Title: Grievance and Appeal Procedure

Prepared By: Recipient Rights Officer

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Purpose:

To define the proper investigation, documentation, and follow-up activities related to consumer complaints, grievances, and appeals.

Scope:

This procedure applies to all employees (including full-time and part-time employees), contract providers, volunteers, students, and/or interns, of Huron Behavioral Health (HBH) programs and all consumers served.

Information:

1. It is the policy of HBH that all consumers will have the right to a fair and efficient process for resolving complaints regarding their services and supports which are managed and/or delivered by HBH. Procedures are in place to ensure a timely, fair, accessible, and understandable process for resolving consumer grievances and appeals based on the Michigan Department of Health and Human Services (MDHHS) Technical Requirement and MDHHS Medicaid contract attachment.
2. The MDHHS Technical Requirement states “conceptually, the grievance system divides beneficiary complaints into two (2) categories, those challenging an action, and those challenging anything else. A challenge to an action is called an appeal. Any other type of complaint is considered a grievance.”
3. Consumers and/or their legal representative (also referred to herein as “guardian”) shall receive written and verbal information about their grievance and appeal options at various stages of treatment, including phone screening by the contracted Access/Customer Services contract provider, intake evaluations, and interim treatment planning at the Community Mental Health Services Program (CMHSP) provider network, annual treatment planning meetings, and whenever requested. It will be provided in a language format needed by the individual to understand the content.
4. All grievances and/or appeals must be filed through HBH’s contracted Access/Customer Service Center at:

   Customer Service
   P.O. Box 882
   Bay City, MI 48707-0882
   1-888-482-8269

5. Individuals may file a grievance or appeal with HBH’s contracted Access Center at any time verbally or in writing without any interference or retaliation. The contracted Access/Customer Services staff will offer assistance in completing required forms when the consumer requests help. HBH staff may also assist ~~in~~ with completing required forms when consumers request help. All processes will promote the resolution of concerns and improvement in the quality of care. Complaints should be resolved at the level closest to service delivery whenever possible.
6. Organizational providers may file an appeal or grievance with the Clinical Director at Huron Behavioral Health. If they are not satisfied with this outcome, they may then appeal to the HBH Executive Director.
7. In accordance with 42 CFR 438.10, written notice (called an “Adverse Benefit Determination” or “ABD”) is given to consumers whenever a Medicaid State Plan, waiver, or alternative service is denied, reduced, suspended, or terminated. The notice is given in writing and in the language which is understandable to the consumer. When an alternative language or communication method is needed, it will be provided at no cost to the consumer. (See “Limited English Proficiency (LEP) Accommodation Policy” RR.1.02). If the consumer disagrees with the action, they may request an appeal through the contracted Access/Customer Service provider. The ABD must include:

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- a description of the adverse benefit determination
- the reason for the adverse benefit determination
- the policy/authority relied upon for making the determination
- notification of the recipient's right to be provided upon request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination

8. If resolution is not reached at the local level, a MDHHS State Fair Hearing may also be requested. An individual can file for a State Fair Hearing by writing to:

   Michigan Administrative Hearing System for the Department of Health & Human Services
   P.O. Box 30763
   Lansing, MI 48909

9. If any consumer has a complaint that is a Michigan mental health code protected right, the consumer will be referred to the HBH Office of Recipient Rights.

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10. Denying an applicant, a current consumer, or guardian access to the grievance process is a recipient rights violation. Recipient rights complaints can be filed with the HBH Recipient Rights Officer if this occurs.

11. HBH staff shall not interfere with a consumer's access to grievance, appeal, or fair hearing processes.

12. Medicaid and Healthy Michigan Plan (HMP) consumers must be notified of the MDHHS State Fair Hearings process as soon as it becomes evident that services will be denied, suspended, reduced, or terminated. Consumers are required to exhaust the local grievance process before accessing the MDHHS Alternative Dispute Resolution Process.

13. For the purpose of this procedure, the term "Current Medicaid-Covered Services" refers to Medicaid State Plan, Waiver, or Alternative Services.

14. The Access/Customer Service staff will ensure that all appeals, second opinions, and notices (adverse benefit determinations) are entered into the tracking system for on-going monitoring and reporting.

15. Consumers will be advised of external advocacy services available to them (see also "Consumer Advocacy Policy" ORI.1.23).

16. New consumers are screened by the contracted Access/Customer Service provider. If services are requested but denied by the contracted Access/Customer Service provider (as a result of not meeting medical necessity, severity of illness, and/or intensity of service needs criteria), they will provide an Adverse Benefit Determination Notice and HBH receives a copy.

