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<b>Approved By: Mohamad Khraizat</b>	<b>Title: Manager of Health Operations</b>
<b>Signature: <i>Mohamad Khraizat</i></b>	<b>Date:</b>

## I. POLICY

It is the policy of ACCESS CHRC that members receiving and requesting behavioral health services have access to an appeal process consistent with the Michigan Department of Health and Human Services (MDHHS) and Center for Medicare and Medicaid Services (CMS).

## II. PURPOSE

To provide guidance regarding the development and consistent processing of member appeals

## III. APPLICATION:

This is a policy that applies to ACCESS employees, interns and volunteers who provide support and treatment on behalf of the agency.

## IV. PROCEDURES

ACCESS will

1. Ensure that all appeal processes are
  - a. Timely
  - b. Fair to all parties;
    - i. Member
    - ii. Member's Authorized or Legal Representative
    - iii. Estate Representative of a Deceased Member
    - iv. Agency
  - c. Administratively simple
  - d. Objective and credible
  - e. Accessible and understandable to members/members and providers
  - f. Subject to quality improvement review
  - g. Developed in a manner to assure that members/members who participate in the appeal process are free from discrimination or retaliation

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- h. Developed in a manner to assure that they do not interfere with communication between member and the receipt of services
2. Ensure compliance with the appeal requirements as evidenced by:
  - a. Including all necessary language in contracts and requiring contractor's language follows state and federal requirements
  - b. Structuring the appeal process that promotes the resolution of the member's concerns about services
  - c. Documenting the substance of the appeal and actions recorded in MH-WIN
  - d. Asks PIHPs providing technical assistance and training on the appeal processes to promote the resolution of concerns as well as support and enhance services
  - e. Participate in consultative meetings to provide information and guidance in implementing appeal policies
  - f. Providing standardized documents related to the appeals policy in the form of templates to give providers the ability to customize with their specific identifying information;
  - g. Ensuring that staff reviewers are licensed practitioners of the healing arts with same or similar clinical expertise in treating the member's condition or disease when the appeal is denied based on medical necessity or involves other clinical issues;
  - h. Ensuring the staff who reviews the appeal will not be the same person who was involved in making the initial decision that is the subject of the appeal nor be the subordinate of the previous reviewer;
  - i. Ensuring access to all forms related to appeal actions (i.e. Appeal bookmarks, Appeal Request forms, Member Handbooks and Request for Hearing forms with envelopes) are available, easily accessible, understandable and linguistically appropriate to members/members and providers via websites, Individual Plan of Service meetings and at provider sites;
  - j. Incorporating a written process in operational manuals consistent and compliant with this appeal policy;
  - k. Ensuring that ACCESS' appeal materials are compliant with all contractual, regulatory and accreditation requirements regarding reading level (at or below a fourth (4th) grade reading level), font, type size, medium and language. Upon request, ACCESS will provide material in alternative formats to meet the needs of vision and/or hearing-impaired member upon request. These services are provided at no cost to the member.

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- i. The availability of vital written information in the prevalent non-English languages in the service area in accordance with the LEP guidelines, Center for Medicare and Medicaid Services (CMS) and/or PIHPs' contract with the Michigan Department of Health and Human Services (MDHHS). Materials will meet the most stringent guideline.
    - ii. Upon request, ACCESS will obtain materials from PIHPs and provide them in alternate formats to meet the needs of vision and/or hearing-impaired members, including large font (at least 18-point), Braille, oral interpretation service, ASL, audio and visual formats.
    - iii. Translation services will be made available to the member, upon request.
    - iv. Interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.
  - I. Provide access to one or more of the following dispute resolution options that may be utilized simultaneously;
    - i. Grievance
    - ii. Local Appeal
    - iii. Recipient Rights Complaint
3. Provide in writing to the member the appropriate standardized notice in the event of an adverse action. The form(s) shall include:
  - a. A statement of what action is being taken in easy, understandable language which does not include:
    - i. abbreviations or acronyms that are not defined; and
    - ii. is culturally and linguistically sensitive to the members' needs; and iii. health care procedure codes that are not explained
  - b. An explanation of the action including the denial of services in amount, scope and duration if less than what is requested;
  - c. The specific jurisdiction that supports or the change in the federal or state law that requires the action including a reference to the benefit provision, guideline, protocol or other similar criterion on which the action is based and the option of the member to have a copy of the benefit provision, guidelines or protocol, upon request;
  - d. If the Enrollee's services were reduced, terminated or suspended without an advance notice, ACCESS CHRC must reinstate services to the level before the action.
  - e. A statement that the member has the right to appeal and a description of the expedited and standard appeal process including time frames

