Grievance, Appeals, & Second Opinion Process

LAPPER COUNTY COMMUNITY MENTAL HEALTH

Who to Call

OPTION	AGENCY	CONTACT NUMBER
Medicaid Fair Hearing	Region 10 PIHP	Due Process Officer **888-225-4447**
Medical Local Appeal		
Non-Medicaid Appeal	Lapeer CMH	Customer Services **810-667-0500**
Medicaid Grievance		
Non-Medicaid Grievance		
Second Opinion	Region 10 PIHP	Specialty Benefits Supervisor **888-225-4447**
Recipient Rights	Lapeer CMH	Rights Officer **810-667-0500**

What is Due Process?

Every person seeking or receiving services from Lapeer County CMH or it's contracted agencies has the **right** to due process.

- It includes the right to Appeal "actions" and to file grievances about other matters of dissatisfaction with treatment.

These rights come from the U.S. Constitution, the Social Security Act of 1965, and the Balanced Budget Act of 1997

DUE PROCESS

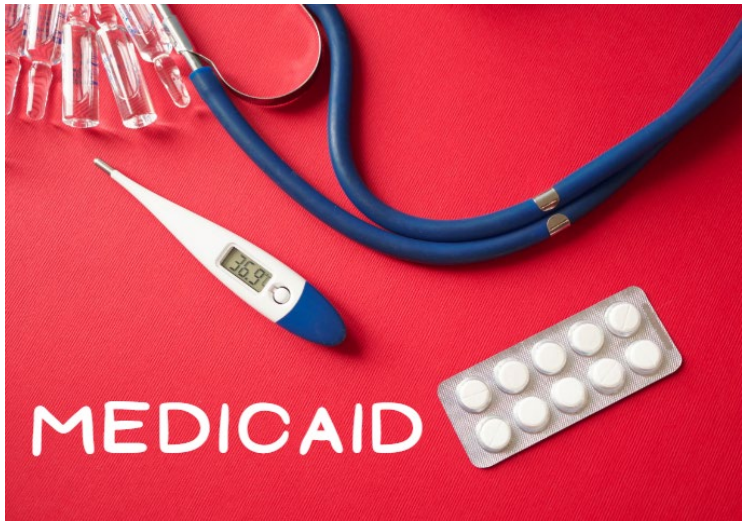
Medicaid Basics

A Medicaid card "entitles" a person to services that are medically necessary

Medicaid is the payer of last resort.

The Plan of Service must specify for each service:

- Scope
- Amount
- Duration
- Dates when service begins/ends



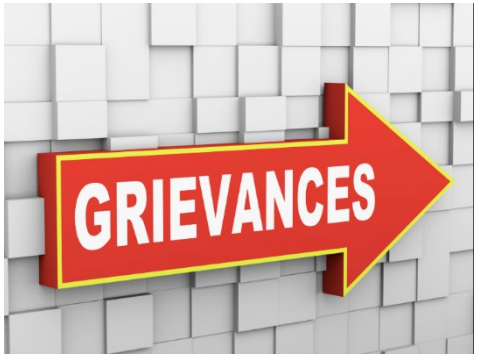
Appeals & Grievances

What is an appeal?

A request for review of a decision to deny, terminate, suspend, or reduce a Medicaid Covered Service

What is a grievance?

A request for review about any matter of dissatisfaction other than those issues covered by the appeal process



Grievances

A grievance may be filed by a person served, guardian, parent of minor child or legal representative, or provider with written permission from the consumer indicating the wish to file a grievance.

The provider may file a grievance or request a state fair hearing on behalf of the enrollee since the State permits the provider to act as the enrollee's authorized representative in doing so.

File a grievance with Customer Services

810-667-0500

Grievances

- CMH will acknowledge the Grievance within 5 days
- If not resolved within 90 days the person may file a Medicaid Fair Hearing (Medicaid)

OR

- Local Appeal (Non-Medicaid)

OR

- A Recipient Rights Complaint can be filed

File a grievance with Customer Services

810-667-0500

Appeal

Timeframes to request Appeal:

- Appeal (other than 2nd opinion)
- Fair Hearing 90 days from date of notice
- Local 45 days from date of notice

Second Opinions:

- Eligibility for services
- 5 days from 1st denial
- Hospitalization 24 Hours

Fair Hearing

A Medicaid beneficiary has the right to request a Fair Hearing when:

- The PIHP takes an "Action"
- A grievance request is not acted upon within 60 calendar days
- The beneficiary does not have to exhaust local appeals before they can request a Fair Hearing

Definition of "Action"

- Reduction, suspension, or termination of a previously authorized service
- Failure to provide service within 14 calendar days of the start date agreed upon during the Individual Plan of Service (IPOS)
- Denial or limited authorization (less than person requests or less than current authorization)
- Failure to make a standard authorization decision and provide notice within 14 calendar days rom the request for services
- Failure to make an expedited authorization decision within three (3) working days from the date of request for expedited service authorization

Timeframes

Initial request or continuation of service - PIPH Must provide written authorization decision:

- Standard request – 14 calendar days
- Expedited request – 3 working days
- And/or as expeditiously as person's health condition requires
- May extend up to additional 14 days if person or provider requests OR more information is needed AND extension is in person's best interest.

