WCHO PIHP POLICY for the COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN	*Policy and Procedure* *Consumer Appeal Policy - Affiliation*
Department: Customer Services **Author: CJ Witherow**	**Local Policy Number (if used)** **N/A**

Revision Date	Approval Date	Implementation Date
4/23/09	1/16/07	Current practice

Archive Information	
Date:	
Reason:	

I. PURPOSE

To establish policy and procedures to receive and resolve consumer appeals regarding the denial, suspension, reduction, or termination of services; the timeliness of service provision; family support subsidy appeals; second opinion requests; local appeals; DCH Administrative Hearing requests; and DCH Alternative Dispute Resolution requests.

II. APPLICATION

All affiliate staff/partners of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), all WCHO staff, students and volunteers, those of organizations under contract to WCHO, the WCHO as the Livingston-Washtenaw Coordinating Agency, and substance abuse agencies/staff under contract to the WCHO.

III. DEFINITIONS

ACCESS Staff – Staff designated to provide intake and/or assessment of an applicants/consumer's eligibility and/or medical necessity for requested services. Provide screenings and referrals using diagnostic criteria for mental health and substance abuse services. Assess the needs of callers, make appropriate referrals, and provide authorization of mental health and substance abuse services based on client need, eligibility, and available funding resources.

Adequate Action Notice - Written notice to an applicant/consumer/legal representative that a service is being denied. This notice must be given or mailed to the consumer on or before the date when the service denial becomes effective.

Administrative Law Judge - A person designated by the Department of Community Health to serve as a member of the Administrative Tribunal to conduct DCH Administrative Hearings/Fair Hearings.

Advance Action Notice - Written notice to a consumer/legal representative that a service is being suspended, reduced, or terminated. This notice must be mailed at least 12 days before the effective date of the service change.

Adverse Action – (1) A denial or limited authorization of a requested Medicaid or non- Medicaid service, including the type or level of service; (2) The reduction, suspension, or termination of a

previously authorized Medicaid or previously provided non-Medicaid covered service; (3) The denial, in whole or in part, of payment for a Medicaid or non- Medicaid covered service; (4) The failure to make an authorization decision and provide notice about the decision, within standard time frames; or (5) The failure to provide Medicaid or non-Medicaid services within the standard timeframes, AND (6) the failure to act within the timeframes required for disposition of grievances and appeals shall be considered an adverse action.

Affiliation Fair Hearings Officer (FHO) – Staff person hired by the Affiliation WCHO Board to handle state level and appeals and maintain appeals-related affiliate data on behalf of the affilation.

Appeal – A request for a review of an adverse action.

Applicant - An individual, or his/her legal representative, who makes a request for CMH or Substance Abuse services, including services provided by agencies under contract to the WCHO.

Authorized Hearing Representative - Any person designated in writing by a consumer (or the consumer's legal representative) to stand in for or represent him/her during a hearing, or a representative/parent of a minor, or the consumer's spouse, widow, or widower if there is no one else with authority to represent the consumer.

Consumer - An individual who is receiving CMH or Substance Abuse services, including services provided by substance abuse agencies under contract with the WCHO.

Administrative Hearing – (Also called a Medicaid Fair Hearing) A hearing at which an Administrative Law Judge from SOAHR completes an impartial review of a decision made by the local CMH or Substance Abuse agency, or one of its contract agencies, regarding Medicaid services.

MDCH Alternative Dispute Resolution Process - A program of the Michigan Department of Community Health with responsibility for conducting hearings for an appeal which was not resolved at the local level through the Local Dispute Resolution Committee. This is a parallel process to the Administrative Hearing/Fair Hearing and is available to non-Medicaid consumers.

Expedited Appeal – The prompt review of an adverse action, requested by a consumer/legal representative or a provider on behalf of the consumer, when the time necessary for the normal/standard review process could seriously jeopardize the consumer's life or health to attain, maintain or regain maximum function. If the consumer/legal representative requests the expedited review, the WCHO/affiliate determines if the request is warranted. If the consumer's provider makes the request, or supports the consumer's request, the WCHO/affiliate must grant the request.

Grievance – An expression of dissatisfaction about any matter related to services, other than an adverse action, which does not involve a rights complaint. 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 consumer.

Legal Representative – The representative, parent of a minor, or other person authorized by law to represent an applicant/consumer.

Local Dispute Resolution Committee – (LDRC) An ad hoc committee, convened by the local CMH Board, chaired by the Designee of the Director, with responsibility for reviewing local appeals regarding CMH services and those of its contract agencies.

Mediation - An informal dispute resolution process in which an impartial, neutral individual, in a confidential setting, assists parties to reach their own settlement of issues in a dispute and has no authoritative decision-making power.

Rights Complaint – A written or verbal statement by a consumer or anyone acting on behalf of a consumer alleging a violation of a consumer's legally protected rights, including rights cited in Michigan Mental Health Code Chapter 7, which is resolved through the processes established in Chapter 7A.

State Office of Administrative Hearings and Rules (SOAHR). (also known as the Administrative Tribunal) - the entity charged by the state with responsibility for conducting Administrative Hearings/ Medicaid Fair Hearings.

Utilization Review (UR) - process in which established criteria are used to recommend or evaluate services provided in terms of cost effectiveness, medical necessity, and efficient use of resources.

IV. POLICY

All grievance processes will be initiated at the local Board level and will be handled by the local Customer Services department of each local Board. All policy and procedures for grievance processes can be found in the Affiliation Customer Services Policy.

All appeal processes will be initiated at the local Board level and will be handled locally until:
(a) a Medicaid consumer requests a DCH Administrative Hearing or
(b) a Non-Medicaid consumer completes the local dispute resolution process and requests a DCH Alternative Dispute Resolution Hearing.
When DCH level hearings have been requested, the WCHO will assume responsibility for the process in collaboration with the local Board.

All appeal processes will be handled by the WCHO and its affiliates in accordance with the procedures attached to this policy.

