

Due Process – Grievance and Appeal Procedures



BEFORE VIEWING THIS TRAINING

- You only need to take this training if your job is on this list:
 - Case Manager or Supports Coordinator
 - Case Management or Supports Coordinator Supervisor
 - Utilization Management staff
- If your job is not on this list, you must still take the Recipient Rights and Due Process Annual Update Training and Test, located under the Rights/Advocacy tab of our website.
- **If you have questions about whether you need this training, contact the Human Resources or Training Department at your agency.**

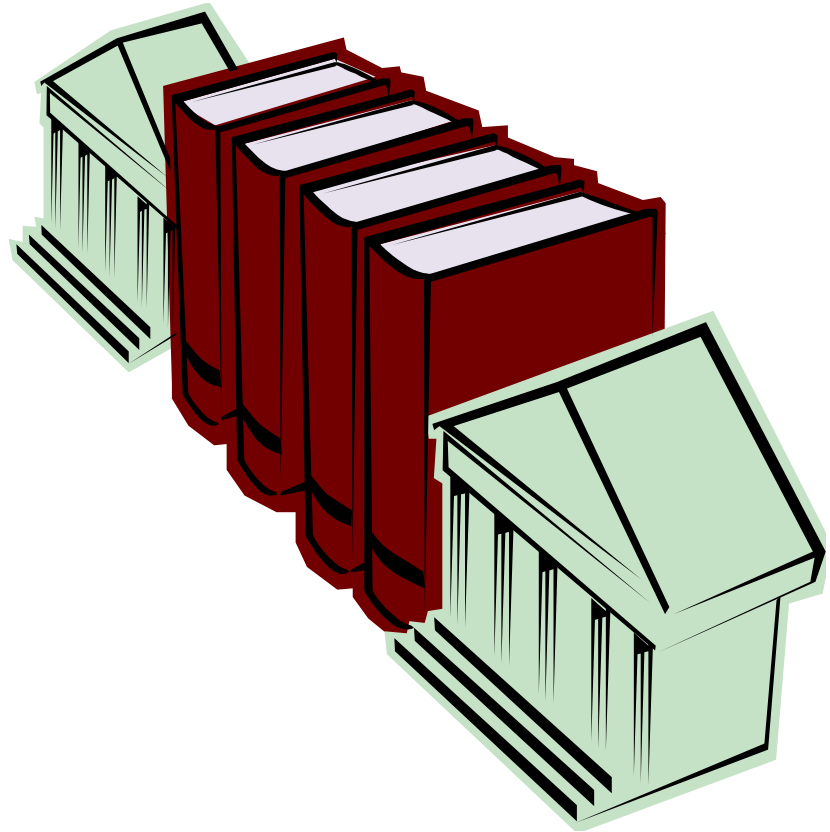
What is Due Process?



- The right of every person seeking or receiving mental health or developmental disability services from Oakland County Community Mental Health Authority or its contracted agencies.
- Includes the right to appeal “actions” and to file grievances about other matters of dissatisfaction with treatment

Where do these rights come from?

- US Constitution
- Social Security Act of 1965
- Balanced Budget Act of 1997



MEDICAID BASICS

- A Medicaid card “entitles” a person to services that are medically necessary
- Medicaid is the payor of last resort



MEDICAID BASICS

- The individual plan of service resulting from person-centered planning must specify for EACH service:
 - ⇒ Scope
 - ⇒ Amount
 - ⇒ Duration
 - ⇒ Dates when the service begins and ends



APPEALS VS. 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

Grievance Processes



- Provider Internal Grievance Mechanism

- Each Core Provider agency required to have internal mechanism for grievances
- Reflected in agency policy and procedures
- Person does not need to go through this procedure before contacting OCCMHA

- OCCMHA Grievance procedure

- Person, family member or guardian calls Customer Services
- If clinical in nature, CMH requests clinical review by provider agency
 - May be further reviewed by CMH Best Practice and Utilization Management

Grievance Timeframes



- No time limit to request
- CMH must acknowledge Grievance within 5 days
- If not resolved within 60 days, person may file Medicaid Fair Hearing (Medicaid) or Local Appeal (non-Medicaid)
- May be filed before, after, or along with, a Recipient Rights complaint

Timeframes to Request Appeal



- **Appeal (other than second opinion)–**

- ✓ Fair Hearing
 - ✓ 90 days from date of notice
- ✓ Local
 - ✓ 45 days from date of notice
- ✓ Before effective date of action to keep services in place

- **Second Opinion**

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

Medicaid Appeal Process



- A Medicaid beneficiary has the right to request a fair hearing when
 - the PIHP or its contractor 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 - Services

- **Reduction, suspension, or termination** of a previously authorized service
- **Failure to provide services within 14 calendar days of the start date** agreed upon during the person-centered planning and as authorized.