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- i. Unless the Enrollee requests an expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal
    - ii. Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal)
  - f. A statement that the member has a right to continue receiving Medicaid covered services if a request is made within ten (10) calendar days from the date of the notice when applicable (per MDHHS and PIHPs contract effective October 1, 2017); and an explanation of the procedures of how to request such services be continued to the end of the currently approved treatment authorization or final decision whichever comes first .
  - g. A statement that the member may have to pay for the continuation of services if the result of the internal appeal or external State Fair Hearing is to uphold the denial;
  - h. A statement that if the decision is found in favor of the member made by either the PIHPs or State Fair Hearing and services have been previously discontinued, the PIHPs and/or ACCESS must reinstate services within 72 hours
  - i. A statement that the member, his/her legal guardian or authorized representative has 14 calendar days from the initiation of the appeal request to present evidence, testimony, and allegations of fact or law in person and/or in writing
  - j. A statement that the member can request copies of all documents relevant to the appeal, free of charge
  - k. A statement that informs the member of their right, with the written consent from the Enrollee, to designate an authorized representative to act on their behalf to file an appeal, as long as the member has provided written permission by submitting the request in writing
  - l. Include a list of titles and qualifications, including specialties of the individuals participating in the appeal review.
4. For all preservice, post service and standard local appeals:
- a. ACCESS and their staff are prohibited from taking any punitive or retaliatory actions towards a member, authorized representative, legal guardian or provider who requests an appeal.
  - b. Appeals for service for which Medicaid and Medicare overlap, the member can file an appeal through either the Medicaid or Medicare process or both. Any determination that overturns the denial will be binding

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5. Will adhere to the Customer Service Appeal Process for Medicaid Standard, Pre-Service or Post Service Appeals which include:
  - a. Local/Internal Appeals (First Level) 1
    - i. Identifying and verifying the individual requesting to appeal an Adverse Benefit Determination (Medicaid) or Denial of Medical Coverage (MI Health Link) decision is legally able to do so in order to ensure and protect the member's rights and information.
    - ii. Sending the member 10 calendar days prior to the effective date of the action the standardized adverse benefit determination (Adequate or Advance) notice or Denial of Medical Coverage notice to inform the member of a denial, reduction, suspension or termination of services.
    - iii. Aiding the member, legal guardian or authorized representative in completing the needed paperwork to file and submit an internal/local appeal.
    - iv. They can request an appeal be resolved in an expedited or standard timeframe. An expedited request requires a 72 hour decision be rendered on the adverse benefit determination as the individual appealing feels a delay in decision making might seriously jeopardize an member's life, health or ability to attain, maintain or regain maximum function. If a decision is made to deny the request for an expedited appeal, an attempt is made to provide the member/ guardian/authorized representative prompt oral notice of the denial as soon as the decision is rendered. Written correspondence is sent to the member/guardian/authorized representative within two (2) calendar days of the denial. A standard resolution of an appeal acknowledges that a decision on the issue will take place no later than 30 calendar days from the date of the appeal request.
    - v. PIHPs may extend the resolution timeframe by no more than 14 calendar days provided that either the member/guardian/authorized representative requests an extension or PIHPs show to the satisfaction of the State there is a need for additional information and how the delay is in the best interest of the member. If the extension is granted, PIHPs will provide the member written notice within two (2) calendar days of the decision to extend the timeframe as well as inform the member of their right to file a grievance if they disagree with the extension.

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- vi. Timely processing and distribution of the standardized acknowledgement letters (Notice of Receipt of Appeal) to the member, legal guardian or authorized representative to indicate the receipt of the appeal request.
  - vii. Accurately documenting in the appropriate EMR all contacts with members/members, guardians and authorized representatives.
  - viii. Providing timely resolution to the appealing party and provide detailed explanation of the appeal decision via the Notice of Appeal Approval or Appeal Denial for Medicaid and Notice of Appeal Decision for MI Health Link members. Resolution and investigation of appeals completed for standard appeals within 30 calendar days and 72 hours for fast/expedited appeals. The appeal decision letters are mailed within two (2) calendar days of the decision. Included with the Notice of Appeal Decision and the Notice of Appeal Denial are instructions to pursue next level review options.
- b. Second Level/External Appeal Review for Pre-Service, Standard and Post-Service Appeals:
- i. The member's request for a Medicaid second level/external appeal must be in writing to the Michigan Administrative Hearing Systems in Lansing. There is a form, Request for State Fair Hearing, that is provided to the member with the receipt of the Notice of Appeal Denial (MI Health Link) or Notice of Appeal Decision form (Medicaid).
  - ii. The member's request for a Medicaid second level external appeal can be standard or expedited. An expedited appeal is a request to review a decision concerning eligibility, screening, admission, continued/concurrent stay or other behavioral healthcare services for an member who has received urgent services but has not been discharged from a facility or when a delay in decision-making might seriously jeopardize an member's life, health or ability to attain, maintain or regain maximum function. The member has 120 calendar days from the date of the Adequate or Advance Notice of Appeal Denial or Notice of Appeal Decision to request a Medicaid second level/external appeal.
  - iii. An Administrative Law Judge (ALJ) from the Michigan Administrative Hearing system will conduct/facilitate the hearing between the appellant (member, authorized representative, legal guardian) and the respondent (PIHPs and/or ACCESS) to determine if proper protocol was adhered to while obeying all federal, state and local rules and regulations.