All appeal processes shall be:
1. Timely
2. Fair to all parties
3. Administratively simple
4. Objective and credible
5. Accessible and understandable to consumers and providers
6. Cost and resource efficient
7. Subject to quality improvement review

In addition, these processes shall:
1. Not interfere with communication between consumers and their service providers;
2. Assure that service providers who participate in an appeal process on behalf of a consumer are free from discrimination or retaliation; and
3. Assure that a consumer/legal representative who files an appeal is free from discrimination or retaliation.

Although it is preferred that appeals be resolved at the level closest to service delivery, all appeal processes for which they are eligible shall be available to applicants/consumers/legal representatives

simultaneously or sequentially. The exception is that the Local Dispute Resolution Process must be utilized by non-Medicaid consumers before accessing the DCH Alternative Dispute Resolution Process

V. STANDARDS

A. General Standards

Appeal processes shall promote the resolution of concerns as well as support and enhance the goal of improving the quality of services.

Consumers/legal representatives shall be informed of their right to access the appeal process if they are dissatisfied or concerned at any point during the delivery of mental health services or supports.

Written appeals information shall be provided to consumers and legal representatives in a language and format that is easily understood.

If at any time during the appeal process an applicant/consumer needs translator services, those services will be provided in accordance with the WCHO Interpreters for Persons with a Hearing Impairment policy or the affiliation Limited English Proficiency policy.

If an applicant/consumer requires large-print materials, all Notices and written communication provided to that person will be typed in a font large enough for the individual to read.

If an applicant/consumer requires written materials in alternative formats (i.e. for visual/hearing impairments or limited English proficiency) materials will be provided to consumers/legal representatives in ways that meet their needs

Translator services and the provision of written materials in large-print/alternative formats shall be provided at no cost to the consumer/legal representative.

Consumers/legal representatives and providers shall be provided written information on their appeal rights, including:

- How to submit written comments or information relevant to the appeal
- An explanation of the appeal process including the right for consumers/legal guardians to have an Authorized Hearing Representative
- The timeframes for deciding appeals
- How to pursue an expedited appeal for urgent denials

Before and during the appeals process, consumers, legal representatives, and Authorized Hearing Representatives shall be given the opportunity to review the consumer's clinical record, and any other documents considered during the appeals process, in a timely manner sufficient for preparation of their case for the appeal.

The Customer Services department or the Office of Recipient Rights shall assist applicants/consumers or their legal representatives to access all grievance and/or appeal processes for which they are eligible.

Providers shall be informed of their right to access the appeal process when they are denied or limited authorization for services, or when they wish to file an expedited appeal on behalf of a consumer.

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 Hearing Representative.

All staff will provide notice of appeal rights through the use of/entry into the Appeals Module in the affiliation electronic record (also known as Encompass), which will generate the appropriate forms as described in the procedures of this policy. The only exception to this standard is in cases where staff/providers do not have access to the electronic clinical record; in these cases staff will provide paper/manual notice using the same procedures and forms attached to this policy.

Medicaid consumers with a Medicaid spend down shall receive Medicaid notices of appeal; SOAHR in conjunction with the Affiliate FHO will determine whether the consumer had active Medicaid during the time of the decision and is eligible for a Medicaid Fair Hearing. If a consumer with a Medicaid spend down is not eligible for a Medicaid Fair Hearing, he/she shall be given the rights to Non-Medicaid appeals processes.

B. Timeliness of Authorization/Service Decisions

State and federal regulations require that specific service decisions shall be made within certain time frames. If these times frames (described below) are not met they are considered denials and staff shall follow the same processes for providing consumers/legal representatives with notices of their appeal rights as all other denials.

Authorization decisions at the initial request for services, or request for hospitalization shall be made within 14 days of when the consumer, legal representative, or provider made the request. If a decision is not made within 14 days and an extension allowable by policy is not pursued, the delay is considered a denial and adequate action notice of a denial must be sent.

Authorization decisions for consumer's currently receiving services shall be made within 14 days of when the consumer, legal representative, or provider made the request. If a decision is not made within 14 days and an extension allowable by policy is not pursued, the delay is considered a denial and adequate action notice of a denial must be sent.

If the WCHO/an affiliate is unable to determine whether to approve, deny or limit a standard service authorization within 14 days, the time frame may be extended up to an additional 14 calendar days. If the WCHO/an affiliate extends the timeframe, it must give the consumer/legal representative written notice no later than the date the current time frame expires with the reason for the decision to extend the timeframe; inform the consumer/legal representative of the right to file an appeal if he/she disagrees with the decision to extend; and make a determination as expeditiously as possible as and no longer than the date the extension expires.

Services shall begin within 14 days from when the authorization was completed, except in cases where the consumer agrees to a start date outside the 14-day timeframe. If services cannot begin within the 14 day time frame, and the consumer does not agree to an extension, this shall be considered an adverse action and staff shall provide the consumer/legal representative with adequate action notice of the denial.

Expedited authorization decisions shall be made in urgent cases where the provider indicates, the consumer/legal guardian requests, or the WCHO/an affiliate determines that following the standard timeframe could seriously jeopardize the consumer/applicant's life or health or ability to attain, maintain, or regain maximum function. In these cases a decision must be made and written/electronic notice provided no later than three (3) working days from receipt of the request for service.

For emergent situations, the timeframe to make expedited decisions will be made on an immediate basis where applicable based on clinical judgment of consumer clinical need, and no later than 24 hours of when the service was requested. When applicable, services will continue until a decision is made.
For ***expedited authorization decisions***, if the consumer/legal representative requests an extension, or the WCHO/an affiliate justifies (to the state agency upon request) a need for additional information and how the extension is in the consumer's best interest; the WCHO/an affiliate may extend the 3 working day time period to 14 calendar days. Justification for the extension must be documented.

Consumer requests for an expedited review of an authorization decision can be denied; if it is denied the consumer shall receive notice of denial for an expedited review and standard 14-day timeframes for an authorization decision shall still be met.
If a provider requests and expedited review of an urgent or emergent authorization decision, such a request from a provider cannot be denied; the review shall follow the expedited process and the provider shall be informed within 24 hours to 3 days (whichever applies) on whether the service request will be approved or denied..