17. There are no incentives to staff for the denial, limitation, or discontinuation of services to any consumer.

Procedure:

1. Recipients of, or applicants for, public mental health services may pursue their complaint in several ways, including:
   - Office of Recipient Rights (as a recipient rights complaint)
   - Second Opinion process
   - Informal conflict resolution
   - Customer Service - Provider Appeal process
   - MDHHS State Fair Hearing (if Medicaid or Healthy Michigan recipient; in relation to adverse actions)
   - MDHHS Alternative Dispute Resolution (if not a Medicaid recipient and local processes have been exhausted; in relation to adverse actions)
   - Customer Service - Provider Grievance Process (for both Medicaid and Non-Medicaid consumers; for all other issues not in relation to adverse actions or recipient rights issues)

A. Grievance/Informal Dispute Resolution/Local Resolution Process:

1. Any consumer may request the grievance resolution process regarding a complaint for services and supports.
2. HBH will record the grievance, send an acknowledgement letter to consumer within five (5) days, and notify the HBH Clinical Director.
3. The HBH Clinical Director will involve the appropriate internal resources to investigate the grievance (e.g., Recipient Rights Officer, Primary Worker, Program Supervisor, etc.) to resolve the issue.
4. Once a resolution is determined, HBH sends a disposition letter to the consumer within ninety (90) days for Medicaid/HMP consumers or sixty (60) days for non-Medicaid/HMP consumers. If the consumer appeals the action, the appeal will be processed by HBH. Any Medicaid/HMP consumers who do not receive a disposition letter within the required ninety (90) days can file for a state hearing.

B. Second Opinion: Hospitalizations & Crisis Residential: Sections 330.1409 & 330.1498(e):

1. If a consumer is screened for in-patient psychiatric hospitalization or crisis residential services and is denied access to either, they may request a second opinion (see "Second Opinion Procedure" RR.2.47).
2. The request for the second opinion shall be processed in accordance with the Michigan Mental Health Code. Within three (3) days of the request for a second opinion (excluding Sundays and legal holidays), the Executive Director shall arrange for an additional evaluation by a psychiatrist, other physician, or licensed psychologist to be conducted. If the conclusion of the second opinion is different from the initial decision, the Executive Director, in conjunction with the Medical Director, shall make a determination based upon the clinical information available within three (3) business days. (See also "Request for Second Opinion Form for Hospitalization" (90-181)).

C. Second Opinion: All Other Services: (330.1705):

1. The request for the second opinion shall be processed in compliance with 330.1705 of the Michigan Mental Health Code. Upon request for a second opinion regarding services, the HBH Executive Director will obtain a second opinion from a physician, licensed psychologist, master's level psychologist, master's level social worker, or registered professional nurse. If the conclusion of the second opinion determines the individual to have a serious mental illness, serious emotional disturbance, or intellectual/developmental disability (I/DD), or if the individual is experiencing an emergent/urgent situation, mental health services will be provided. (See "Second Opinion Form for Non-Emergent Services" # 90-370).
2. The Executive Director (or designee) will complete their determination within the following timeframes:
   a. Standard Determinations: HBH staff has fourteen (14) calendar days from the receipt date to make a determination and notify the consumer of the decision.
   b. Expedited Determinations: HBH staff has three (3) working days from receipt date to make a determination and notify the consumer of the decision.

D. Recipient Rights Complaints:

1. If staff is made aware or if they suspect that a rights violation has occurred, they will:
   a. immediately contact the HBH Recipient Rights Officer
   b. complete (or assist the consumer in completing) a complaint form (DCH - 0030)
   c. forward the completed complaint form to the Recipient Rights Officer

E. MDHHS State Fair Hearing Process:

1. All Medicaid beneficiaries will be informed of their right to access the State Fair Hearing process. Information on how to access this is provided in the "MDHHS State Fair Hearing Brochure" (from MDHHS) and also the Regional Consumer Handbook and includes:
   a. The right to a state fair hearing

- the method of obtaining a hearing
- the rules that govern representation at the hearing

b. The right to file grievances and appeals

- the requirements and time frames for filing a grievance or appeal
- the availability of assistance in the filing process
- the toll-free number which beneficiaries can use to file a grievance or appeal by phone

c. Continued benefits when requested by the beneficiary. Benefits may continue if they file an appeal or a request for fair hearing within the time frames specified for filing. The beneficiary may be required to pay the cost of services furnished, if the final decision is adverse to the beneficiary.

2. HBH employees shall not limit or interfere with the applicant's or consumer's right to make a request for a hearing and will assist the consumer in submitting the grievance or appeal when requested.

3. Consumers of service or service providers who assist a consumer in the grievance and dispute resolution process shall be protected from discrimination and/or retaliation.

4. HBH must reinstate and continue services until a hearing decision if any of the following occurs:

a. Action/Adverse Benefit Determination was taken without the required Adverse Benefit Determination Notice
b. The consumer requests a hearing within twelve (12) calendar days of the mailing of the action/Adverse Benefit Determination
c. HBH determines that the action resulted from factors other than the application of Federal or State law or policy

5. A consumer may request a Fair Hearing by filling out the MDHHS Hearing Request Form DCH-0092 (www.michigan.gov/documents/Dch-0092_9635_7.doc) with assistance from HBH staff, if needed.

