LAKESHORE BEHAVIORAL HEALTH ALLIANCE
Community Mental Health Services of Muskegon County
Community Mental Health of Ottawa County
Lakeshore Coordinating Council for Substance Abuse Services

POLICY AND PROCEDURE

No. 04-023 and
20-054

Prepared by:	Judith E. Cohen Network Manager	Effective: Revised:	October 1, 1998 June 1, 2010
Approved by:		Subject:	Managed Care Grievances and Disputes

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John North, Executive Director

I. POLICY:

Lakeshore Behavioral Health Alliance and its Affiliates will provide for a fair and efficient process for resolving reduction, suspension, termination or denial of service as well as, Medicaid and non-Medicaid grievances.

II. PURPOSE:

To ensure all individuals receiving services from the members of the Lakeshore Behavioral Health Alliance have a right to a fair and efficient process for resolving grievances and disputes related to the denial, reduction, suspension or termination of services and supports. This policy in no way requires the exhaustion of grievance or alternative dispute resolution processes prior to the filing of a recipient rights complaint pursuant to Chapter 7 and 7a of the Mental Health Code and Affiliate policies relative to the filing of Recipient Rights Complaints.

III. APPLICATION:

All mental health programs, services, and facilities directly operated by or under contract with Lakeshore Behavioral Health Alliance as well as it's Affiliate members.

IV. DEFINITIONS:

A. Action:

1. Denial or limited authorization of a requested Medicaid or non-Medicaid service, including the type or level of service.
2. Reduction, suspension, or termination of a previously authorized Medicaid or previously provided non-Medicaid covered service.
3. Denial, in whole or in part, of payment for a Medicaid or non-Medicaid covered service.
4. Failure to make an authorization decision and provide notice about the decision within standard time frames.
5. Failure to provide Medicaid or non-Medicaid services within standard time frame.
6. In regard to Medicaid covered services, failure of the PIHP to act within the time frames required for disposition of grievances and appeals.

7. For a resident of a rural area with only one PIHP, the denial of a Medicaid enrollee's request to exercise his or her right to obtain services outside the network.

B. Adequate notice:

Notice to individual at the same time an action takes effect or at the time of the signing of the individual plan of services/supports.

C. Advance notice:

Notice provided to the individual prior to the action, when previously authorized or provided services are reduced, suspended or terminated.

D. B3 Services:

A set of MDCH and CMS approved services which may be provided under the authority of Section 1915(b)(3) of the Social Security Act. The intent of B3 Services (formerly known as alternative services) is to fund medically necessary supports and services that promote community inclusion and participation, independence and/or productivity when identified in the individual plan of service as one or more of goals developed during the person-centered planning process.

E. Appeal:

A request for a review of an action (as defined above) relative to a Medicaid covered service or non-Medicaid covered service.

F. Grievance:

An expression of dissatisfaction about any matter relative to a Medicaid or non-Medicaid covered service, other than an action as defined above, which does not involve a Recipient Rights complaint as defined in Section I. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the individual.

G. Medicaid covered service:

A Medicaid State Plan, B3, Children's Waiver, or Habilitation Supports Waiver service as defined in the most recent version of Chapter III of the Michigan Department of Community Health, Medical Services Administration Bulletin.

H. Reasonable Person:

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

I. Resolution notice:

Notice to the individual that is required within established time frames relative to disposition of grievances and resolution of appeals and disputes.

J. Rights complaint:

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

V. PROCEDURE:

A. Notice is given whenever a Medicaid State Plan, B3, or Waiver Service is denied, reduced, suspended or terminated. The notice must be in writing and must be provided in the language format needed by the individual to understand the content (i.e., the format meets the needs of those with limited English proficiency, and/or limited reading proficiency).