Timeframes

If the PIHP extends the timeframe, they must:

- Give the person written notice, no later than the date the current timeframe expires that includes:
  - The reason for the decision to extend
  - Inform the person of the right to file an appeal if they disagree with that decision
  - Issue and carry out determination as expeditiously as the person's health condition requires and no later than the date the extension expires.

Appeals and Grievances

- Standard Appeal: Failure of the PIHP to act within 45 calendar days from the date of the request
- Expedited Appeal: Failure of the PIHP to act within 3 working day from the date of the request
- Local Grievance: Failure of the PIHP to provide disposition and notice within 60 calendar days of the date of the request

Fair Hearing Process

- Person must be notified in writing
- Person's request for a Fair Hearing may not be limited
- Person has 90 calendar days to file a request for hearing
- Person may request services to be reinstated/continued until the disposition
- If notice is not give then services must be reinstated/continued
- Expedited hearings are available – must be requested – Tribunal Decision

Local Appeals Process

For Appeal of an "Action" **Medicaid Beneficiary**

- A person has 45 calendar days from date of notice to request a local appeal
- Services may be continued / reinstated if person requests it and appeal field no more than 12 calendar days from date of notice
- The local appeal process can be done before, at the same time, or instead of a Fair Hearing

Local Appeals Process

For Appeal of an "Action" **Non-Medicaid Beneficiary**

- A person has 45 calendar days from date of notice to request a local appeal
- Can request agency-level review, local appeal, or state level Alternative Dispute Resolution Process this must be done sequentially
- Person must be notified in same manner as Medicaid
- May not have services continued pending outcome of Appeal

Expedited Appeals Process

- Can be granted if "the time necessary for normal appeal process could seriously jeopardize the person's life or health or ability to attain, maintain, or regain maximum function"
- Must be completed within 3 days
- If the person requests the expedited review, the PIHP determines if the request is warranted

Adequate Notice

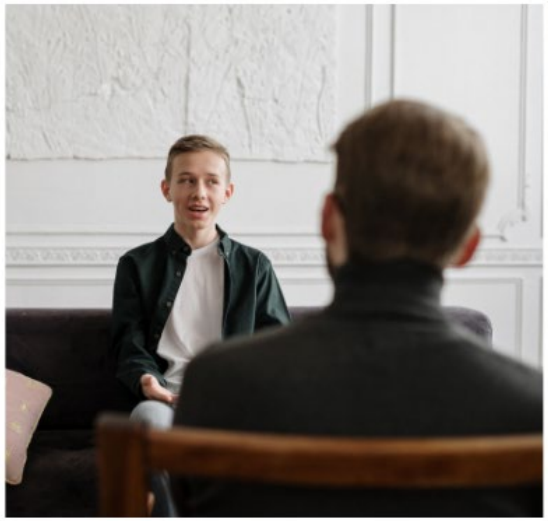
A written notice provided to the person at the time of action:

- Denial of eligibility
- Denial of hospitalization
- Denial for request for new or increased services
- Limited authorization (time or amount of service)
- The IPOS must include, or have attached, the adequate notice provisions

Advance Notice

Written notice required when an action is being taken to reduce, suspend or terminate services that the person is currently receiving

- Must be mailed or given to the person no less than 10 calendar days before the intended action takes effect



Advance Notice Exceptions

Notice may be mailed not later than date of action if:

- Death of the person is confirmed
- The person gives clear written statement they no longer wish services
- The person is admitted to jail where they are ineligible under Medicaid for further services
- The person's whereabouts are unknown or their mail was returned with no forwarding address
- Facts established that person had been accepted for Medicaid services by another local jurisdiction
- A change in the level of medical care is prescribed by their physician

Mailing Timeframes

Adequate Notice:

- Within 14 calendar days of when service will be denied or limited
- Within 3 working days for expedited request
- At the time of the decision to deny payment for a service

Advance Notice:

- At least 10 calendar days before the date of an action to terminate suspend or reduce previously authorized Medicaid covered service

Questions?

Lisa Jolly, Recipient Rights Officer
810-245-8279

Customer Services for Due Process
810-667-0500