6. A Fair Hearing Officer has been designated at HBH whose responsibilities include:

- serving as the HBH representative for the alternative dispute resolution process
- scheduling a private room and ensuring that all the equipment is available for the Administrative Law Judge to conduct the Fair Hearing
- contacting the Administrative Law Judge if it is anticipated that someone critical to the case will be late for the hearing
- ensuring all witnesses relevant to the case and all documents supporting HBH's case are available at the hearing

10. An Administrator or Legal Counsel shall be designated by the Executive Director as the individual representing HBH at the Fair Hearing whose responsibilities will include:

- Completing a Hearing Summary Report (DCH-0367 (www.michigan.gov/documents/Dch-0367(E)_9638_7.doc). This report and all relevant documents to be entered into evidence will be submitted to the Administrative Law Judge ten (10) days prior to the Fair Hearing date. A copy of these materials will be forwarded to the consumer prior to the Fair Hearing.
- Assisting the consumer (when requested) with contacting the Administrative Tribunal to reschedule the Fair Hearing meeting if the consumer cannot attend the scheduled Fair Hearing
- Making the opening and closing statements representing HBH's position, calling and questioning the witnesses relevant to the case, and ensuring that all HBH evidence is presented for consideration by the Administrative Law Judge

11. The Primary Worker is responsible for:

- assisting the consumer with transportation needs if requested so that the consumer can attend the hearing
- modifying the Individual Plan of Service (IPOS) after the hearing results are available (when applicable)

12. The Administrative Tribunal will notify HBH and the consumer as to the date of the Fair Hearing.

13. In instances where medical issues are involved, the Administrative Law Judge may determine that a medical assessment other than that completed by the original treating physician is necessary. In these cases, HBH will be responsible for obtaining the additional assessment at no expense to the consumer. The assessment will be retained by HBH in the consumer's case record.
14. The consumer may withdraw a request for a Fair Hearing in writing by submitting a Hearing Withdrawal Form DCH-0093. HBH employees will ensure the consumer understands that, at no point, are they required to withdraw their request for a Fair Hearing. Only the consumer or their legal representative can withdraw the Fair Hearing request.
15. If HBH's action is supported by the Fair Hearing decision, HBH may seek reimbursement from the consumer for the cost of any services provided to the consumer during this period of time, up to the consumer's ability to pay (see "Sliding Fee Discount Program/Ability to Pay (ATP) Policy" FM.1.11).

F. Adverse Benefit Determination Notices (previously known as Advance Notice and Adequate Notice):

1. When it is determined that a covered service is suspended, reduced, or terminated, the consumer shall be given the Adverse Benefit Determination Notice per the table below:

Action/Adverse Benefit Determination	Adverse Benefit Determination Notice *(previously Advance Notice)*	Adverse Benefit Determination Notice *(previously Adequate Notice)*	Time frame for Notice
Denial of Service Request		X	At the time of the decision
When the IPOS is developed		X	At the time of the IPOS
Reduction, Suspension, or Termination of Service(s) currently being received per the IPOS	X		At least 10 calendar days PRIOR TO the proposed effective date (***NOTE*** – EFFECTIVE 12/01/16, for GF Consumers 30 calendar days BEFORE the action occurs)
Standard Authorization Decision that denies/limits service(s) requested		X	Within 14 calendar days of the request
Expedited/Quickened Authorization Decision that denies/limits services requested		X	Within 72 hours of request
Consumer is deceased, cannot be reached, has relocated out of county or to another PIHP, admitted to institution where ineligible for further services, or consumer clearly states (in writing) that they wish services to be terminated/reduced		X	At the time of the decision

2. If the consumer receives notice to terminate, reduce, suspend, or deny treatment or services, and disagrees with the action/adverse benefit determination, they may request a local appeal. For consumers with Medicaid/HMP, a local appeal must be filed within sixty (60) calendar days. Other consumers have forty-five (45) calendar days to appeal. HBH has five (5) days to send an acknowledgement letter and then thirty (30) calendar days to send a disposition letter informing the Medicaid/HMP consumers of the results of the appeal (or 45 days for non-Medicaid/HMP consumers). If HBH does not notify the consumer within thirty (30) calendar days, Medicaid/HMP consumers can file for a state hearing. If waiting thirty (30) days could cause the consumer serious harm, they may request a quick/expedited appeal. Medicaid/HMP consumers may also file a quick/expedited appeal. Quick appeals must be processed within seventy-two (72) hours for Medicaid/HMP consumers or three (3) business days for non-Medicaid/HMP consumers.

G. MDHHS Alternative Dispute Resolution Process for Non-Medicaid Consumers:

1. Consumers must begin with the local resolution process first. The consumer is entitled to the MDHHS Dispute Resolution Process only after completion of the local appeal resolution process. (See section "A. Grievance/Informal Dispute Resolution/Local Resolution Processes" section of this procedure).
2. The notice of Informal Dispute Resolution/Local Grievance decision or Second Opinion Action Notice (90-181) to a consumer will include information on the consumer's right to request access to the MDHHS Alternative Dispute Resolution process. This notice will also include information regarding the consumer's right to file a

Recipient Rights Complaint with the Recipient Rights Officer, alleging a violation of the recipient's right to treatment suited to his/her condition.