B. Actions not related to second opinions:

PROCEDURE FOR ACTIONS NOT RELATED TO SECOND OPINIONS

Action	Type of Notice	Time frame for Notice
Denial of service request	Adequate	At the time of decision
Person-Centered Plan developed	Adequate	At the time of plan development
Increase in benefits	Adequate	At the time of the action
Reduction, suspension or termination of service currently being received	Advance	Twelve (12) days before action
Standard authorization decision that denies or limits services requested	Adequate	Within fourteen (14) days of request*
Expedited authorization decision that denies or limits services requested	Adequate	Within three (3) working days of request*
Unreasonable delay of start of services	Adequate	At the time of the action

**The timeframe may be extended up to another fourteen (14) days at the request of the individual or provider.*
Note: *If an individual's physician makes a determination that a particular Medicaid State Plan or Waiver service is not medically needed, no adverse action occurred. In these instances, an advance notice of adverse action is not required.*

1. The written notice of action (as defined above) must contain the following:
   a. The action taken or intends to take.
   b. The reasons for the action.
   c. The date of the intended action.
   d. If access to services or hospitalization is denied, the right to request a second opinion and an explanation of the process.
   e. The individual's right to file an appeal, dispute and/or rights complaint (the latter is relative only to the suspension, reduction or termination of a service or the denial of hospitalization) and the time frames for doing so.
   f. In regard to Medicaid covered services, the individual's right to request a MDCH Fair Hearing and the timeframes for doing so.

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

2. Time frames for written notice of action: The Affiliates must mail/provide the notice to the individual within the following time frames:

a. For termination, suspension or reduction of previously authorized or provided services at least twelve (12) calendar days before the date of action. (advance notice)
b. For authorization or service decisions that deny or limit services within fourteen (14) calendar days of the standard request for services, or three (3) working days of the request for expedited authorization. If either of these time frames is extended at the individual's or provider's request (up to an additional fourteen (14) calendar days), the PIHP and/or its Affiliates must give the individual written notice of the reason for the extension, and inform the individual of the right to file a grievance if dissatisfied with the decision to extend. (adequate notice).
c. For authorization decisions that are not made within fourteen (14) calendar days (or three days for expedited authorization), and for which an extension has not been agreed to, a notice must be provided to the individual on the fourteenth (14th) day, or third (3rd) working day for an expedited authorization).
d. In the case of the written individual plan of service/support (IPOS), at the time the plan is signed by the individual, his/her guardian, or parent of a minor individual. (adequate notice)

3. Exceptions to the Advance Notice Rule: In addition to B.2. above, the Affiliates may mail a notice not later than the date of action if:

a. It has factual information confirming the death of the individual.
b. The Affiliates receive a clear written statement signed by the individual or his/her legal representative that:
    i. He/she no longer wishes services; or
    ii. Gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying the information.

c. The individual has been admitted to an institution where he/she is ineligible under Medicaid for further services.
d. The individual's whereabouts are unknown and the post office returns the Affiliate's mail directed to him/her indicating no forwarding address.
e. It establishes the fact that the individual has been accepted for Medicaid services by another PIHP.
f. A change in the level of medical care is prescribed by the individual's physician.
g. The Affiliate may shorten the period of advance notice to five (5) days before the date of action if it has facts indicating that the action should be taken because of probable fraud and these facts have been verified, if possible, through secondary sources.

C. Maintaining Medicaid-covered services and supports.

1 If the Affiliate mails the advance notice of action impacting Medicaid covered services as required above and the individual served by the Medicaid program or his/her legal representative requests a MDCH Fair Hearing before the date of action in lieu of, or in addition to, filing an appeal, the Affiliate may not terminate or reduce services until a decision is rendered after the hearing unless:

a. It is determined at the hearing that the sole issue is one of Federal or State law, **AND**

b. The Affiliate promptly (i.e., in the advance notice) informs the individual that services are to be terminated, reduced or suspended pending the MDCH hearing decision.

2. If the Affiliate's action is sustained by the Fair Hearing Decision, the Affiliate may seek reimbursement from the individual for the cost of any services provided the individual during this period of time, up to the individual's ability to pay as determined by the Code.

D. Reinstatement of Medicaid covered services.

1. The Affiliate must reinstate Medicaid covered services if an individual or his/her legal representative requests a MDCH Fair Hearing not more than twelve (12) calendar days after the date of action.
2. The reinstated Medicaid covered services must continue until the hearing decision unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.
3. The Affiliate must reinstate and continue Medicaid covered services until a hearing decision, if:
   a. Action was taken without the required advance notice; **AND**
   b. The individual or his/her legal representative requests a hearing within twelve (12) calendar days of the mailing of the notice of action; **AND**
   c. The Affiliate determines the action resulted from factors other than the application of Federal or State law or policy.