C. Providing Notice of Approved Services

State regulation requires that consumers/legal representatives receive notice of their hearing rights when services are approved at the onset of services and during the person-centered planning process. See Procedures A and E; Exhibits A and F for providing notice of services approved.

D. Providing Notice of Denial Decisions

Federal and state regulation requires that consumers/legal representatives receive notice of their appeal rights when any adverse action is taken regarding consumers' services/supports.

Adequate action notice shall be provided to a consumer/legal representative whenever any of the following decisions are made/action taken:
1) A denial or limited authorization of a requested Medicaid or non- Medicaid service, including the type or level of service;
2) The denial, in whole or in part, of payment for a Medicaid or non- Medicaid covered service;
3) The failure to make an authorization decision and provide notice about the decision, within standard time frames;
4) The failure to provide Medicaid or non-Medicaid services within the standard timeframes;
5) The failure to act within the timeframes required for disposition of grievances and appeals shall be considered an adverse action.
Adequate action notice must be given or mailed to the consumer on or before the date when the service denial becomes effective. (See Procedures E and F; Exhibits M and L)

Advance action notice shall be provided to a consumer/legal representative whenever there is a reduction, suspension, or termination of a previously authorized Medicaid or previously provided non-Medicaid covered service. All Advance Action Notices *must be mailed at least 12 days before the effective date of the action* to allow consumer time to request a hearing and continuation of services. (See Procedure F; Exhibits G and L)

All notices provided to consumers/legal representative and providers regarding denial decisions shall include the following:

- What action is being taken and the regulation that supports the action
- The date of the notice and the effective date of the denial decision
- The specific reasons for the denial in language that is easily understood

- Reference to the benefit provision, guideline, protocol, or other similar criteria on which the denial decision was based
- A description of appeal rights including the right to submit any written information relevant to the appeal
- An explanation of the appeal process including the consumer/legal representative's right to an Authorized Hearing Representative and the timeframes in which they can file an appeal.
- A description of the expedited appeal process for urgent denials and how to access that process
- Information on how a consumer/legal representative can receive a copy of the actual benefit provision, guideline, protocol, or other similar criteria on which the denial decision was based at their request.

For advance action notice should also include:

- The circumstances under which services will be continued pending resolution of the appeal;
- How to request that benefit be continued; and
- The circumstances under which the consumer/guardian may be required to pay the costs of these services.

There are exceptions under which advance notice can be waived; see Exhibit L for details on advance action notice and the conditions for continuance of services.

All staff will provide notice of appeal rights through the use of/entry into the Appeals Module in the affiliation electronic record (also known as Encompass), which will generate the appropriate forms as described in the procedures of this policy. The only exception to this standard is in cases where staff/providers do not have access to the electronic clinical record; in these cases staff will provide paper/manual notice using the same procedures and forms attached to this policy.

Notice of denials given to providers/practitioners shall include information on the opportunity for providers to discuss any denial decision with the reviewer and how to contact the reviewer.

E. Second Opinion Process

Applicants/consumers/legal representatives may request a second opinion for a denial of access to services and of access to hospitalization within 30 days of the denial. A second opinion will be provided within the CMHPSM at no extra cost to applicants/consumers by a physician, licensed psychologist, registered professional nurse, master's level social worker or master's level psychologist.

- Non-urgent requests for a second opinion will be completed for applicants/consumers within five (5) business days from the receipt of the request.
- Urgent requests for a second opinion will be provided within two (2) business days.
- Emergent requests for a second opinion will be provided on an immediate basis where applicable, based on clinical judgment of consumer clinical need, and no later than 24 hours of when the service was requested.

Upon completion of the second opinion, the applicant/consumer will be provided verbal notification of the outcome within one (1) business day from the completion of the second opinion; this notification will be followed by a written notification within five (5) business days from the completion of the second opinion.

If the second opinion upholds the original denial, the notification to the applicant/consumer shall include the next steps available to them, including filing a recipient rights complaint.

If the second opinion reverses the original denial, staff (Access, Psychiatric Emergency Services, or the local designee) shall arrange for services to be provided per the appropriate required timeframes for authorization decisions. (See Exhibits B and C)

F. Local Level Appeal Process

All consumers/legal representatives/AHRs may file a local appeal within 45 days of their receipt of a denial decision. Requests for local appeals received orally will be treated as a formal appeal request to establish the earliest possible filing date for a local appeal. An oral appeal must be confirmed in writing unless the applicant/consumer/legal representative/provider requests expedited resolution of an appeal.

Receipt of local appeals (whether received verbally or in writing) shall be acknowledged in writing to the consumer/legal representative who requested the local appeal (and Authorized Hearing Representative where applicable) within (5) days of receipt of the request for a local appeal.

The person(s) reviewing the local appeal shall not be subordinate to or the same person involved in making the initial decision that is the subject of the appeal, and shall have the authority to make decisions for the local board and require corrective action where needed. If the local appeal involves clinical issues or denials based on medical necessity, the reviewer(s) making the decision will include the professional/s with the appropriate clinical expertise in treating the consumer's condition.

Review of all local appeals will include:

- A full investigation of the substance for the appeal and any aspects of clinical care involved.
- The right of the consumer/legal representative/Authorized Hearing representative to be present at the LDRC and bring anyone they wish to testify on their behalf.
- The opportunity for the consumer/legal representative to submit written comments, documents, or other information before or during the LDRC meeting.