3. Consumers interested in accessing the Alternative Dispute Resolution Process must request a review in writing using the "Dispute Resolution Request Form" (90-290) within five (5) business days of the written outcome of the Local Appeal Resolution or Second Opinion. The request will include the following (as applicable):
   a. Name of consumer
   b. Name of Guardian legally empowered to make treatment decisions or parent of minor child
   c. Daytime phone number where the consumer, guardian legally empowered to make treatment decisions, or parent of a minor child may be reached
   d. Name of the Agency/Program where services have been denied, suspended, reduced or terminated
   e. Description of the service being denied, suspended, reduced or terminated
   f. Description of the adverse impact on the consumer caused by the denial, suspension, reduction or termination of service
4. The Fair Hearing Officer will work with the MDHHS representative (from the division of Program Development, Consultation, and Contacts) to complete the MDHHS Alternative Dispute Resolution process.
5. MDHHS representative will refer the dispute to the appropriate MDHHS Bureau of Community Mental Health Services representative for contractual action within one (1) business day if the denial, suspension, termination, or reduction of services and/or supports will pose an immediate and adverse impact upon the individual's health and safety. Contractual action will be taken consistent with the applicable provisions of the MDHHS/CMHSP contract. This referral will be communicated in writing to the consumer, guardian, or parent of a minor child within twenty-four (24) hours.
6. The assigned MDHHS representative will complete his/her review within fifteen (15) business days in cases that do not pose an immediate danger to the individual's health and/or safety. Written notice of the resolution shall be submitted to the consumer, his/her guardian, or parent of a minor.

H. Denial or Termination of Family Support Subsidy:

1. The responsible HBH employee will review all applications for the Family Support Subsidy and promptly approve or deny the application.
2. HBH employees will provide written notice to the applicant of the adverse benefit determination and the right of the parent or guardian to administratively appeal the decision.
3. If the application is denied due to insufficient information on the application form or the required attachments, the HBH employees shall identify the insufficiency in the written notification.
4. If an application for a Family Support Subsidy is denied or terminated by HBH, the parent or legal guardian will be informed of their right to request an Informal Dispute Resolution/Local Grievance Process.
5. The request for an Informal Dispute Resolution/Local Grievance Process must be submitted in writing within two (2) months of the notice of termination or denial. HBH employees will provide assistance if requested by the consumer.
6. An Informal Dispute Resolution/Local Grievance Process will 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, being sections 24.271 to 24.287 of the Michigan Compiled Laws.

Definitions/Acronyms:

Acronyms:

ABD – Adverse Benefit Determination
ADA – Americans with Disabilities
CA - Coordinating Agency

CMHSP – Community Mental Health Service Programs
EMR – Electronic Medical Record
HBH – Huron Behavioral Health
HMP – Healthy Michigan Plan
I/DD – Intellectual/Developmental Disability
IPOS – Individual Plan of Service
MCO – Managed Care Organization
MDHHS – Michigan Department of Health and Human Services
MSHN – Mid-State Health Network
PIHP – Pre-paid Inpatient Health Plan

Definitions:

Administrative Law Judge: this refers to a qualified individual designated by MDHHS to conduct a hearing in accordance with rules of evidence, Department rules, and state and federal regulations and statutes.

Administrative Tribunal: this refers to a division of MDHHS responsible for oversight, operations, and decisions of the Administrative Law Judges carrying out their responsibility conducting Fair Hearings as required by the Michigan Mental Health Code, Public Health Code, Social Welfare Act, Administrative Code, Administrative Procedures Act, and/or federal law/ regulation.

Administrative Tribunal Hearing: this refers to an evidentiary hearing for a Medicaid consumer conducted by an Administrative Tribunal regarding a decision by HBH to deny, terminate, reduce or suspend services.

***Adverse Benefit Determination*:** this refers to a decision that adversely impacts an enrollee's claim for services *(42 CFR 438.400)* due to:

1. Denial or (a) limited authorization of a requested service, including determinations based on the type or level of service, requirements for (b) medical necessity, (c) appropriateness, (d) setting, or (e) 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 service.
4. Failure to provide services in a timely manner, as defined by the state notice about the decision within fourteen **(14) calendar days** from the date of receipt of a standard request for-service.
5. Failure to make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization.
6. Failure to provide services within fourteen **(14) calendar days** of the start date agreed upon during the person-centered planning process and as authorized.
7. Failure to resolve standard appeals and provide notice within thirty **(30) calendar days** from the date of a request for a standard appeal.
8. Failure to resolve expedited appeals and provide notice within seventy-two **(72) hours** from the date of a request for an expedited appeal.
9. Failure to resolve grievances and provide notice within ninety **(90) calendar days** of the date of the request.
10. For a resident of a rural area with only one Managed Care Organization (MCO), the denial of an enrollee's request to exercise his or her right to obtain services outside the network.
11. Denial of an enrollee's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other enrollee financial responsibility.