4. If an individual's whereabouts are unknown as indicated by return of non-forwardable mail from the Affiliate, any discontinued Medicaid State Plan or Waiver services must be reinstated if his/her whereabouts become known during the time he/she is eligible for services.

E. Provider's Right to Appeal.

A provider acting on behalf of a Medicaid eligible individual and with the individual's written consent may file an appeal to the PIHP. The provider may file a grievance or request for a State hearing on behalf of the individual **only** if the State permits the provider to act as the individual's authorized representative in doing so.

F. APPEALS AND GRIEVANCE RESOLUTION PROCESSES

Action	Local Processes	State Level Processes
Denial of request for hospitalization	Step 1. Request a 2nd Opinion, then Step 2. Complaint to the Office of Recipient Rights Step 1.or 2. Appeal to the Local Dispute Resolution Process	Step 1.or 2. Request for a Fair Hearing (for Medicaid beneficiaries) Last Step: MDCH Alternative Dispute Resolution Process (for individuals without Medicaid)
Denial of access to PIHP/CMHSP services	Step 1. Request a 2nd Opinion Step 1.or 2. Appeal to the Local Dispute Resolution Process	Step 1.or 2. Request for Fair Hearing (for Medicaid beneficiaries) Last Step: MDCH Alternative Dispute Resolution Process (for individuals without Medicaid)
Denial, reduction, suspension, termination, or unreasonable delay of Medicaid services.[1]	Step 1.or 2. Appeal to the Local Dispute Resolution Process and/or, Step 1.or 2. Complaint to the Office of Recipient Rights (treatment suited to condition)	Step 1.or 2. Request for Fair Hearing (for Medicaid beneficiaries)
Dissatisfaction with program, provider, other	Step 1. Grievance with Local Dispute Resolution Process and/or, Step 1. Office of Recipient Rights (if the complaint is a violation of a Mental Health Code protected right.)	
Denial of Family Support Subsidy	Step 1. Appeal to CMHSP	Step 2. MDCH Alternative Dispute Resolution Process

[1] *Action taken at the time of Person-Centered planning, or as an outcome of the service authorization process or management decision.*
[2] *Medicaid beneficiaries are not required to exhaust local dispute processes before they request a Medicaid Fair Hearing.*

Note about the steps: *The Local Dispute Resolution Process may be engaged concurrently with an appeal to ORR, and/or request for State Fair Hearing, unless otherwise noted. The individual is entitled to the formal processes if he/she chooses even if a mediation process is available.*

G. Second Opinions.

PROCEDURE FOR SECOND OPINIONS

1. Denial of hospitalization – Any or all of the following processes may be utilized:

   a. Request for second opinion:

      i. If a pre-admission screening unit or children's diagnostic and treatment service of the Affiliate denies hospitalization, the individual, his/her guardian, or his/her parent in the case of a minor child, may request a second opinion from the Executive Director of the Affiliate.
      ii. The request for the second opinion shall be processed in compliance with Sections 409(4), 498e (4) and 498h (5) of the Code. If the conclusion of the second opinion is different from the conclusion of the children's diagnostic and treatment service or the pre-admission screening unit, the Executive Director, in conjunction with the Medical Director, shall make a decision based upon all clinical information available within one (1) business day.

   b. Rights complaint:

      i. If the request for a second opinion itself is denied, the individual or someone on his/her behalf may file a rights complaint with the Affiliate's Office of Recipient Rights for processing under Chapter 7A.
      ii. If the initial request for inpatient admission is denied, and the individual is a current beneficiary of other Affiliate services, the individual or someone on his/her behalf may file a rights complaint alleging a violation of his/her right to treatment suited to condition.
      iii. If the second opinion determines the individual is not clinically suitable for hospitalization and the individual is a current beneficiary of other Affiliate services, and a Recipient Rights complaint has not been filed previously on behalf of the individual, the individual or someone on his/her behalf may file a complaint with the Affiliate's Rights Office for processing under Chapter 7A.

   c. Appeal- See Local Appeals Resolution Requirements and Process.

   d. MDCH Level:

      i. Medicaid Fair Hearing: For Medicaid beneficiary appeals on actions that impact Medicaid covered services.
      ii. MDCH Alternative Dispute Resolution: For appeals on actions that impact non-Medicaid covered services.