A written disposition letter shall be provided to the consumer/legal representative/Authorized Hearing representative within 10 days of completion of the LDRC. The written disposition will include:

- Those who participated in the LDRC including their titles and qualifications/ credentials (including specialties).
- The consumer's position.
- The local board's position.
- Reference to the benefit provision, guideline, protocol, or other similar criteria on which the appeal/LDRC decision was based.
- Any other information reviewed at the appeal.
- The specific reasons for the appeal decision in language that is easily understood
- Information on how a consumer/legal representative can receive a copy of the actual benefit provision, guideline, protocol, or other similar criteria on which the appeal/LDRC decision was based at their request.
- The decision made from the LRDC
- Any next steps to be taken
- What actions the consumer/legal representative has the right to pursue after the local appeal/LDRC decision, including:
    - the right to request a state level appeal and how to request a state appeal
    - If a Medicaid Fair Hearing, the right to request to receives services while the hearing is

pending if there was advance action and if the request is made within 12 days, and how to make such a request
- The right to contact Customer Services or the Office of Recipient Rights
- Any other appeal rights or subsequent avenues available if they are not satisfied with the result.

All non-urgent/non-emergent local appeals shall be completed (including the disposition sent out),within 45 days of receipt of the request for local appeal. Pre-service local appeals shall be resolved within 30 calendar days of receipt of the request for appeal. Post-service local appeals shall be resolved within 45 days of receipt of the request for appeal. (See Exhibits H and I)

Expedited resolution of local appeals shall be carried out in cases when, by request from the consumer/legal representative, the WCHO/an affiliate determines or the provider indicates (in making the request on the consumer's behalf or /supporting the consumer's request) that following the standard timeframe could seriously jeopardize the consumer/applicant's life or health or ability to attain, maintain, or regain maximum function. The expedited appeal must be resolved and notice of disposition given no later than three (3) days from the request. In emergent situations, the timeframe to make expedited decisions will be made on an immediate basis where applicable, based on clinical judgment of a consumer's needs. As with appeals of adverse actions, the consumer's services will continue until a decision is made.
For ***expedited resolution of local appeals,*** the WCHO/an affiliate may extend the (3) three day notice of disposition time frame by up to 14 calendar days if the consumer/ legal representative requests an extension or if the WCHO/an affiliate shows to the satisfaction of the state that there is a need for additional information and how the delay is in the consumer's best interest. Justification for the extension must be documented.
If the request for an expedited resolution of a local appeal is denied, the WCHO/an affiliate must: transfer the appeal to the timeframe for standard resolution or no longer than 45 days from the date the WCHO/the affiliate received the appeal; make reasonable efforts to give the consumer/legal representative prompt oral notice of the denial for and expedited appeal; send the consumer/legal representative written notice of the denial for an expedited appeal within two (2) calendar days; inform the consumer/legal representative of their right to file a grievance for denial of an expedited appeal.

G. State Level Appeal Processes

Medicaid consumers/their legal representatives may file an appeal with SOAHR within 90 days of their receipt of a denial decision. (See Exhibits J, K and L)

Non-Medicaid consumers/their legal representatives may file a state level appeal with MDCH after they complete a local level appeal; Non-Medicaid consumers/their legal representatives have 45 days from completion of the local appeal to file a state level appeal. (See Exhibits I, M and N)

State level appeal processes for both Medicaid and Non-Medicaid consumers will be followed in accordance with federal and state requirements per the SOAHR Administrative Hearing Pamphlet and the MDCH contract.
For further information on state level appeals see SOAHR Administrative Hearings Pamphlet, March 2008 and the 08/09 MCDH PIHP Contract

H. Performance Improvement

Each local board will maintain a log of second opinion requests, Family Support Subsidy appeals, Local Dispute Resolution Committee requests/resolutions, SOAHR Administrative Hearing requests/ resolutions, and DCH Alternative Dispute Resolution requests/resolutions. This information will be provided to the CMHPSM Fair Hearings Officer quarterly.

Quarterly aggregate reports of appeals data shall be provided by the CMHPSM Fair Hearings Officer to the Affiliation Customer Services Committee and the Affiliation Performance Improvement Committee, for their review and recommendations on any trends or improvement opportunities.

V. EXHIBITS

A. Adequate Notice Of Hearing Rights
B. Request For Second Opinion/Denial Of Hospitalization Or Other Services
C. Instructions For Request For Second Opinion/Denial Of Services
D. Instructions For Request For Second Opinion/ Denial Of Hospitalization
E. Adequate Action Notice - Denial Of Service To Medicaid Consumer
F. Notice Of Denial Or Change Of Service(S) For Non-Medicaid Consumers
G. Advance Action Notice - Suspension, Reduction, or Termination of Service
H. Local Dispute Resolution Committee Request For Review Of Appeal
I. Local Dispute Resolution Committee Procedures
J. Request For An Administrative Hearing Instructions
K. Request For An Administrative Hearing Michigan Department Of Community Health
L. DCH Administrative Hearing Instructions For Affiliation Staff
M. Request For Review By Department Of Community Health Alternative Dispute Resolution Process
N. DCH Alternative Dispute Resolution Instructions For Affiliation Staff

VI. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
42 CFR Parts 400 et al. (Balanced Budget Act)	X	42CFR434.32, 42CFR431.200-431.246, 42CFR440.230 42CFR Part 438
Balance Budget Act (including 42CFR Part 438)	X	
Michigan Mental Health Code Act 258 of 1974 as amended	X	Section 100b,409(4),705
MDCH Medicaid Contract and Attachments	X	3.4.1.1 Person Centered Planning Best Practice Guideline; 6.3.2.1 Appeal & Grievance Resolution Process
DCH Medical Services Administration (MSA) Bulletin: Medicaid Eligibility Manual - Beneficiary Hearings.	X	
Family Support Subsidy Act, Public Act 249 of 1983, as amended.	X	

Administrative Procedures Act of 1969, Public Act 306 of 1969	X	Sec. 24.271-24.287.
MDCH Administrative Rules	X	
MDCH Policy Hearing Authority Decision #01-0358CMH, and subsequent MDCH clarifications	X	
Office of Recipient Rights Policy	X	
WCHO Interpreters for Persons with Hearing Impairment Policy	X	
Affiliation Limited English Proficiency Policy	X	
Affiliation Utilization Management Policy	X	
Affiliation Customer Services Policy	X	
MI Medicaid Provider Manual – Mental Health and Substance Abuse	X	
SOAHR Administrative Hearings Pamphlet, March 2008	X	