Alternative Services: this refers to a set of MDHHS-approved, flexible services that are offered to beneficiaries in lieu of Medicaid state plan services, and for which Medicaid-capitated funds may be used to pay under the authority of the Section (A) (1) (a) of the Social Security Act and approved for use via Michigan's 1915 (b) waiver by the Centers for Medicare and Medicaid.

Appeal: this refers to a review at the local level of an Adverse Benefit Determination.

Appropriateness: this refers to authorizing the suitable type of service for the consumer's condition to receive the full benefit of the service being provided.

Authorization of Services: this refers to the processing of requests for initial and continuing service delivery. *42 CFR 438.210(b).*

Authorized Hearing Representative: this refers to an individual who stands in for (or represents) the consumer in the hearing process. The legal right to do so comes from one of the following sources (an individual who assists, but does not stand in for the beneficiary in the hearing process does not need to meet the criteria):

- Written authorization, signed by the beneficiary, giving the individual authority to act for the beneficiary in the hearing process;
- Court appointed guardian or conservator;
- Legal parent of a minor child;

- The beneficiary's spouse, or a deceased beneficiary's widow or widower, only when no one else has the authority to represent the beneficiary.

Consumer: this refers to a person who is requesting or receiving mental health services, including Medicaid beneficiaries, and all other recipients of CMHSP services. It could also apply to the person's authorized representative, his/her family, his/her representative of a decreased enrollee's estate, and other referral sources. Unless otherwise noted, this requirement applies to all funding sources (they may also be referred to as "Recipient", "Beneficiary", or "Customer").

Expedited Appeal: this refers to the expeditious review of an Adverse Benefit Determination, requested by an enrollee or the Enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the enrollee requests the expedited review, HBH determines if the request is warranted. If the enrollee's provider makes the request, or supports the enrollee's request, HBH must grant the request. *42 CFR 438.410(a).*

Fair Hearing: this refers to an impartial review conducted by an impartial Administrative Law Judge of MDHHS regarding a consumer's dissatisfaction with an HBH decision related to actions taken (see above).

Grievance: this refers to an enrollee's expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the enrollee's rights regardless of whether remedial action is requested, or an enrollee's right to dispute an extension of time proposed by HBH to make an authorization decision. *42 CFR 438.400*.

Grievance and Appeal System: this refers to the processes HBH implements to handle Appeals of an Adverse Benefit Determination and Grievances, as well as the processes to collect and track information about them. *42 CFR 438.400*.

Grievance Process: **this** refers to an **i**mpartial local level review of an enrollee's grievance**.**

Individual Plan of Service (IPOS): this refers to a plan for treatment that includes clearly stated goals, measurable objectives and methodology that specifies the amount, scope, duration, and intensity of services to be provided. The plan is derived from the assessment of the individual's condition, the persons' wishes and desires and considering health and safety factors. This plan is developed in the context of Person and/or Family Centered Planning.

Informal Dispute Resolution: this refers to a process by which the customer may resolve grievances or appeals directly with the treating staff, supervisor, or administrator prior to accessing the formal Local Appeal and Grievance Process and/or MDHHS Medicaid Fair Hearing/Dispute Resolution Processes. Also referred to as "Local Resolution Process".

Legal Representative: this refers to an individual who has been appointed by the court to act on a consumer's behalf who is a minor, legally incapacitated, or developmentally disabled. (At HBH, the term "Guardian" is used interchangeably. See ORI.1.15 - Personal Representative/Guardian Policy).

Limited Authorization: this refers to approving a service request at a lower duration than what was requested by the beneficiary or provider.

MDHHS Alternative Dispute Resolution Process: this refers to the MDHHS dispute resolution process established to provide an Administrative forum for grievances and disputes by consumers of Community Mental Health services and public substance abuse services who are not covered by the federal standards related to State Fair Hearing. If a non-Medicaid consumer is dissatisfied with a decision of the contracted Access/Customer Service provider related to a local appeal regarding a suspension, reduction or termination of services they may request this review within five (5) business days of the decision.

MDHHS Fair Hearing: this refers to an impartial review by a MDHHS Administrative Law Judge of a decision regarding public mental health and/or substance use disorder services specific to a consumer. A Consumer completes the necessary process to access this service, with PIHP, CMHSP, or CA assistance as needed.

Medicaid Services: this refers to services provided to an enrollee under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

Medical Necessity: A determination that a specific service is medically (clinically) appropriate, necessary to meet an individual's needs, consistent with the person's diagnosis, symptomology, and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical Necessity Criteria Mental health, developmental disabilities, and substance abuse services are supports,
services, and treatment:

- necessary for screening and assessing the presence of a mental illness, developmental disability, or substance use disorder; and/or
- required to identify and evaluate a mental illness, developmental disability, or substance use disorder; and/or
- intended to treat, ameliorate, diminish, or stabilize the symptoms of mental illness, developmental disability, or substance use disorder; and/or
- expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

- designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

The determination of a medically necessary support, service, or treatment must be:

- based on the information provided by the beneficiary, the beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;
- based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- for beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- made within federal and state standards for timeliness;
- sufficient in amount, scope, and duration of the service(s) to reasonably achieve its/their purpose; and
- documented in the individual plan of service

Notice of Resolution: this refers to a written statement regarding the resolution of a Grievance or Appeal, which must be provided to the enrollee as described in *42 CFR 438.408*.