2. Denial of access to any services for individuals not receiving any Affiliate's services, any or all of the following processes may be utilized:

   a. Request for second opinion:
   If an initial applicant for public mental health services is denied such services, the applicant or his/her guardian, or the applicant's parent in the case of a minor must be informed of their right to request a second opinion of the Executive Director. The request shall be processed in compliance with Section 705 of the Code and must be resolved within five (5) business days.

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

c. Appeal: Please see the Local Appeals Resolution Requirements and Process.

d. MDCH Level:

i. Medicaid Fair Hearing: for Medicaid beneficiary appeals on actions that impact Medicaid covered services.
ii. MDCH Alternative Dispute Resolution: for appeals on actions that impact non-Medicaid covered services**.**

3. Denial through the service authorization process of the request for Medicaid State Plan, B3, or Waiver, or denial of the requested amount, scope or duration of a service that was identified and agreed upon by the individual during Person-Centered planning. Any or all of the following processes may be utilized.

a. Rights complaint.
b. Appeal - See Local Appeals Resolution Requirements and Process.
c. MDCH level:

i. Medicaid Fair Hearing: For Medicaid beneficiary appeals on actions that impact Medicaid covered services.
ii. MDCH Alternative Dispute Resolution: For appeals on actions that impact non-Medicaid covered services.

4. Unreasonable delay of a Medicaid State Plan, B3, or Waiver beyond the start date agreed upon during Person-Centered planning and as authorized by the Affiliates. Unreasonable delay is defined as fourteen (14) or more calendar days. Any or all of the following processes may be utilized.

a. Rights complaint.
b. Appeal - See Local Appeals Resolution Requirements and Process.
c. MDCH level:

i. Medicaid Fair Hearing: For Medicaid beneficiary appeal on actions that impact Medicaid covered services.
ii. MDCH Alternative Dispute Resolution: For appeals on actions that impact non-Medicaid covered services.

5. Suspension, reduction or termination of a current Medicaid State Plan, B3, or waiver: Any or all of the following processes may be utilized:

a. Rights complaint.
b. Appeal - See Local Appeals Resolution Requirements and Process.
c. MDCH level:

i. Medicaid Fair Hearing: For Medicaid beneficiary appeals on actions that impact Medicaid covered services.
ii. MDCH Alternative Dispute Resolution: For appeals on actions that impact non-Medicaid covered services.

6. Dissatisfaction about any matter relative to a Medicaid State Plan, B3, or Waiver other than an action as described above.
   a. Grievance – See Grievance Process. Possible subjects include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a provider and the individual.
   b. Rights Complaint: Statements or allegations, verbal or written, by the individual or anyone acting on his/her behalf that allege a violation of a Code-protected right cited in Chapter 7 will be resolved through processes established in Chapter 7A.

VI. APPEAL OF DENIAL OF FAMILY SUPPORT SUBSIDY:

A. Demand for CMHSP Hearing and Appeal.

1. Pursuant to Section 159(3) of the Code, if an application for a family support subsidy is denied or a family support subsidy is terminated by a Community Mental Health Services Program (CMHSP), the parent or legal guardian of the affected eligible minor may demand, in writing, a hearing by the CMHSP. The hearing shall be conducted in the same manner as provided for contested case hearings under Chapter 4 of the Administrative Procedures Act of 1969, Act No. 306 of the Public Acts of 1969, and being Sections 24.271 to 24.287 of the Michigan Compiled Laws.

2. Pursuant to the Administrative Rules: Copies of blank application forms, parent report forms, the forms for changed family circumstances, and appeal forms shall be available from the CMHSP. (R330.1616 Availability of forms) (Note: It is acceptable to ask families to write a letter to the CMHSP requesting an appeals hearing, in lieu of a standardized form.)

3. A CMHSP shall review an application, promptly approve or deny the application, and provide written notice to the applicant of its action and of the opportunity to administratively appeal the decision if the decision is to deny the application. If the denial is due to the insufficiency of the information on the application form or the required attachments, the CMHSP shall identify the insufficiency. (Rule R330.1641 Application review)

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

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

   Michigan Department of Community Health
   Division of Program Development, Consultation and Contracts
   Bureau of Community Mental Health Services
   ATTN: Request for DCH Level Dispute Resolution
   Lewis Cass Building – 6th Floor
   Lansing, MI 48913

VII. MEDICAID FAIR HEARING REQUIREMENTS:

For beneficiaries receiving Medicaid Covered services, the Affiliates must comply with applicable sections of Federal Law 42 CFR 431.200-250 regarding Fair Hearings, as defined through the MDCH policy communications listed as references at the end of the policy.