VII. PROCEDURES

A. At Time of Service Authorization or Reauthorization

WHO	DOES WHAT
Local CMHSP ACCESS and/or Utilization Review Staff	1. Provide screening, utilizing medical necessity and affiliation service eligibility criteria. Make authorization decisions within the required timeframes. 2. If determination is made that the applicant meets criteria for services a. Ensures the form for Complete ADEQUATE NOTICE of HEARING RIGHTS (Exhibit A) and give or mail to applicant within 24 hours. b. If the applicant is a Medicaid beneficiary, the following enclosures must be attached: • REQUEST for an ADMINISTRATIVE HEARING INSTRUC-TIONS Michigan Department of Community Health (Exhibit J) and ▪ REQUEST FOR AN ADMINISTRATIVE HEARING Michigan Department of Community Health (and return envelope if the state has made them available) (Exhibit K) c. If provided paper/manual notice, document in applicant's clinical record that notice was provided in a manner consistent with the local affiliate's procedures; using the Appeals module in Encompass will automatically document this information. 3. If determination is made that the applicant does not meet criteria for

services, follow procedures in the applicable section below:

- Denial of Services - Initial Request
- Denial of Hospitalization
- Denial of Additional or Alternate Services - Current Consumer

Consumer/Applicant, Legal Representative, or Provider on behalf of Consumer

1. May accept or refuse the services.
2. If services are denied may request an appeal (See procedures B and C)

B. Denial of Services – Initial Request (See Section C for Denial of Hospitalization)

WHO	DOES WHAT
Local CMHSP ACCESS staff	1. Provide screening, utilizing affiliation medical necessity and affiliation service eligibility criteria. Make authorization decisions within the required timeframes. 2. **If the person receives Medicaid** and a determination is made that he or she does not meet criteria for services: Complete and give or mail on the effective date of the action: a. REQUEST FOR SECOND OPINION/DENIAL OF HOSPITALIZATION OR OTHER SERVICES (Exhibit B), and b. ADEQUATE ACTION NOTICE – Denial of Service to Medicaid Consumer (Exhibit E) with the following enclosures: • REQUEST for an ADMINISTRATIVE HEARING INSTRUCTIONS (Exhibit J), and • REQUEST for an ADMINISTRATIVE HEARING Michigan Department of Community Health (and return envelope if the state has made them available) (Exhibit K). 3. **If the person does not receive Medicaid** and a determination is made that he or she does not meet criteria for services: Complete and give or mail on the effective date of the action: a. REQUEST FOR SECOND OPINION/DENIAL OF HOSPITALIZATION OR OTHER SERVICES (Exhibit B), and b. NOTICE OF DENIAL OR CHANGE OF SERVICES FOR NON-MEDICAID CONSUMERS (Exhibit F) 4. If provided paper/manual notice, document in applicant's clinical record that notice was provided in a manner consistent with the local affiliate's procedures; using the Appeals module in the electronic clinical record/Encompass will automatically document this information.
Applicant, Consumer, or Legal Representative	1. May accept the decision to deny services. 2. May request a second opinion within 30 days of the date of the Notice (see Exhibit C). 3. May request review by a Local Dispute Resolution Committee (LDRC) within 45 days of the date of the Notice.

	4. May request an expedited local appeal. 5. If the person is a Medicaid consumer, may request a DCH Administrative Hearing at any time within 90 days of the date of the Notice.
Local Appeals Administrator or Designee	1. Log second opinion/appeal as applicable. 2. Acknowledge request for local appeal in writing to the consumer/guardian within 5 days of receipt of the request. 3. Notify the Affiliation Fair Hearings Officer immediately upon the receipt of: a. Local Dispute Resolution Committee Request for Review of Local Appeal; or b. Request for an Administrative Hearing. 4. Assist applicant/consumer/legal representative as needed. 5. Provide summary data on second opinions, local dispute resolution committee meeting outcomes, and administrative hearings to the Affiliation Fair Hearings Officer quarterly.
Local CMHSP Designee	1. If applicant/legal representative requests a second opinion, see Instructions for Request for Second Opinion/Denial of Services (Exhibit C). 2. If applicant/legal representative requests a local appeal, see Local Dispute Resolution Committee Procedures (Exhibit I). 3. If applicant/legal representative requests an expedited appeal, reviews request and give notice of disposition given no later than three (3) days from the request. 4. If expedited appeal occurs, follow Local Dispute Resolution Committee Procedures (Exhibit I) within expedited timeframes. 5. If applicant is a Medicaid consumer and requests a DCH administrative hearing, see *DCH* Administrative Hearing Instructions for Affiliation Staff (Exhibit L). 6. If applicant is not a Medicaid consumer and requests a DCH Alternative Dispute Resolution Process <u>after</u> receiving a response from a Local Dispute Resolution Committee, see DCH Alternative Dispute Resolution Process Instructions for Affiliation Staff (Exhibit N).

C. Denial of Hospitalization

<u>WHO</u>	**<u>DOES WHAT</u>**
Local CMHSP Access, Crisis, and/or Utilization Review staff, or Psychiatric Emergency Services	1. Makes decision regarding hospitalization, utilizing established criteria and within the required timeframes. 2. **If the person receives Medicaid**, and a decision is made that he/she does not meet criteria for admission, complete and give or mail on the effective date of the action: • REQUEST FOR SECOND OPINION/DENIAL OF HOSPITALIZATION OR OTHER SERVICES (Exhibit B), and • ADEQUATE ACTION NOTICE – Denial of Service to Medicaid Consumer (Exhibit E), along with the following enclosures: • REQUEST for an ADMINISTRATIVE HEARING INSTRUCTIONS

(Exhibit J), and
- REQUEST FOR AN ADMINISTRATIVE HEARING Michigan Department of Community Health (and return envelope if the state has made them available) (Exhibit K).