Partial Denial: this may be done when multiple services are requested, but not all of the services are authorized, or the service is a lower amount than what was requested by the consumer or provider

Pre-paid Inpatient Health Plan (PIHP) Provider Network: This refers to the regional provider network for both public mental health and public substance abuse services. For public mental health, this includes the PIHP named Mid-State Health Network (MSHN), the CMHSP Affiliates within the MSHN, and the CMHSP Affiliates' contracted provider networks.

Primary Worker: refers to the staff with primary responsibility for the coordination of the consumer's services. This may be a Case Manager, Supports Coordinator, Clinical Specialist, Family Support/Respite Services Worker, Therapist, ACT or Home-Based Services staff.

Provider Network: This refers to the regional provider network for both public mental health and public substance abuse services. For public mental health, this includes the PIHP named Mid-State Health Network (MSHN), the CMHSP Affiliates within the MSHN, and the CMHSP Affiliates' contracted provider networks.

Recipient: this refers to a person receiving services, or the individual's authorized representative (if applicable) or the individual's parent (if they are a minor child), and/or guardian (if applicable). Also referred to as "Consumer".

Reduction: this refers to providing services at fewer units that the previously authorized units.

Residential Facility: this refers to a specialized residential, 24-hour supervised, program where treatment is provided and is operated under contract with HBH.

Recipient Rights Complaint – this refers to statements or allegations, verbal or written, by the consumer or anyone acting on his/her behalf that alleged a violation of a Mental Health Code protected right cited in Chapter 7 will be resolved through processes established in Chapter 7A of the Michigan Mental Health Code.

Scope: this refers to the focus or intent of the requested service.

Service Authorization: this refers to the PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to *42 CFR 438.210.*

Setting: this refers to the place or surroundings where services are being requested to occur (e.g., community, residential, family setting, etc.).

State Fair Hearing: this refers to an impartial state level review of a Medicaid enrollee's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as an "Administrative Hearing". (The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.) The enrollee has 120 days to request a State Fair Hearing whereby the state can offer and arrange for an external medical review. HBH must implement a reversal of an adverse benefit determination and provide services no later than seventy-two (72) hours from the overturn. A state fair hearing is available only after HBH has upheld an adverse benefit determination through the local appeals process.

Suspension: this refers to a temporary hold/pause when a service cannot/will not be provided due to external factors, such as the consumer being away for an extended period.

Termination: this refers to the end of a previously authorized service(s)

Treatment Plan (specifically for substance use disorder services: this refers to a plan for treatment that includes clearly stated goals, measurable objectives, and methodology that specifies the amount, scope, duration, and intensity of services to be provided. The plan is derived from an assessment of the individual's condition and includes the customer in its development.

***Unreasonable Delay* –** this refers to postponing of services beginning by fourteen (14) or more calendar days beyond the start date agreed upon during the person-centered planning and as authorized.

Forms:

90-181 Second Opinion Form (for hospitalizations and crisis residential)
90-290 Dispute Resolution Request Form
90-370 Second Opinion Form (For non-emergent services)
90-709 Adverse Benefit Determination for Non-Medicaid Recipients Form
90-710 Adverse Benefit Determination for Medicaid Recipients Form
Adverse Benefit Determination Form (Medicaid and Non-Medicaid) in EMR
DCH-0030 Recipient Rights Complaint Form
DCH-0092 Request for Administrative Hearing Instructions Form (www.michigan.gov/documents/Dch-0092_9635_7.doc)
DCH-0093 Hearing Request Withdrawal Form (www.michigan.gov/documents/Dch-0093_9637_7.doc)
DCH-0367 Hearing Summary Form (www.michigan.gov/documents/Dch-0367(E)_9638_7.doc)
DCH Medicaid Fair Hearings Brochure (www.michigan.gov/documents/ADMINISTRATIVEHEARINGS_81632_7.brochure.pdf)

Records:

Records of all grievances and appeals are retained by the HBH Grievance and Appeals Coordinator. Records of all grievances, appeals, and complaints are also tracked and retained by the contracted Access/Customer Services provider.