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- iv. The Administrative Law Judge will hear the case and a ruling will be made based upon the information presented by the appellant and the respondent. The ruling is issued to the appellant and/or the appellant's authorized representative and/or legal guardian, respondent and state officials in the form of the Order and Decision notification within 90 days of the hearing.
- v. If the decision is in favor of the member and services were not continued during the appeal process, services must be restored within 72 hours of receiving the decision.
- vi. The member, authorized representative and/or legal guardian is then given the opportunity to appeal the decision within 30 days to the Third Judicial Circuit Court. Instructions are provided in the Order and Decision notification that is disseminated to the member and/or their representative.
- c. Will adhere to the Customer Service Appeal Process for MI Health Link Pre-Service, Standard and Post-Service:
  - i. First Level/External Appeal Review:
    1. The member is given a Notice of Denial of Medical Coverage. Such notice shall be provided at least ten (10) calendar days in advance of the date of notice of Denial of Medical Coverage for ongoing services.
    2. The member has up to 60 calendar days from the receipt of the Notice of Denial of Medical Coverage to request a first level internal/local appeal for MI Health Link covered services.
    3. The member's request for first level internal/local appeal for MI Health Link covered services can be verbally or in writing. Unless the request is an expedited request, the appeal request must be followed up in writing.
    4. The request for a MI Health Link first level internal/local appeal can be standard or expedited. An expedited appeal is a request to review a decision concerning eligibility, benefit, screening, admission, continued/concurrent stay or urgent services but has not been discharged from a facility or when a delay in decision-making might seriously jeopardize an member's life, health or ability to attain, maintain or regain maximum function.
    5. PIHPs shall send a Notice of Appeal Receipt within three (3) calendar days of a non-expedited MI Health Link first level appeal request and



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within 24 hours of an expedited MI Health Link first level appeal request.

6. PIHPs have 72 hours from the receipt of the expedited MI Health Link first level request to review and decide and within 30 calendar days from receipt of the non-expedited MI Health Link first level internal/local appeal request to the member.
  7. If PIHPs need to extend the time frame for an appeal, the member must receive prompt oral notice of the delay and in addition provide written notice of the reason for extension. It can be extended up to the 14 calendar days. If the member disagrees with this decision, the Member has the right to file a grievance.
  8. A MI Health Link first level internal/local appeal request that results in upholding part or all the initial denial is communicated verbally to the provider. Written notification using the standardized Notice of Appeal Decision MHL is sent for partial or full denial of services appealed and the Notice of Decision Approval (MHL) letter is sent to the member for fully approved services.
  9. The Notice of Appeal Decision must include an explanation that the case is automatically forwarded to Maximus for a second level appeal if the determination is to uphold, all or in part, the non-authorization of eligibility, screening admission, continued/concurrent stay or other behavioral healthcare services.
6. Second Level Appeal Review for MI Health Link Covered Services:
- a. For services that are Medicare approved, these appeals will be sent directly to Maximus for review. Maximus will respond with a decision within 30 calendar days. For an expedited MI Health link external appeal, the resolution will be made within 72 hours unless a 14-day extension had been granted.
  - b. For services that are Medicaid covered, the member can file a State Fair Hearing through Michigan Administrative Hearing Systems 120 days from the date on the Notice of Appeal Decision. MAHS has up to 72 hours to decide on an expedited appeal and up to 90 days to provide a written decision and order on a non-expedited state fair hearing request.
  - c. For services that are covered by both Medicare and Medicaid, (in which services overlap), members may file an appeal through either or both processes. PIHPS will



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automatically forward the information to Maximus however, the member can request for a State Fair Hearing. Any determination that is in favor of the Member will be binding and PIHPS is to enforce the decision as expeditiously as possible.