3. **If the person does not receive Medicaid**, and a decision is made that he/she does not meet criteria for admission, complete and give or mail on the effective date:
   a. REQUEST FOR SECOND OPINION/DENIAL OF HOSPITALIZATION OR OTHER SERVICES (Exhibit B), and
   b. NOTICE OF DENIAL OR CHANGE OF SERVICES FOR NON-MEDICAID CONSUMERS (Exhibit F)

4. If provided paper/manual notice, document in applicant's clinical record that notice was provided in a manner consistent with the local affiliate's procedures; using the Appeals module in Encompass will automatically document this information.

Applicant/Consumer, Legal Representative, or Provider on Behalf of Applicant/Consumer

1. May accept the decision to deny hospitalization.
2. May file a complaint with the Office of Recipient Rights.
3. May request a second opinion within 30 days of the date of the Notice (see Exhibit D).
4. May request review by the Local Dispute Resolution Committee within 45 days of the date of the Notice.
5. May request an expedited local appeal.
6. If the person is a Medicaid consumer, request a DCH Administrative Hearing within 90 days of the date of the Notice.

Local Appeals Administrator or Designee

1. Log second opinion/appeal as applicable.
2. Acknowledge request for local appeal in writing to the consumer/guardian within 5 days of receipt of the request.
3. Notify the Affiliation Fair Hearings Officer immediately upon the receipt of:
   a. Local Dispute Resolution Committee Request for Review of Local Appeal, or
   b. Request for an Administrative Hearing.
4. Assist applicant/legal representative as needed and investigate complaint, if one is filed.
5. Provide summary data on second opinions, local dispute resolution committee meeting outcomes, and administrative hearings to the Affiliation Fair Hearings Officer quarterly.

Local CMHSP Designee

1. If applicant/legal representative requests a second opinion, see Instructions for Request for Second Opinion/Denial of Hospitalization (Exhibit D).
2. If applicant/legal representative requests a local appeal, see Local Dispute Resolution Committee Procedures (Exhibit I).
3. If applicant/legal representative requests an expedited appeal, reviews request and gives notice of disposition given no later than three (3) days from the request.
4. If expedited appeal occurs, follows Local Dispute Resolution Committee Procedures (Exhibit I) within expedited timeframes.

5. If applicant is a Medicaid consumer and requests a DCH administrative hearing, see DCH Administrative Hearing Instructions for Affiliation Staff (Exhibit L).
6. If applicant is not a Medicaid consumer and requests a DCH Alternative Dispute Resolution Process after receiving a response from a Local Dispute Resolution Committee, see DCH Alternative Dispute Resolution Process Instructions for Affiliation Staff (Exhibit N).

D. Denial or Limited Authorization of a Requested Service - Current Consumer

WHO	DOES WHAT
Local Clinical or Utilization Review Staff	1. Utilizing the person centered planning or utilization review processes as well as medical necessity and affiliation service eligibility criteria, make a decision to deny the requested service, or to authorize the requested service in an amount, scope, or duration less than that identified and agreed upon during the person centered planning process. 2. Makes the authorization decision within 14 calendar days of receiving the request for the service. If the consumer/legal representative requests to extend the timeframe, makes the decision within 28 calendar days of receiving the request for the service. If a decision is not made within the required timeframe, it will be considered an unreasonable delay; provides notice on the 14th (or 28th) day in accordance with procedures below. 3. For a situation in which the provider indicates or staff determines that the standard 14-day timeframe for authorizations would endanger the consumer's life or health, makes an authorization decision no later than 3 working days of receiving the request for the service. 4. **If the person receives Medicaid**, complete and give or mail on or before the effective date of the action: a. ADEQUATE ACTION NOTICE Denial of Services to a Medicaid Consumer (Exhibit E), along with the following enclosures: ▪ REQUEST for an ADMINISTRATIVE HEARING INSTRUCTIONS (Exhibit J), and ▪ REQUEST for an ADMINISTRATIVE HEARING Michigan Department of Community Health (and return envelope if the state has made them available) (Exhibit K). 5. **If the person does not receive Medicaid**, complete and give or mail on or before the effective date of the action: NOTICE OF DENIAL OR CHANGE OF SERVICES FOR NON-MEDICAID CONSUMERS (Exhibit F) 6. If provided paper/manual notice, document in applicant's clinical record that notice was provided in a manner consistent with the local affiliate's procedures; using the Appeals module in Encompass will automatically document this information.
Consumer, Legal Representative, or Provider on Behalf of Consumer	1. May accept the decision to deny the requested service. 2. May file a Recipient Rights complaint for services suited to condition. 3. May request review by the Local Dispute Resolution Committee within 45 days of the date of the Notice.

4. May request an expedited appeal.
5. And/or, if the person is a Medicaid consumer, may request a DCH Administrative Hearing within 90 days of the date of the Notice.

Local Appeals Administrator or Designee

1. Log second opinion/appeal as applicable
2. Acknowledge request for local appeal in writing to the consumer/guardian within 5 days of receipt of the request.
3. Notify the Affiliation Fair Hearings Officer immediately upon the receipt of:
   a. Local Dispute Resolution Committee Request for Review of Appeal, or
   b. Request for an Administrative Hearing.
4. Assist applicant as needed and refers any rights-related issues to the local ORR.
5. Provide summary data on second opinions, local dispute resolution committee meeting outcomes, and administrative hearings to the Affiliation Fair Hearings Officer quarterly.

Local CMHSP Designee

1. If applicant/legal representative requests a local appeal, *see Local Dispute Resolution Committee Procedures* (Exhibit I).
2. If applicant/legal representative requests an expedited appeal, reviews request and gives notice of disposition given no later than three (3) days from the request.
3. If expedited appeal occurs, follows Local Dispute Resolution Committee Procedures (Exhibit I) within expedited timeframes.
4. If applicant/legal representative files a grievance, see procedure *G – Grievances* of this policy.
5. If applicant is a Medicaid consumer and requests a DCH Administrative Hearing, see *DCH* Administrative Hearing Instructions for Affiliation Staff (Exhibit L).
6. If applicant is not a Medicaid consumer, and the applicant requests a DCH Alternative Dispute Resolution Process <u>after</u> receiving a response from a Local Dispute Resolution Committee, see DCH Alternative Dispute Resolution Process Instructions for Affiliation Staff (Exhibit N).