Reference(s) and/or Legal Authority

Mid-State Health Network "Adverse Benefit Determination Regional Technical Guide" @ https://midstatehealthnetwork.org/application/files/6617/5448/6180/MSHN_ABD_REGIONAL_TECHNICAL_GUIDE.2025.pdf
PA 55 of 2020 section 206(a)
PA 516 of 1996
PA 258 of 1974, as amended
PA 306 of 1969, being sections 24.271 to 24.287 of the Michigan Compiled Laws.
S.353-Health Insurance Bill of Rights of 1997
42 CFR sections 438.10 (Information Requirements), 431.200 (Fair Hearings), 438.400 (Appeals and Grievances) @ http://www.gpo.gov/fdsys/granule/CFR-2010-title42-vol4/CFR-2010-title42-vol4-sec438-404/content-detail.html
MDHHS Appeal & Grievance Resolution Processes Technical Requirement (Medicaid version)
Michigan Mental Health Code MCL 330.1772 (Recipient Rights Complaints) & MCL 330.1705 (Second Opinions)
ORI.1.23 Consumer Advocacy Policy
RR.2.47 Second Opinion Procedure
FM.1.11 Sliding Fee Discount Program/Ability to Pay (ATP) Policy
RR.1.02 Limited English Proficiency Accommodation Policy

Change History:

Change Letter	Date of Change(s)	Changes
A	05/27/03	Brought into new procedure template and controlled documentation system with minimal changes to content.
B	08/31/04	Re-ordered Information section and added items: a, b, d, f, g, j, k, l, m, n, o, p, & q in "Procedure" section, added Grievance types, items 1, 2, 3, 4, 5, 6, & 7; Changed Level One from "5" to "3" days, changed Level Two from "20" to "2" days, changed Level Three from "10" to "2" days, , changed Level Four from "21" to "3" days. Added "Notice Requirements" section, added "Definitions" section, added "acronyms" section: AAM, ADA, CMHSP, PCP; added "Reference" section "Section 504…." . Added clarification to comply with the balanced budget act (42 CFR parts 438). Reformatted entire procedure and added numerous sections to more clearly define process and comply with recent Office of Recipient Rights Technical Guidelines and the Balanced Budget Act.
C	2/27/05	Changed #2 in information section to include filing verbally or in writing. Deleted #3 in same section due to incorporating in #2. Local Appeals, #4 changed that services may continue rather than will be and added if the consumer request…, added to #8 bullet 4 that the primary worker will not be involved in this process, #9 added the ED will determine and direct all corrective action, Moved adequate and Advance process before the Fair Hearing process, added reference to deceased consumer's estate under the local appeals section, changed the wording that benefits may (will) continue, moved what must be sent to the consumer prior to the action taken to f. under the local appeal section, added the consumer may request a fair hearing into the Advance Notice section, added definition of when a local appeal and/or State Fair Hearing may be requested in the information section #29, added when adequate notice will be sent under the adequate notice section first bullet, added statement regarding Medicaid consumers right to request hearing….. in Local Appeals section #13, b to comply with BBA & EQR requirements
D	05/23/06	In "Information" section – reworded #8, made #9 & 10 bullets under #8, removed #11, 12, 15, 16, 17, 18, 22, 23, 25, 26, and moved #13 to PCP Procedure (QI.2.18) and added a new #12, added "Second Opinion" section and reworded to include "All other services" and referenced a new form (90-366), changed the form numbers to reflect the AAM regional forms issued02/06, under "Denial of Services" section removed all steps defined for AAM activity, removed "Reduction, Suspension, Termination" section, removed #7 from "Alternative Dispute Resolution…" section, removed references to HBH forms and added in AAM regional forms, added definitions for "Rights Complaint" and "Unusual Delay", added "All Other Services" under "Second Opinion" section. (For full detail of changes and previous revisions see the QI Coordinator), added form 90-370 for non-emergent services, changed title from "Appeal & Grievance" to "Grievance & Appeal". Numerous additional changes made to consolidate and

