HEALTHWEST

POLICY AND PROCEDURE

No. 04-023

Prepared By:

Customer Services Department

Effective: October 1, 1998
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Approved By:

Julia Rupp, Executive Director

Subject: Resolution of Complaints, Disputes and Grievances

I. POLICY

HealthWest will provide for a fair and efficient process for resolving disputes and grievances related to reduction, suspension, termination or denial of covered services, as well as all other non-Medicaid grievances.

II. PURPOSE

To ensure all individuals receiving services from HealthWest have a right to a fair and efficient process for resolving grievances and disputes. This policy in no way requires the exhaustion of grievance or alternative dispute resolution processes prior to the filing of a Recipient Rights complaint, pursuant to Chapter 7 and 7a of the Mental Health Code and HealthWest policies related to the filing of Recipient Rights complaints.

III. APPLICATION

All programs, services, and facilities directly operated by or under contract with HealthWest.

IV. DEFINITIONS

A. Adequate notice: Written statement advising the individual of a decision to deny or limit authorization of Medicaid services requested. Notice to the individual must be provided on the same date as the Adverse Benefit Determination takes effect.

B. Advance notice: Written statement advising an individual of a decision to reduce, suspend, or terminate Medicaid services currently provided. Notice must be provided or mailed at least ten (10) calendar days prior to the proposed date the Adverse Benefit Determination is to take effect.

C. Action Or Adverse Benefit Determination: A decision that adversely impacts a Medicaid participants claim for services due to:

1. Denial or limited authorization of a requested Medicaid or non-Medicaid service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

2. Reduction, suspension, or termination of a previously authorized service.

3. Denial, in whole or in part, of payment for a covered service.

4. Failure to make an authorization decision, whether standard or expedited, and provide notice about the decision within standard time frames.

5. Failure to provide services within fourteen (14) calendar days of the start date agreed upon during the person centered planning process and as authorized.

6. In regard to Medicaid covered services, failure of HealthWest to act within the time frames required for resolution of grievances and appeals.

D. Appeal: A review at the local level of an Adverse Benefit Determination.

E. Dispute Resolution: A local appeal for non-Medicaid consumers of an Adverse Benefit Determination.

F. Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by an individual, the individual's provider (as permitted by legal requirements), or the individual's legal representative, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the individual's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the individual or individual's legal representative requests an expedited review, the PIHP determines if the request is warranted. If the individual's provider makes the request, or supports the individual's request, the PIHP must grant the request.

G. Grievance: An expression of dissatisfaction about any matter relative to a covered service, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the individual.

H. Grievance Process: Impartial local level review of a grievance (expression of dissatisfaction) about service issues other than an Adverse Benefit Determination.

I. Grievance System: Federal terminology for the overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process.

J. Local Appeal Process: Impartial local level PIHP review of an individual's appeal of an action presided over by individuals not involved with decision-making or previous level of review.

K. Medicaid Covered Service: Services provided to an individual under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

L. Michigan Administrative Hearing System (MAHS): Independent agency within the Michigan Department of Licensing and Regulatory Affairs that hears contested matters for agencies within state government.

M. Notice of Disposition: Written statement of the decision for each local appeal and/or grievance provided to an individual.

N. Notice of Resolution: Written statement of the PIHP of the resolution of a Grievance or Appeal.

O. Reasonable Person: A phrase frequently used in Tort and Criminal Law to denote a hypothetical person in society who exercises average care, skill, and judgment in conduct and who serves as a comparative standard for determining liability.

P. Recipient Rights Complaint: A written or verbal statement by an individual or anyone acting on behalf of an individual alleging a violation of a Code-protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

Q. State Fair Hearing: Impartial state level review of an Appeal of an Adverse Benefit Determination presided over by an MDHHS Administrative Law Judge. May also be referred to as an "Administrative Hearing."

V. PROCEDURE

A. Notice is given any time there is an Adverse Benefit Determination, as defined above, that must be in writing and must be provided in the language format needed by the individual to understand the content (i.e., the format meets the needs of those with limited English proficiency, and/or limited reading proficiency).