7. Third Level Medical Necessity Appeal Review for MI Health Link Covered Services:
  - a. The third level of appeal is the Administrative Law Judge (ALJ) hearing. This hearing allows the member to present the appeal to a new person who will review the facts independently and listen to testimony before making a new and impartial decision. An ALJ hearing is usually held by phone, videoconference or in some cases, in person. To secure an ALJ hearing, the minimum amount of the case must be \$150. All requests for an ALJ hearing must be written and forwarded to the Office of Medicare Hearing and Appeals (OMHA). The address is documented in MAXIMUS' decision notice.
  - b. In most cases, the ALJ will review a case, decide and notify PIHPs, ACCESS and the member within ninety (90) days of the request.
  - c. If the ALJ upholds part or all of the second level decision by MAXIMUS, they provide written notification of their decision to PIHPs and the member. The Notice also includes an explanation of the next (fourth) level appeal process.
  - d. If the ALJ overturns part or all of the second level decision by MAXIMUS, PIHPS will inform ACCESS to reinstate the services and submit the services for payment no later than thirty (30) calendar days from the ALJ's decision.
8. Fourth Level Appeal Review for MI Health Link Covered Services:
  - a. The fourth level of appeals is with the Medicare Appeals Council (MAC). The request for a review by MAC must be submitted in writing, must be within 60 calendar days of the ALJ decision and must specify the issues and finding that are being contested.
  - b. In most cases, MAC will review a case, make a decision and notify PIHPs and the member/ member within 90 days of receipt of the request. However, that time frame may be extended for various reasons including but not limited to the case being escalated from an ALJ hearing. If MAC does not issue a decision within the applicable time frame, the member can ask MAC to escalate the case to the next (fifth) level review, the Judicial Review.
  - c. If MAC overturns part or all of the third level decision by the ALJ, PIHPs will inform ACCESS to reinstate services and submit the claim no later than 30 calendar days from MAC's decision.
9. Fifth Level Medical Necessity Appeal Review for MI Health Link Covered Services:

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- a. If at least \$1,460 or more is still in controversy following the MAC decision, a judicial review before a U.S. District Court judge can be requested. This is the fifth and final level of appeal. The request must be submitted in writing and must be within 60 calendar days of MAC's decision.
  - b. There is no statutory time frame for the Federal Court decision.
  - c. If the Federal Court upholds part or all of MAC's decision, they provide written notification of their decision to PIHPS and the member. The Notice also includes an explanation that this is the final level for appeal.
  - d. If the Federal Court overturns part or all of MAC's decision, PIHPS will notify the servicing provider to re-instate services and submit claims for payment no later than thirty (30) calendar days from the Federal Court decision.
10. Will adhere to the Customer Service Appeal Process for Services provided to the Uninsured/Underinsured population (Pre-Service, Post Service and/or Standard):
- a. First Level Appeal Review for Uninsured/Underinsured Services:
    - i. The member, authorized representative or legal guardian has up to 30 calendar days (per the MDHHS CMHSP contract effective October 1, 2017) from the date of the Adequate or Advance Notice of Adverse Benefit Determination to request a first level internal/ local dispute resolution review. PIHPS and/or ACCESS must provide written notification 30 calendar days in advance of any changes to services that are currently being provided.
    - ii. The member's request for a first level internal/ local dispute resolution review can be verbal or in writing to PIHPS.
    - iii. The member's request for a first level internal local dispute resolution can be standard or expedited. An expedited appeal is a request to review a decision concerning eligibility, benefit coverage, screening, admission, continued/concurrent stay, or other behavioral healthcare services for an member who has received urgent services but has not been discharged from a facility or when a delay in decision-making might seriously jeopardize an member's life, health or ability to attain, maintain or regain maximum function. The member can request an expedited first level local dispute resolution based on the information from the Adequate or Advance Notice of Adverse Benefit Determination.
    - iv. PIHPs shall send a standardized Notice of Local Dispute Resolution Review Request within 24 hours of an expedited first level local dispute resolution

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request and within five (5) calendar days of a non-expedited internal first level/ local dispute resolution review request to the member.