		condense sections; see QI Coordinator for additional details/copies.
E	08/25/06	Added second sentence in the first paragraph in the "Procedure" section to comply with 42 CFR 438.406(a) and the MDCH Grievance system.
F	06/28/07	Revised to comply with the Delegated Managed Care audit requirements. Added # 6, 7, & 8 under "A. Local Resolution Process". Refined the definition of "Appeals" by adding the word "adverse", and also "with which the consumer….".
G	12/03/08	Reviewed and revised to comply with COA 8th Edition Standards and present practices – added "without any interference or retaliation to the first sentence in #2 (Information section), added the second sentence in A.3.
H	12/08/09	Changes made to correct for regional responsibilities/CMHSP responsibilities as part of the follow-up to AAM's 2009 Delegated Managed Care Audit, removed references to HBH conducting on-site grievance – this is now a regional function, made numerous other changes to support this responsibility change (see QI Coordinator for details and old versions)
I	04/23/12	Changes made to comply with AAM Technical Requirements. Throughout document- changed Medicaid Fair Hearing to MDCH State Fair Hearing, changed Medicaid consumers to Medicaid and ABW consumers, changed Local Resolution Process to Local Grievance Process/Informal Conflict Resolution Processes, added "MDCH" to Alternative Dispute Resolution. Information section- Added #2, #4 first sentence changed HBH to AAM, removed "will offer", added "may", changed "assistance" to "assist". #5- fourth sentence added "through AAM". #11 changed "HBH" to "AAM". Removed sentence starting with "Aggregate report". Procedure section- removed first paragraph and added new first paragraph. A #1 changed "AAM Customer Service" to "the HBH Office of Recipient Rights", #2 changed "AAM" to "HBH" changed "Program Director" to "Clinical Director", #3 changed "program" to "clinical", "complaint" to "grievance", and removed the last sentence. #4 added "via Secure Desktop", changed "AAM" to "HBH", and removed "(See AAM protocols)". Removed original number #5 and #7. Second opinion section A #1changed "Instruction ER.3.03" to "Procedure RR.2.47". Advanced & Adequate Notices section- added last sentence to #1. Definition section- "consumer" added entirely new definition and added "customer" to the last statement, "grievance" added "quality of care, services" and removed "activities". Added "informal dispute resolution". Removed "Local Resolution Process". "Legal Representative" added "act on a consumers behalf" and removed "exercise specific powers…". "MDCH Alternative Dispute…" added "public substance abuse services". Added "MDCH Fair Hearing". "Person centered Plan" added statement after "methodology" to "is derived". Added "Pre-paid Inpatient Health Plan (PIHP) Provider Network". Added "recipient" to "Rights Complaint" and added last sentence. Added "treatment Plan. "Unreasonable Delay" removed definition and added new one. Acronyms- Added CA-Coordinating Agency. References- removed ER3.03 and added RR.2.47 4/23/12 approved by the HBH Rights Advisory Committee.
J	06/04/14	Changed "AAM" and "BABH" to "contracted Access/Customer Service" provider or staff (9 places). In "Definition" section under "PIHP" changed "AAM" to "MSHN" (2 places) in "Records" section removed "AAM Reference Tracking Log database and replaced with "tracked by contracted Access/Customer Service provider", removed "AAM" from "Acronym" section.
K	04/08/15	In "Scope" section changed "employees" to "providers" (2 places) and added "including organizational providers", changed "ABW" to "Healthy Michigan" throughout document (3 places), added #5 in "Information" section, in "Acronym" section removed "OBRA" & "RRO" and added "EMR", in "Forms" section removed references to form numbers and regional forms and replaced with references to EMR forms, under "Advance & Adequate Notices" #1 (page 4) removed references to form numbers and regional forms and replaced with references to EMR forms, added #14 in "Information" section.
L	05/25/16	Changed "MDCH" to "MDHHS" throughout document (32 places), made several minor grammatical/wording changes/corrections throughout document without changing sentence content.
M	12/02/16	In table under "Advance & Adequate Notices added "(NOTE"- Effective December 01, 2016, 30 calendar days BEFORE the action occurs for GF consumers)" to comply with HB 5294, sect. 942, In "Definitions" section "Advance Notice" added "NOTE-…"
N	10/31/17	Total rewrite of procedure – see Controlled Documentation Manager for previous versions and changes.
O	08/21/18	In "Information" #10 removed "a." & "b." which was redundant information regarding MDHHS alternative dispute resolution system, in "Procedure" section A added "Grievance" to section title in A.2 added "within five (5) days", in #4 added "within 90 days for MC consumers and 60 days for non-Medicaid consumers", & removed A.5 which was incorrect timeframes for standard resolution, added E.2, renumbered procedure
P	11/26/19	Changed "Adequate Notice" and "Advance Notice" to "Adverse Benefit Determination Notice" throughout procedure (19 places), changed "Person Centered Plan/PCP" to "Individual Plan of Service/IPOS" (6 places). In "Definitions" section removed "Adequate Notice" Advance Notice", in "Acronyms" section added "IPOS", made several minor wording/grammatical changes/corrections throughout document without changing sentence content.
Q	07/14/20	In "Information" section added last sentence in #3, added #4, added last sentence in #7 & address, in #10 added "mediation", in #13 added "requests for mediation", in "Acronyms" section added "HMP" & "I/DD", made several minor wording/grammatical changes/corrections throughout procedure without changing sentence content.
R	06/20/22	Made several minor wording/grammatical changes/corrections throughout procedure without changing sentence content.
S	01/19/24	The following revisions were made to better align with newly revised version (December 19, 2023) of MSHN "Adverse Benefit Determination Regional Technical Guide": in "Acronyms" section removed "PCP", in "Definitions" section added "appropriateness", "Limited Authorization", "Medical Necessity", "Reduction", "Scope", "Setting", "Suspension", "Termination", in "References" section added "Adverse Benefit Determination Regional Technical Guide", made several minor wording/grammatical/formatting changes/corrections throughout procedure without changing sentence content.
T	11/07/24	Removed references to mediation throughout procedure (3 places – in "Information" section #3, #10, & #13) to comply with Recipient Rights Audit findings.
U	09/30/26	In "Purpose" section added "grievances, and appeals", in "Information" section #1 added "and MDHHS Medicaid contract attachment", in #7 added "In accordance with 42 CFR 438.10" and "(called an "Adverse Benefit Determination" or "ABD")" and added "The ABD must include:" and bullets, in #15 added reference to ORI.1.23, in "Acronyms" section added "ABD", in "References" section added ORI.1.23, made numerous minor wording/grammatical/formatting changes/corrections throughout procedure without changing sentence content.