B. Actions and Timeframes for Adverse Benefit Determination not related to second opinions:

Action	Type of Notice	Time frame for Notice
Denial of service request	Adequate	At the time of decision
Person-Centered Plan developed	Adequate	At the time of plan development
Increase in benefits	Adequate	At the time of the action
Reduction, suspension or termination of service currently being received (Medicaid Recipients)	Advance	Ten (10) calendar days before Adverse Benefit Determination
Reduction, suspension or termination of service currently being received (Non-Medicaid Recipients)±	Advance	Thirty (30) calendar days before the Adverse Benefit Determination
Standard authorization decision that denies or limits services requested	Adequate	Within fourteen (14) calendar days from the date of receipt of a request, excluding the conditions noted in V.B.1.a-b below.
Expedited authorization decision that denies or limits services requested	Adequate	Within 72 hours from the date of receipt of a request, excluding the conditions noted in V.B.1.a-b below.

1. Exceptions to the Adequate Notice Rule: HealthWest may extend the Standard Service Authorization timeframe under the following circumstances:

    a. At the request of the individual, or
    b. If the PIHP/HealthWest shows to the satisfaction of the State there is need for additional information and how the delay is in the individual's best interest.

2. Exceptions to the Advance Notice Rule: HealthWest may mail a notice later than the date of action to terminate, suspend, or reduce previously authorized services if:

    a. It has factual information confirming the death of the individual.
    b. The PIHP/HealthWest receives a clear written statement signed by the individual or his/her legal representative that:

        i. He/she no longer wishes services, or
        ii. Gives information that requires termination or reduction of services and indicates that he/she understands this must be the result of services.

    c. The individual has been admitted to an institution where he/she is ineligible for further Medicaid services.
    d. The individual's whereabouts are unknown and the post office returns agency mail with no forwarding address.
    e. It is established that the individual 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 individual's physician.
    g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act.
    h. The date of action will occur in less than ten (10) calendar days.
    i. There are known facts indicating that action should be taken because of possible fraud by the individual, in which case the advance notice period may be shortened to five (5) days before the intended date of action.

3. The written notice of action or Adverse Benefit Determination must contain the following:

    a. The action that has been or will be taken.
    b. The reason for the action.
    c. The date the action or intended action is to take effect.
    d. If access to services or hospitalization is denied, the individual's right to request a second opinion and an explanation of how to initiate that process.
    e. The individual's right to file an appeal, dispute, and/or rights complaint, as defined above, and the time frames for doing so.
    f. The procedures for exercising the resolution options.
    g. The circumstances under which expedited resolution is available and how such a request can be made.

h. In regard to Medicaid covered services, the individual's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the individual may be required to pay the costs of these services. The notice must specify that if the individual requests a local appeal prior to the date of action (i.e., suspension, reduction, or termination of a Medicaid covered service), in most circumstances HealthWest may not reduce, suspend, or terminate the services until a decision is rendered after the hearing.

4. Notices of Adverse Benefit Determination must be provided to:

a. The individual in written notice.
b. The requesting provider, when a decision to deny a Service Authorization request or authorize service in an amount, scope, or duration that is less than requested. Notice to the provider does not need to be provided in writing.

C. Appeal Rights and Processes

1. An individual who wishes to challenge an Adverse Benefit Determination will be provided reasonable assistance in completing forms and taking other procedural steps to access the Local Appeal and State Fair Hearing processes. This includes, but is not limited to, auxiliary aides and services upon request, such as interpreter services and toll free numbers with adequate TTY/TTD and interpreter capabilities.