- v. PIHPs have 72 hours from the receipt of the expedited internal first level/ local dispute resolution request to review and make a determination and 30 calendar days from receipt of the non-expedited internal, first level/ local dispute resolution request to review and make a determination.
  - vi. An internal, first level/ local dispute resolution request that results in upholding part or all of the initial denial is communicated verbally to the member and/or their representative. If it is an expedited local dispute resolution request, the Notice of Local Dispute Resolution Denial will be sent within 72 hours. If the first level local dispute resolution request is found in favor of the member, Notice of Local Dispute Resolution Approval is sent. If it is a non-expedited appeal request and the request is partially or fully denied, the standardized Notice of Local Dispute Resolution Denial will be sent. For approved appeals, the Notice of Local Dispute Resolution Approval is sent. The resolution letters are sent within 2 calendar days of the decision.
  - vii. The Notice of Local Dispute Resolution Denial must include an explanation of how to file a second level external/alternate dispute resolution.
- b. Second Level Review for Uninsured/Underinsured Services
- i. After the exhaustion of the local dispute resolution process, the member, guardian or authorized representative may request an alternate dispute resolution within ten (10) days from the date on the Notice of Adequate Benefit Determination or Notice of Advance Adverse Benefit Determination. This request must be in writing and submitted to: Department of Health and Human Services, Division of Program Development, Consultation and Contracts, Bureau of Community Mental Health Services. Attn: Request for MDHHS Level Dispute Resolution, Lewis Cass Building-5th Floor, Lansing, MI 48913
  - ii. MDHHS shall review all requests within two (2) business days of receipt.
  - iii. If MDHHS determines that the denial, suspension, termination or reduction of services/supports will pose an immediate or adverse impact upon the consumer's health and safety, the issue is referred within one (1) business day to the Community Services Division within Mental Health and Substance Abuse Services for contractual action consistent with Section 8.0 of the MDHHS /CMHSP contract.

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11. Independent Review Organization (IRO)
  - a. ACCESS will advise members at least annually of the availability and right to an external appeal of the final internal determination for Medicare and Medicaid covered services by an independent review organization (IRO) including their contact information. Under federal and state law ACCESS is responsible to forward to PIHPs and the IRO all relevant medical records and any supporting documentation that was used in the adverse action determination such:
    - i. A summary of applicable issues;
    - ii. The final decision;
    - iii. Relevant portions of the criteria used to make the decision;
    - iv. For medical necessity decisions, the clinical reasons for the decision;
    - v. Communications from ACCESS and member to PIHPs, the Access Center, Mobile Crisis Stabilization Unit and/or service provider; and
    - vi. Any new information related to the case that became available after the final internal appeal decision.
12. ACCESS do not influence the IRO review process and must adhere to and implement the IRO's decision within the time frame specified by the IRO. The IRO decision is final and binding.
13. Written notification of the IRO decision will be given to the member and to ACCESS by the PIHPs and if the IRO overturns any part of the denial decision, the written notification includes the time and procedure for claim payment or approval of services. The PIHPs will maintain data and track all IRO requests and review findings on each appeal case and forward the information to the ICOs for the MI Health Link population. The PIHPs will also use this information in evaluating and revising its medical necessity decision-making process.
14. ACCESS CHRC is expected to develop their policies in alignment with PIHPs directives.

## **VI. QUALITY ASSURANCE/ IMPROVEMENT**

ACCESS will monitor contractor adherence to this policy as one element in its network management program, and as one element of the Quality Assurance Performance Improvement Program (QAPIP) Goals and Objectives. The quality improvement programs of contracted service providers must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy

## **VII. COMPLIANCE WITH ALL APPLICABLE LAWS**



Community Health &  
Research Center

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ACCESS, its affiliates, service providers, and other contracted and subcontracted employees are bound by all applicable local, state and federal laws, rules, regulations, all Federal waiver requirements, and state and county contractual requirements, policies and administrative directives in effect, or as amended.

### **VIII. LEGAL AUTHORITY AND REFERENCES**

Federal Regulation 42 CFR: Sections 431.200 et seq., 435.911-920, 438.400 et seq;

Michigan Department of Community Health (Administrative Hearings, Policies and Procedures)

Michigan Mental Health Code, PA 258 of 1974, as amended;

Contract between United States Department of Health and Human Services, Center for Medicare and Medicaid Services in Partnership with the State of Michigan and the Integrated Care Organizations, current or as amended (The Three-Way Contract)

Agreement between Michigan Department of Health and Human Services (MDHHS) and PIHPs for the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Programs, Healthy Michigan Programs, and Substance Use Disorder Community Grant Programs, Attachment 6.3.1.1 Revised Judiciary Act of 1961, P.A. 236 of 1961 as amended, MCL 600.5851.

### **IX. EXHIBITS**

PIHPs Customer Service (CS) Member Appeals Policy and attachments