Note: ***Access to the Fair Hearing process applies to all beneficiaries who receive or request Medicaid covered services, including B3 Services and the Habilitation and Supports Waiver for persons with Developmental Disabilities and the Children's Waiver.***

The individual who has received notice of an action has the right to request a Fair Hearing with a MDCH Administrative Law Judge. Beneficiaries are given ninety (90) calendar days from the date on the notice to file a request for Fair Hearing. They may concurrently file an appeal for Local Resolution. If the individual files a request for Fair Hearing prior to the Affiliate taking an adverse action, the Affiliate must continue the service and not take the action until a Fair Hearing decision has been made.

Please refer to MDCH's Administrative Hearings Policy for detailed information and instructions about the Medicaid Fair Hearings process.

[Note: Failure to make an authorization decision and provide written notice within fourteen (14) calendar days of receipt of a non-emergent request for a service constitutes a service <u>denial or adverse action</u>. Failure to make authorization decisions within three (3) working days after the receipt of an urgent (i.e., following a standard time frame for authorization could seriously jeopardize the individual's health condition) request for service constitutes a service <u>denial or adverse action</u>. The Affiliate may extend either time frame up to fourteen (14) additional calendar days if the individual or provider requests an extension.]

VIII. MDCH ALTERNATIVE DISPUTE RESOLUTION PROCESS:

A. Within ten (10) days of receipt of the written decision on the Local Dispute (appeal or grievance), the individual, his/her guardian, or parent of a minor individual may file a request for a MDCH level Dispute Resolution to:

Michigan Department of Community Health
Division of Program Development, Consultation and Contracts
Bureau of Community Mental Health Services
ATTN: Request for DCH Level Dispute Resolution
Lewis Cass Building – 6th Floor
Lansing, MI 48913

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

In all other cases, MDCH shall complete its review of the dispute within fifteen (15) business days of receipt. Written notice of the resolution shall be submitted to the individual, his/her guardian, or parent of a minor beneficiary.

The Affiliates must provide reports of disputes, complaints, and grievances periodically to its Governing Board with a copy to the PIHP Regulatory Management staff.

Reports of disputes, complaints, and grievances are to be reviewed by the Affiliate's Quality Improvement Program to identify opportunities for improvement. The Affiliate's Quality Improvement Program must send a copy of its actions to the PIHP Regulatory Management staff.

IX. RECORDKEEPING AND REPORTING REQUIREMENTS:

The Affiliates must maintain a record of appeals and grievances and their disposition that is available for review by State staff. The Affiliates must forward their record of appeals and grievances to the PIHP Regulatory Management staff in January and June of each calendar year.

X. LOCAL APPEALS RESOLUTION REQUIREMENTS AND PROCESS:

A. Special Requirements for Appeals. The process for appeals must:

1. Provide that oral requests for appeal of an action are treated as appeals (to establish the earliest possible filing date for the appeal). The oral request must be confirmed in writing, unless the individual requests an expedited resolution.
2. Give the individual reasonable assistance in completing forms and taking other steps to complete the appeals process. This assistance includes, but is not limited to, Interpreter Services, and Affiliate's toll-free numbers that have TTY/TTD and interpreter capability. These numbers are to be found in the: Member Handbook, brochures, and on the notice forms.
3. Provide the individual a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The Affiliates must inform the individual of the limited time available for this in the case of expedited resolution.)
4. Provide the individual and his/her representative the opportunity, before and during the appeals process, to examine the individual's case file, including medical records, and any other documents considered during the appeal process.
5. Include, as parties to the appeal:
   a. The individual and his/her representative; or
   b. The legal representative of a deceased individual's estate.