2. Medicaid Services Continuation

a. If the an Appeal involves the termination, suspension, or reduction of previously authorized services, the benefits must continue at the level authorized prior to the Adverse Benefit Determination until resolution has been reached, if all of the following criteria have been met:

i. The individual files the request for Appeal within sixty (60) calendar days from the date of the Adverse Benefit Determination.
ii. The individual files the request for continuation of benefits on or before:

(a) Ten (10) calendar days from the date of the notice of Adverse Benefit Determination, or
(b) The intended effective date of the proposed Adverse Benefit Determination, and
(c) The period covered by the original authorization has not expired.

b. Any benefits that have been continued or reinstated, at the individual's request, while the Appeal or State Fair Hearing is pending, must continue until one of the following occurs:

i. The individual withdraws the Appeal or request for State Fair Hearing.

ii. The individual fails to request a State Fair Hearing and continuation of benefits within ten (10) calendar days after the PIHP issues notice of an adverse resolution to the individual's Appeal.
iii. A State Fair Hearing office issues a decision adverse to the individual.

c. If the final resolution of the Appeal or State Fair Hearing upholds the PIHP's Adverse Benefit Determination, the PIHP may, within the limits of usual policies regarding recovery and as specified in the PIHP contract, recover the cost of services furnished while the Appeal and State Fair Hearing was pending.

d. If an Adverse Benefit Determination involving a denial, limitation, or delay of services is reversed, either through Appeal or State Fair Hearing, and the individual received a continuation of benefits, those benefits must be covered in accordance with State policy and regulations.

e. If an Adverse Benefit Determination involving a denial, limitation, or delay of services is reversed, either through Appeal or State Fair Hearing, and a continuation of benefits was not granted, those services must be authorized and provided as expeditiously as the individual's health conditions requires.

3. The PIHP/HealthWest shall assure the following:

a. Individuals completing Appeal decisions were not involved in any previous level of review or decision-making, or were a subordinate of any such individual.

b. Appropriate clinical expertise, as determined by the State, is involved in either:

i. Clinical issues, or
ii. A denial based on lack of medical necessity.

c. Individuals completing Appeal decisions account for all comments, documents, records, and other information submitted by the individual or their representative, as defined above, without regard to whether such information was submitted or considered as part of the initial Adverse Benefit Determination.

4. An individual will be given a reasonable opportunity to present evidence, testimony, and allegations of fact or law in person and in writing, and be informed of the limited time available for this sufficiently in advance of the resolution time frame for Appeals.

5. The individual and/or his/her representative will be provided the individual's case file, including medical records or other documentation or records considered or generated in connection with the Appeal of an Adverse Benefit

Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for Appeals.

6. Opportunity to include as parties to the Appeal the individual and his/her representative or the legal representative of a deceased individual's estate.

7. Information shall be given with regard to the right to request a State Fair Hearing and the process to request one, should there be an adverse resolution to the Local Appeal.

8. With the written consent of the individual, the individual's provider may, acting on the individual's behalf, may file an Appeal or Grievance to the PIHP, or request a State Fair Hearing if the local Appeal processes has been exhausted. In this circumstance, the PIHP/HealthWest shall ensure:

   a. That no punitive action is taken against a provider who acts on the individual's behalf with written consent to do so.

   b. The requesting provider will be given notice of any decision that denies a service authorization request or to authorize a service in an amount, duration, and scope that is less than requested. This notice does not need to be in writing.

D. Appeals and Grievance Resolution Processes

Action	Local Processes	Level
Denial of request for hospitalization	Step 1. Request a 2nd Opinion Step 2: Request Local Appeal Step 3. Request State Fair Hearing	HealthWest PIHP State/MDHHS
Denial of access to PIHP/CMHSP services	Step 1. Request a 2nd Opinion Step 2: Request Local Appeal Step 3. Request State Fair Hearing	HealthWest PIHP State/MDHHS
Denial, reduction, suspension, termination, or unreasonable delay of Medicaid services.	Step 1: Request Local Appeal Step 2. Request State Fair Hearing	PIHP State/MDHHS
Denial of Family Support Subsidy	Step 1. Appeal to CMHSP Step 2: Alternative Dispute Resolution Process	HealthWest State/MDHHS

1. Appeal Resolution and Timing Requirements

    a. Standard Appeal Resolution: The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the individual's health condition requires, but not exceed thirty (30) calendar days from the day the PIHP receives the Appeal.

