

# Due Process: *Grievance and Appeals*

Rights for those with Medicaid  
& Non-Medicaid

Encompass Appeals Module

# Grievance and Appeal Options

- **Grievance (local)**
- **Local Dispute Resolution Process (local level appeal for all)**
- **Medicaid Fair Hearing (Medicaid state level appeal)**
- **Alternative Dispute Resolution Process (Non-Medicaid state level appeal)**

# Grievance

## Medicaid and Non-Medicaid

- A consumer's expression of dissatisfaction about the PIHP/CMHSP services issues, other than an action/decision. Includes (but not limited to) quality of care or services provided and aspects of interpersonal relationships between a service provider and the beneficiary.
- A consumer's ability to address decisions made by the CMHSP and/or their provider networks that impact the consumer's satisfaction with services and supports. (Non-Medicaid)
- Not under the jurisdiction of ORR (not a rights issue/a right protected by law).

# Grievance Process

- Done on the **local level** (Customer Services)
- Recipient, guardian, or parent of a minor can file a grievance orally or in writing
- Expression of dissatisfaction about PIHP service issues, other than an action
- No statute of limitations on filing grievance
- Grievances are handled by the Customer Services department of your local CMHA

# Appeal Process

- A consumer/guardian's ability to question or challenge a decision made about their services, including decisions about whether they receive services, and the amount, scope, and duration of the services they receive.

# Appeal Rights

- Consumers/legal reps have appeal rights for **ALL** Medicaid services
- State has provided similar appeal rights for Non-Medicaid consumers
- All appeal criteria that relates to CMHSPs also applies to private Medicaid HMO's and to FIA/DHS
- Consumers/legal reps have appeal rights with HMO's, and FIA/DHS as well.

# Appeal Rights

- **Providers can file an appeal when they are denied or limited authorization for services, or when they wish to file an appeal on behalf of a consumer.**
- **Enrolled providers participating or wishing to participate in Medicaid program may appeal an adverse action taken by DCH.**
- **Providers, acting on behalf of a consumer/applicant and with the consumer's/legal representative's written consent, may file an appeal as the consumer's authorized representative.**

# Access to Record

Consumers have the right to access their record in order to prepare for their appeal.

They should be able to have copies without being charged in preparing for their appeal. If the amount to be copied would be a financial/staff cost to the agency, contact the Office of Recipient Rights/ your supervisor for consultation on whether there should be a charge.

# Local Dispute Resolution Process (Impartial Local Level Appeal)

- LDRC available to ALL recipients
- Consumers have 45 calendar days from the date of notice to request local appeal
- Medicaid recipients can request an LDRC or an Administrative Hearing at any time
- Non-Medicaid recipients **must** go through the LDRC before they can take their case to a state-level appeal (Alternative Dispute Resolution Process)

# Local Dispute Resolution Process

- A local appeal review of an adverse action taken by the WCHO or the local CMH, to reach a resolution that is acceptable to all parties
- An LDRC may be requested by a recipient, a recipient's legal guardian, a parent of a minor recipient, or an **Authorized Hearing Representative** with written permission to represent the recipient

# Expedited Appeals

- Can be requested by a consumer/legal rep. or a provider, when following the standard timeframe could seriously jeopardize the consumer or applicant's life, health, or ability to function.
- A decision will be made no later than 3 working days, and more immediately in emergent cases as needed.

# Medicaid Fair Hearing (Medicaid state level appeal)

- The right to a Medicaid **fair hearing/impartial review** before an Administrative Law Judge.
- Medicaid recipients appealing an **adverse action** related to Medicaid covered and additional (B3) services or when a grievance request is not acted upon within 60 calendar days.
- Consumers/guardian/legal rep. can request a hearing within 90 calendar days from the date of the notice.
- If fair hearing is requested not more than 12 calendar days from the date of notice of action, then PIHP must reinstate services until disposition of the hearing by the ALJ.

# Medicaid Fair Hearing Process

- Consumer can have an Authorized Hearing Representative present their case on their behalf
- Conducted through the Administrative Tribunal - DCH and DCIS connection
- Administrative Law Judge (ALJ) hears each party present their case/argument
- ALJ completes an impartial review of adverse action made & gives written decision
- ALJ's decision is legally binding

## Alternative Dispute Resolution Process (Non-Medicaid state level appeal)

- MDCH requires that non-Medicaid recipients have state-level appeal rights through the DCH Alternative Dispute Resolution Process
- Can **only** happen **after** they have had a Local Dispute Resolution Committee (LDRC) meeting.
- Appeal reviewed by staff at the state through the MDCH division that manages our Contracts with MDCH

## When Consumers Need To Receive Notice of Their Appeals Rights

- Approved to enter CMH services
- Approved for hospitalization
- Denied entry to CMH services
- Denied for hospitalization
- **When the Person Centered Plan/Individual Plan of Service is done**
- Any time consumer requests a service and are denied or get less than consumer wanted and consumer disagrees (limited authorization)

## When Consumers Need To Receive Notice of Their Appeals Rights

- Unreasonable delay of a decision of a service request Y or N (over 14 days).
- Unreasonable delay of initiation of a service. (over 14 days for an authorized service to start and consumer didn't agree to later appointment).
- Whenever a service already authorized/provided has been reduced, suspended or terminated (unless this was already agreed on in the PCP).