E. At Time of Person Centered Planning/Treatment Planning

<u>WHO</u>	**<u>DOES WHAT</u>**
Person Centered Planning Team or Utilization Review Staff	1. In partnership with the consumer, develop a person centered plan/treatment plan. 2. If the consumer/legal representative indicates his/her agreement with the plan, complete and give or mail to the consumer within 24 hours the ADEQUATE NOTICE of HEARING RIGHTS (Exhibit A). 3. If consumer/legal representative does not agree with the plan, and attempts at resolving the disagreement have been unsuccessful, follow applicable procedures for: a. Denial of Additional or Alternate Services – Current Consumer; or b. Suspension, Reduction, or Termination of Services

4. If services cannot be provided within 14 calendar days of the start date agreed upon in the plan and authorized by the WCHO or affiliate, it will be considered an unreasonable delay. Notice will be provided on the 14th day:
   a. **If the person receives Medicaid**, complete and give or mail: ADEQUATE ACTION NOTICE Denial of Services to a Medicaid Consumer (Exhibit E), along with the following enclosures:
      - REQUEST for ADMINISTRATIVE HEARING INSTRUCTIONS (Exhibit J), and
      - REQUEST for ADMINISTRATIVE HEARING Michigan Department of Community Health (and return envelope if the state has made them available) (Exhibit K).
   b. **If the person does not receive Medicaid**, complete and give or mail: NOTICE OF DENIAL OR CHANGE OF SERVICES FOR NON-MEDICAID CONSUMERS (Exhibit F).
5. If provided paper/manual notice, document in applicant's clinical record that notice was provided in a manner consistent with the local affiliate's procedures; using the Appeals module in Encompass will automatically document this information

F. Suspension, Reduction, or Termination of Services

WHO	**DOES WHAT**
Person Centered Planning Team/ UR Staff	1. Determine need for suspension, reduction, or termination of service(s). 2. Provide notice as follows: a. **If the consumer receives Medicaid**, complete and **mail** to the consumer a minimum of 12 days prior to the effective date of action: ADVANCE ACTION NOTICE Suspension, Reduction, or Termination of Services to Medicaid Consumers (Exhibit G) with the following enclosures: ▪ REQUEST for ADMINISTRATIVE HEARING INSTRUCTIONS (Exhibit J), and ▪ REQUEST FOR AN ADMINISTRATIVE HEARING Michigan Department of Community Health (and return envelope if the state has made them available) (Exhibit K) b. **If the consumer does not receive Medicaid**, complete and **mail** to the consumer a minimum of 12 days prior to the effective date of action: NOTICE OF DENIAL OR CHANGE OF SERVICES FOR NON-MEDICAID CONSUMERS (Exhibit F) **NOTE: All Advance Action Notices must be mailed at least 12 days before the effective date of the action to allow consumer time to request a hearing and continuation of services. The Advance Action Notice must be mailed pursuant to 42CFR431.211.** 3. If provided paper/manual notice, document in applicant's clinical record that notice was provided in a manner consistent with the local affiliate's

	procedures. (using the Appeals module in Encompass will automatically document this information)
Consumer, Legal Representative, or Provider on Behalf of Consumer	1. May accept the decision to suspend, reduce, or terminate the requested service. 2. May file a recipient rights complaint for services suited to condition. 3. May request review by the Local Dispute Resolution Committee within 90 days of the date of the Notice. 4. May request an expedited appeal. 5. And/or, if the person is a Medicaid consumer, may request a DCH Administrative Hearing within 90 days of the date of the notice.
Local Appeal Administrator or Designee	1. Log appeal as applicable 2. Acknowledge request for local appeal in writing to the consumer/guardian within 5 days of receipt of the request. 3. Notify the Affiliation Fair Hearings Officer immediately upon the receipt of: a. Local Dispute Resolution Committee Request for Review of Local Appeal, or b. Request for an Administrative Hearing. 4. Assist applicant/legal representative as needed and any issues of legally protected right(s) to the local ORR. 5. Provide summary data on second opinions, local dispute resolution committee meeting outcomes, and administrative hearings to the Affiliation Fair Hearings Officer quarterly.
Local CMHSP Designee	1. If consumer/legal representative requests a local appeal, see *Local Dispute Resolution Committee Procedures* (Exhibit I). 2. If applicant/legal representative requests an expedited appeal, reviews request and gives notice of disposition no later than three (3) days from the request. 3. If expedited appeal occurs, follows Local Dispute Resolution Committee Procedures (Exhibit I) within expedited timeframes. 4. If consumer is a Medicaid consumer and requests a DCH administrative hearing, see DCH Administrative Hearing Instructions for Affiliation Staff (Exhibit L). 5. If consumer is not a Medicaid consumer, and the consumer requests a DCH Alternative Dispute Resolution Process <u>after</u> receiving a response from a Local Dispute Resolution Committee, see DCH Alternative Dispute Resolution Process Instructions for Affiliation Staff (Exhibit N).

G. Family Support Subsidy Denial or Termination

<u>WHO</u>	**<u>DOES WHAT</u>**
Local CMHSP Designee or Children's Advocate	1. If a Family Support Subsidy Application is denied or services are terminated, sends the consumer's parent or legal representative a memorandum stating the reason for ineligibility and timeline for an appeal. 2. If the parent or representative had an income increase that resulted in

	the family exceeding the statutory limit, and the parent or representative did not notify the CMH within two weeks of the change, sends the parent or representative a memorandum explaining that the subsidy will be terminated, and any amount illegally received will be repaid together with interest as provided in Administrative Rule 330.1621.
Parent or legal Representative	1. Accepts decision or files an appeal within two months of the date of the notice of ineligibility or termination. This may be done by letter or by appeal form available from the Local Board.
Local CMHSP Designee	1. Using a "reasonable person" standard, determines if the denial or termination of the subsidy will pose an immediate and adverse impact upon the consumer's health and safety. If so, hears the appeal within one business day. If not, follows the steps below. 2. Sends parent or legal representative notice of receipt of appeal, indicating the following information about the scheduled hearing: a. Date, hour, place and nature of hearing b. Statement of legal authority and jurisdiction under which the hearing is to be held c. Reference to statues and rules involved, and d. Short and plain statement of the matters asserted. If the timeline for an appeal was exceeded, sends a response indicating that the appeal was not received within two months of the action.
Local CMHSP Designee	1. Conducts a hearing in the manner provided for a contested case hearing under Chapter 4 of the Administrative Procedures Act of 1969.