Definition of Action - Authorizations

- **Denial or limited authorization** (less than person requests or less than current authorization) of a **requested service, including type or level** of service
- **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 three (3) working days** from the date of receipt of a request for expedited service authorization



Authorization Timeframes



- **Initial request or continuation** of service – PIHP must provide written authorization decision
 - Within specified timeframes
 - 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 info is needed **AND** extension is in person's best interest

Authorization Extension

- **IF** the PIHP extends the timeframe it must:
- Give the person written notice, **no later than the date the current timeframe expires**, including:
 - reason for the decision to extend the timeframe and
 - inform the person of the right to file an appeal if they disagree with that decision AND
- Issue and carry out determination as expeditiously as person's health condition requires and **no later than the date the extension expires**



Definition of Action - Payment

- The denial, in whole or in part, of **payment** for a service
- Notice goes to person, not provider



Definition of Action– Appeals and Grievances

- **STANDARD APPEAL** - Failure of the PIHP to act within 45 calendar days from the date of a request
- **EXPEDITED APPEAL** - Failure of the PIHP to act within 3 working days from the date of a request
- **LOCAL GRIEVANCE/COMPLAINT** - 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 freedom to make a request for a Fair Hearing may not be limited or interfered with
- Person has **90 calendar days** from the date of the notice to file a request for hearing
- If hearing is requested **not more than 12 calendar days** from date of notice, **person may request** services be reinstated/continued until disposition of FH
- If notice not given, services must be reinstated to pre-action level
- Expedited hearings are available – must be requested, Tribunal makes decision


Local Appeal Process



- For appeal of an “action” – either Medicaid or non-Medicaid beneficiary
- Person has **45 calendar days** from date of notice to request Local appeal
- Oral request ok – person needs to call OCCMHA Due Process
- If person has Medicaid, services may be continued/reinstated if person requests it and appeal filed no more than 12 calendar days from date of notice
- If person has Medicaid, may be done before, at same time, or instead of a Fair Hearing
- Person without Medicaid can request agency-level review, local appeal, or State-level Alternative Dispute Resolution Process
 - Must be done sequentially

Non-Medicaid Appeal Process



- Person without Medicaid can request agency-level review, local appeal, then State-level Alternative Dispute Resolution Process
 - Must be done sequentially 
- Person must be notified in same manner as Medicaid
- May not have services continued pending outcome of appeal

Expedited Appeal 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 in **3 days**
- May be requested by the person **or the person's provider – with person's written permission**
- If the **person** requests the expedited review, **the PIHP determines if the request is warranted**
- If the **provider** makes request, or supports request, **the PIHP must grant the request**



Adequate Notice



- A written notice provided to the person **at the time of action.**
 - Denial of Eligibility
 - Denial of Hospitalization
 - Denial of request for new or increased service
 - 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 person **no less than 12 calendar days before** the intended action takes effect.

Exceptions to advance notice



- Notice may be mailed not later than date of action (adequate notice) **IF**:
 - Death of the person is confirmed
 - The person gives clear written statement they **no longer wish service** or gives info requiring termination **AND** indicates they understand that this must be result of giving that information
 - The person is admitted to institution (jail) where they are ineligible under Medicaid for further services
 - The person's whereabouts are unknown and mail returned with no forwarding address

Exceptions, continued



- Fact is established that person has been accepted for Medicaid services by another local jurisdiction, State, territory or commonwealth
- A change in the **level of medical care** is prescribed by the beneficiary's physician
- The date of the action will occur in less than **10 calendar days** (LTC facility)

Notice Mailing Timeframes



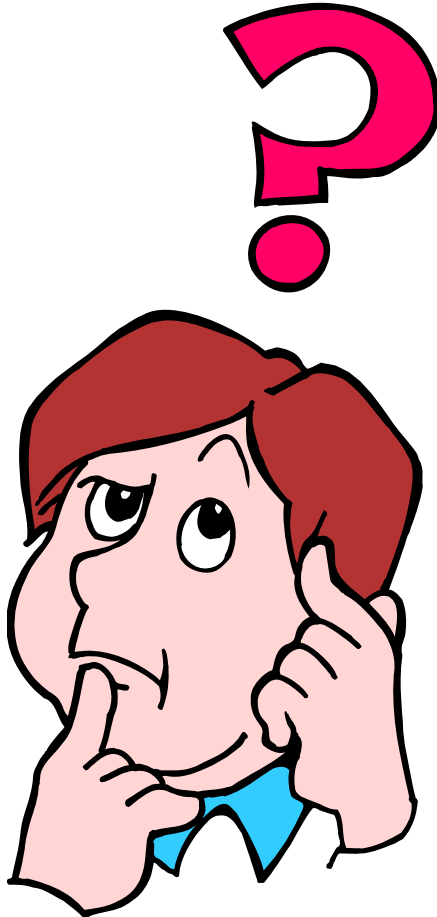
- **ADVANCE NOTICE**

- At least **12 calendar days before the date of an action** to terminate, suspend or reduce previously authorized Medicaid covered service

- **ADEQUATE NOTICE**

- Within **14 calendar days of a request for a standard service authorization** decision to deny or limit services
- Within **3 working days of the request for an expedited service authorization** decision to deny or limit services
- At the time of the decision to **deny payment** for a service

Questions?



Due Process
(248) 858-1262

Customer Services
1-800-341-2003

Recipient Rights
1-877-744-4878

Due Process Test

- Now that you have viewed this training, please click on the link below to take the test.
- Your score will be automatically sent to your employer – there is no certificate or form for you to fill out.
- Thank You
- Link to test:

<http://www.hostedtest.com/taketest.asp?c=DuePro172833>