# Giving Written Notice of an Adverse (Denial) Decision

Notice in Encompass needs to explain:

- What service(s) is/are being denied
- The effective date
  - Adequate Notice is sent on effective date of action when denying a service request or a denial of a new authorization
  - Advance Notice of Action required 12 calendar days prior to when service currently provided is reduced, suspended, or terminated. Ex: Date of Notice mailed 12/12, Effective Date of Action 12/24)
- The reason (drop down box in Encompass)
- An explanation of the reason in language that is easily understood
- Use modified language from medical necessity criteria (Medicaid Provider Manual 2.5) and the definition of service in the explanation (MPM)



January 22, 2009  
Client Test

Ann Arbor MI 48108

Dear Client Test

This letter is being sent/given to you to let you know that Washtenaw Community Health Organization has made a decision about services you requested or services you already receive from our agency.

Action	Service	Reason	Effective Date
Reduction	Community Living Supports  Old Amount: 20 hour(s) per week	Not medically necessary - Not medically necessary -Your CLS services are being reduced from 20 hours per week to 10 hours per week because you have achieved/completed the parts of your goals that include caring for your own personal hygiene, you can now manage your own money, and you are now able to shop for and prepare your own food. Because you can now do these things by yourself without reminders/help, you do not need the 10 hours per week it took for CLS staff to help you with these areas. New Amount: 10 hour(s) per week	02/03/2009

The legal basis for these decisions is 42CFR440.230(d). If you agree with this decision you do not have to do anything. If you do not agree with these decisions, you can do any or all of the following at any time:

- Speak to your case manager or the supervisor;** they are happy to help you work out your concerns. They can also help you with your other choices below.

# Service Decisions within Medicaid Managed Care/ Michigan's State Plan

-Applying Medical  
Necessity Criteria

# Medical Necessity

- Must be used when services are approved or denied.
- Expected to treat a qualifying diagnosis. (MH, DD, SA)
- The CMHA must assess the need for each service.
- Assessments done by appropriate clinician.
- Services are designed to assist one to reach/keep maintain a sufficient level of functioning in order to achieve goals of community inclusion/participation, independence, recovery, or productivity.

# Medical Necessity

- Service needs to be tied to a goal in consumer's PCP and developed using PCP principles.
- Must be established for each service.
- Meet cultural needs & accommodation needs.
- Provided in the least restrictive, most integrated setting.
- Information on service decisions must include others who know the consumer wherever possible.

# Medical Necessity

- Services need to be sufficient in amount, scope, and duration to reasonably be expected to achieve one's goals as identified in the PCP and without which would be impossible to attain.
- Service can't be provided anywhere else/in any other ways. (no duplication)
- Delivered based on research findings/best practices.

# Amount, Scope, & Duration

- **Amount**: The number of units (ex- 25 15 minute units of community living supports) of service, identified in the individual plan of service (IPOS) or treatment plan, to be provided to the consumer.
- **Scope**: The parameters within which the service will be provided, including: Who How Where.
- **Duration**: The length of time (ex- three weeks, six months) it is expected that a service, identified in the individual plan of services (IPOS) or treatment plan, will be provided.

# Ways to Determine Medical Necessity

- Consumer report
- Family/guardian/friend report
- Assessments (observation)
- Professionals reports (internal and external)
- Other staff reports (direct care staff, other providers providing other services)

## Role of Affiliate Fair Hearings Officer

- Represent all four affiliate CMHA's at state level Medicaid appeal/fair hearing
- Case preparation for state level hearing (SOAHR)
- Assist to prepare staff who will testify at hearing
- Provide training and consultation as needed
- Data trending/analysis for affiliation (PI)
- State/federal reviews/audits
- Represent affiliation at State FHO meetings

Stephanie Risk  
Affiliate Fair Hearings Officer

(734) 544-6714  
[risks@ewashtenaw.org](mailto:risks@ewashtenaw.org)

Please contact me with any questions or concerns.  
You can also consult your local G&A representative.

Sally Amos O'Neal– Washtenaw  
Larry Newberg- Livingston  
Bridgitte Gates – Monroe  
Melinda Perez – Lenawee