    b. Expedited Appeal Resolution: If the individual or his/her legal representative believes the Standard Appeal Resolution timeframe could seriously jeopardize the individual's life, physical or mental health, or ability to attain, maintain, or regain maximum function, then they may request that an Appeal Resolution be granted, giving the PIHP no more than 72 hours from the date of the request for expedited resolution to resolve the Appeal and provide notice to affected parties.

    c. If a PIHP denies such a request, then:

        i. The appeal timeframe must be transferred to a Standard Appeal resolution, and the resolution must be reached and notice given as expeditiously as possible, but not to exceed thirty (30) days,
        ii. The PIHP must make reasonable efforts to orally notify the individual of the denial, and provide written notice of the denial and reasons for the denial within two (2) calendar days, and
        iii. Provide information on the right to file a Grievance if they disagree with the decision.

    d. The PIHP may extend the resolution and notice timeframe by up to fourteen (14) calendar days if the individual or his/her representative requests and extension, or if the PIHP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the individual's interest. Under these circumstances, the PIHP must:

        i. Make reasonable effort to give the individual prompt oral notice of the delay.
        ii. Within two (2) calendar days, give the individual written notice of the reason for the decision to extend the timeframe.
        iii. Provide information on the right to file a Grievance if they disagree with the decision.
        iv. Resolve the Appeal as expeditiously as the individual's health conditions requires and not later than the date the extension expires.

    e. HealthWest shall work in partnership with the PIHP to ensure that Notices of Resolution provided within the requirements of this policy will conform to the established standards of MDHHS.

2. Procedure for Second Opinions

    a. Denial of Hospitalization

i. If a Pre-Admission Screening Unit or Children's Diagnostic and Treatment Service of the Affiliate 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 Executive Director of HealthWest.

ii. The request for the second opinion shall be processed in compliance with Sections 409(4), 498e (4) and 498h (5) of the Code. If the conclusion of the second opinion is different from the conclusion of the Children's Diagnostic and Treatment Service or the Pre-Admission Screening Unit, the Executive Director, in conjunction with the Medical Director, shall make a decision based upon all clinical information available within one (1) business day.

b. Denial of Access to any services for individuals not receiving any HealthWest services

i. If an initial applicant for public mental health services is denied such services, 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 Executive Director. The request shall be processed in compliance with Section 705 of the Code and must be resolved within five (5) business days.

3. Procedure for Appeal – See Appeals Resolution Requirements and Process, Section V.D above.

a. Local Medicaid Fair Hearing and State Level Medicaid Fair Hearings: for Medicaid beneficiary Appeals on Adverse Benefit Determinations that impact Medicaid covered services.

b. Alternative Dispute Resolution: for Appeals that impact non-Medicaid covered services, such as Family Subside Support (see below).

4. Family Subsidy Support Denial

a. Pursuant to Section 159(3) of the Code, if an application for a family support subsidy is denied or a family support subsidy is terminated by a Community Mental Health Services Program (CMHSP), the parent or legal guardian of the affected eligible minor may demand, in writing, a hearing by the CMHSP. 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 Compiled Laws.

b. 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 the CMHSP. (R330.1616 Availability of forms) (Note: It is acceptable to ask families to write a letter to the CMHSP requesting an appeals hearing, in lieu of a standardized form).

c. A CMHSP shall review an application, promptly approve or deny the application, and 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, the CMHSP shall identify the insufficiency. (Rule R330.1641 Application review).

d. If an application is denied or the subsidy is terminated, a parent or legal guardian may file an appeal. The appeal shall be in writing and be presented to the CMHSP within two (2) months of the notice of the denial or termination (R330.1643 Appeal).

e. If the MDHHS representative, using a "reasonable person" standard, believes that the denial or termination of the subsidy will pose an immediate and adverse impact upon the individual's health and safety, the issue is to be referred within one (1) business day to the Bureau of Community Mental Health Services for contractual action consistent with applicable provisions of the MDCH/CMHSP contract.