B. Appeal Process:

1. Within forty-five (45) calendar days of receipt of the action notice, the individual or his/her legal representative, or the provider on his/her behalf, may file an appeal with the local Affiliate's Recipient Rights Office which shall then:
   a. Log receipt of the appeal for reporting to the Affiliate's Quality Improvement Program.
   b. Acknowledge receipt of the appeal; and for a Medicaid beneficiary disputing an action that impacts a Medicaid covered service, advise the individual, guardian, or in the case of a minor, the parent, that he/she may file a request for a MDCH Fair Hearing in lieu of, or in addition to, the appeal. Information shall include the process for filing the request for a hearing, an offer of assistance in filing the request and an explanation of time frames and circumstances under which Medicaid services will be continued pending the hearing decision.
   c. Submit the appeal for review by appropriate staff, including a health care professional who has the appropriate clinical expertise in treating the individual's condition, with none having been involved in the initial determination to deny, suspend, terminate, or reduce the Medicaid covered service.
   d. Facilitate the review of the appeal within forty-five (45) calendar days from receipt of the appeal.

e. Assure an expedited review of an appeal involving an emergent situation where the standard forty-five (45)-day time frame would seriously jeopardize the health or life of the individual. Such a review shall be completed within three (3) working days of receipt of the appeal.

f. Assure the content of the resolution notice and time frame for submission to the individual and his/her legal representative complies with the Resolution Notice requirements.

2. Resolution Notice:

a. Content of resolution notice: Written notice of the appeal resolution must include:

i. The results of the resolution process and the date it was completed.

ii. For appeals not resolved wholly in favor of the Medicaid beneficiary disputing action taken that impacts Medicaid covered services:

a. The right to request a MDCH Fair Hearing, and how to do so, including an offer of assistance;

b. The right to request to receive services while the hearing is pending, how to make the request, including an offer of assistance; and

c. The individual may be held liable for the cost of those services if the hearing decision upholds the PIHP and/or Affiliate's action.

iii. For appeals not resolved wholly in favor of the individual who is disputing action taken that impacts non-Medicaid covered services:

a. The right to seek MDCH alternative dispute resolution, how to do so, and an offer of assistance.

iv. For appeals resolved to the satisfaction of the individual or his/her legal representative, an explanation of, and an offer of assistance in the process for withdrawing any request filed for a MDCH Fair Hearing.

b. Timing of Resolution Notice:

i. Written notice of the appeal resolution must be submitted to the individual and his/her legal representative within forty-five (45) calendar days following receipt of the appeal.

ii. For notice of an expedited appeal, the PIHP and/ or Affiliate must make reasonable efforts to provide oral notice as soon as possible followed by written notice within three (3) calendar days following the receipt of the appeal.

XI. GRIEVANCE PROCESS:

A. The individual, guardian, parent of a minor child, or his/her legal representative may file a grievance at any time regarding dissatisfaction with any aspect of service provision other than an adverse action as defined in this requirement or an allegation of a individual rights violation. The individual must be given reasonable assistance in completing forms for filing a grievance. The grievance shall be filed with the Affiliate's Recipient Rights Office.

B. The Recipient Rights Office shall then:

1. Log receipt of the verbal or written grievance for reporting to the Affiliate's Quality Improvement Program.

2. Determine whether the grievance is more appropriately an individual Recipient Rights complaint, and if so, refer the grievance, with the individual's permission, to the Office of Recipient Rights.
3. Acknowledge to the individual the receipt of the grievance.
4. Submit the written grievance to the appropriate staff including an Affiliate administrator with the authority to require corrective action. Further, no staff members making decisions on the grievance shall have been involved in the original determination.
5. Individuals making the decision on the grievance will be health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease if the grievance involves clinical issues, or involves the denial of an expedited resolution of an appeal of an action.
6. Facilitate resolution of the grievance within thirty (30) calendar days of receipt of the grievance.
7. Within thirty (30) calendar days of a decision by the Affiliates regarding the grievance, notification of the outcome of the process is provided to the individual, guardian, or parent of a minor child.
8. Provide a written disposition within sixty (60) calendar days of the PIHP's receipt of the grievance to the beneficiary, guardian, or parent of a minor child.

   The content of the notice of disposition includes:

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

XII. REFERENCES:

PA 516 of 1996
PA 258 of 1974, as amended
S.353-Health Insurance Bill of Rights of 1997
42 CFR Chapter IV, Subpart E, Sections 431.200 et seq
42 CFR Chapter IV, Subpart F, Sections 438.402 to 424
MDCH-MSA Policy Bulletin: Medicaid Eligibility Manual - Beneficiary Hearings
MDCH-MSA Policy Bulletin: Hourly Home Care - Criteria for Determining Number of Hours (Children's Waiver)
Amendment #2, MDCH Contract, 2003-2005