy services.

Completing the ABD document

- Double click on image below for walkthrough of an ABD in PCE
  (PowerPoint must not be in presentation mode for link to open)

PCE ABD Walkthrough



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Provide Notice of Adverse Benefit Determination

- All Adverse Benefit Determinations should be addressed/written to:
  - The Customer
  - Customer's Legal Guardian (if applicable)
  - Customer's parent (if a minor child)
- Whenever mailed, Notice should be sent to the last known address on file for the Customer, Legal Guardian or Parent (whoever has legal authority to make treatment decisions)
- If a provider asks for approval of authorization on behalf of customer, ensure the provider agency also receives notice of the decision.

For more information

- Southwest Michigan Behavioral Health
  - Customer Handbook
  - Customer Service Policies (6.1-6.10)
- MDHHS PIHP/Contract
- MDHHS Customer Service Standards
- MDHHS Appeal and Grievance Technical Requirement
- Michigan Mental Health Code
- Code of Federal Regulations (42CFR 438)

Customer Service Contacts

- Barry
  - Tina Williams
  - 269-948-8041
- Berrien/Riverwood
  - Leanne Adams
  - 866-729-8716
- Branch/Pines
  - Kammy Ladd
  - 866-877-4636
- Calhoun/Summit Pointe
  - Amy Vincent
  - 877-275-5887
- Cass/Woodlands
  - Regina Wolverton
  - 800-323-0335
- Kalamazoo
  - Teresa Lewis
  - 877-553-7160
- St. Joseph/Pivotal
  - Michelle Crittenden
  - 855-203-1730
- Van Buren
  - Sandy Thompson
  - 269-657-5574

Southwest Michigan
BEHAVIORAL HEALTH

Thank-you

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customerservice@swmbh.org