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 – 6th Floor
Lansing, MI 48913

5. Fair Hearings Process

a. HealthWest must comply with all Federal Regulations to provide Medicaid Beneficiaries the right to an impartial review by a MDHHS Administrative Law Judge under the following circumstances:

i. After reviewing notice of an adverse determination of a Local Appeal of an Adverse Benefit Determination, or
ii. When the PIHP fails to adhere to the notice and timing requirements stated in Section V.B above for Grievances and Appeals.

b. An individual who has exhausted Local Appeals processes must submit a request for Fair Hearing within 120 calendar days from receiving notice of adverse resolution.

c. The PIHP or HealthWest may in no way impede, limit, or interfere with an individual's right to request a State Fair Hearing

d. Any benefits must be continued if the conditions outlined in Section V.5.C.2(a)-(e) above are met.

e. Expedited hearings are available upon request.

6. Recipient Rights Complaint

a. Note: A Recipient Rights complaint form can be filed concurrently with any of the above actions.

i. Denial of Hospitalization

a. If the request for a second opinion itself is denied, the individual or someone on his/her behalf may file a rights complaint with HealthWest's Office of Recipient Rights for processing.
b. If the initial request for inpatient admission is denied, and the individual is a current beneficiary HealthWest services, the individual or someone on his/her behalf may file a rights complaint alleging a violation of his/her right to treatment suited to condition.
c. If the second opinion determines the individual is not clinically suitable for hospitalization and the individual is a current beneficiary of HealthWest 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 Recipient Rights complaint.

ii. Denial of services

a. Recipient Rights Complaint: The applicant or his/her guardian may not file a recipient rights complaint for denial of services suited to condition as he/she does not have standing as a beneficiary of mental health services. The applicant or his/her guardian may, however, file a recipient rights complaint if the request for a second opinion is denied.

E. HealthWest Grievance Response Process

1. HealthWest must comply with all Federal regulations regarding an individual's right to seek resolution to issues not related Adverse Benefit Determinations.

2. The individual, guardian, or parent of a minor child, or his/her legal representative may file a grievance at any time regarding the dissatisfaction with any aspect of service provision not related to an Adverse Benefit Determination.

3. An individual filing a grievance must be given reasonable support in completing necessary documentation to access the Grievance system.

4. Upon receiving a grievance request, the HealthWest Customer Services Department shall:

a. Log receipt of the grievance for reporting and tracking purposes.

b. Make a determination if the grievance is more appropriately handled via a Recipient Rights Complaint and, with the individual's permission, refer the grievance to the Office of Recipient Rights.

c. Acknowledge to the individual receipt of the grievance.

d. Submit the written grievance to the appropriate staff including the PIHP Representative with the authority to require corrective action. Further, no staff members making decisions on the grievance shall have been involved in the original determination.

e. Facilitate resolution of the grievance within sixty (60) calendar days of receipt of the grievance.

f. Within sixty (60) calendar days of a decision by the Affiliates regarding the grievance, notification of the outcome of the process is provided to the individual, guardian, or parent of a minor child.

g. Provide a written disposition within sixty (60) calendar days of HealthWest's receipt of the grievance to the beneficiary, guardian, or parent of a minor child.

h. Provide a written disposition within sixty (60) calendar days of HealthWest's receipt of the grievance to the beneficiary, guardian, or parent of a minor child.

i. The content of the notice of disposition includes:

i. The date the grievance process was concluded;
ii. The results of the grievance process; and
iii. The beneficiary's right to request a Fair Hearing if the notice is more than sixty (60) calendar days from the date of the request for a grievance; and how to access the Fair Hearing process.

VI. REFERENCE

PA 516 of 1996
PA 258 of 1974, as amended
S.353-Health Insurance Bill of Rights of 1997
42 CFR Chapter IV, Subpart E, Sections 431.200 et seq
42 CFR Chapter IV, Subpart F, Sections 438.402 to 424
MDCH-MSA Policy Bulletin: Medicaid Eligibility Manual - Beneficiary Hearings
FY18 Medicaid Managed Specialty Contract Attachment P6.3.1.1, Grievance and Appeal Technical Requirement
MDHHS FY18 Contract Attachment C6.3.2.1, CMHSP Local Dispute Resolution Technical Requirement

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