EXHIBIT A

Community Mental Health Partnership of Southeast Michigan
(Local Affiliate Name Here)

ADEQUATE NOTICE OF HEARING RIGHTS
Service Authorization/Person Centered Plan/Treatment Plan

_____

(Recipient Name and I.D.#) (Date)

Services that will be provided to you are listed below or are described in your Person Centered Plan.

_____

Washtenaw Community Health Organization and your local CMH authorizes these services, and the legal basis for these decisions is 42CFR440.230(d). If you do not agree with the scope, duration, or intensity of the authorized services, you can ask for a review by using one or more of the following options:

If you applied for services or requested hospitalization and you were denied, you can ask for a second opinion within 30 days by filling out and returning the enclosed "Request for Second Opinion" form.

If you are already receiving services, speak with the staff that developed this service plan with you, or speak with his/her supervisor. They will be happy to work with you and try to resolve your concerns.
They can also help you with any of the options listed below.

To get help with your appeal options you can call your local Appeals Officer, Customer Services, or your local Office of Recipient Rights at ***local number here***. You can also contact the Affiliation Fair Hearings Officer at 734-544-3000 for help with your appeal. To make a rights complaint you can call the Office of Recipient Rights.

You can ask for a review by the Local Dispute Resolution Committee by calling your local Appeals Officer or your local Office of Recipient Rights at ***local number here*** within 90 days of the date of this notice. In an emergency, an LDRC review can be held within three days (or less) of receiving the necessary information.

If you are a Medicaid enrollee, you can also ask for an administrative hearing before an administrative law judge. Your request must be in writing, signed by you or your authorized hearing representative and it must be received by the Department of Community Health within 90 days of the date the services were authorized. If you want to know more about how a hearing works, call toll-free (877) 833-0870. To ask for a hearing, fill out the enclosed Hearing Request form and mail it to:

Administrative Tribunal
Michigan Department of Community Health
P.O. Box 30763
Lansing, MI 48909

PLEASE NOTE: if you are *not* a Medicaid enrollee, you may ask for a review by the Department of Community Health Alternative Resolution Process. However, this review is only available after the Local Dispute Resolution Committee has met and made a decision that you don't agree with.

EXHIBIT B

Community Mental Health Partnership of Southeast Michigan
(Local Affiliate Name Here)

REQUEST FOR SECOND OPINION/DENIAL OF HOSPITALIZATION OR OTHER SERVICES

Professional Assessment provided by_____
(Signature of Clinician)

on _____ I.D.# _____
(Date) (Applicant/Recipient)

Request for hospitalization or other services is denied at this time due to:

****

Applicant/Recipient Request for Second Opinion

If you disagree with the decision to deny services, you have the right to request a second opinion within 30 days of the date of this notice. To ask for a second opinion, sign your name and the date and return this form to:

(Local address/contact information here)

Second Opinion requested by _____ on _____
(Signature of Applicant/Recipient) (Date)

Note to Applicant/Recipient: Please contact your local Appeals Officer, Customer Services, or your local Office of Recipient Rights at ***local number here*** if you have questions or would like more information.

****

Second Opinion

Second opinion provided by _____ on_____
(Signature of Clinician) (Date)

After consultation with the original assessor, reviewing criteria and/or conducting an evaluation, services for this applicant/recipient:

Are denied _____ Will be provided _____

Request for services is denied at this time due to:

Copy: Applicant/Recipient Record

EXHIBIT C

INSTRUCTIONS FOR
REQUEST FOR SECOND OPINION / DENIAL OF SERVICES

WHO	DOES WHAT
Local CMHSP Designee/Access staff	1. Upon request for second opinion, or receipt of a Request for Second Opinion/Denial of Hospitalization or Other Services form, arranges for a second opinion at no cost to the applicant. The second opinion will be provided at no cost to the consumer by a physician, licensed psychologist, registered professional nurse, master's level social worker or master's level psychologist to be completed within five business days from receipt of the request.
Mental Health Professional rendering second opinion	1. Reaches decision, completes Second Opinion section of the Request for Second Opinion/Denial of Hospitalization or other Services form, and returns the form to the Local CMH Designee
Local CMHSP Designee	1. Arranges for verbal notification to applicant within one business day of the date the second opinion decision was made, and mails the completed form to applicant. 2. Sends copies of the completed form to the originating program and to the Local Appeals Administrator or Affiliation Fair Hearings Officer.
ACCESS Staff or MI Choice Intake Specialist	1. Arranges for services to be provided if this was the outcome of the second opinion. 2. Files copy of completed Request for Second Opinion/Denial of Hospitalization or Other Services form in applicant's record.
Local Appeals Administrator or Designee	1. Logs request for second opinion and outcome. If the applicant/legal representative was not told of his/her right to a second opinion or if the request for a second opinion was denied, informs consumer s/he may file a recipient rights complaint.

INSTRUCTIONS FOR
REQUEST FOR SECOND OPINION / DENIAL OF HOSPITALIZATION

WHO	DOES WHAT
Local CMHSP Designee	1. Upon receipt of a Request for Second Opinion/Denial of Hospitalization or other Services form, arranges for an additional evaluation at no cost to the applicant. The second opinion will be provided at no cost to the consumer by a psychiatrist, other physician, or licensed psychologist within three days, excluding Sundays and holidays. 2. If the conclusion of the second opinion is different from the original opinion, the Associate Director, with the Medical Director, makes a decision based on all clinical information available within one business day. 3. Informs the applicant/consumer/legal representative orally and in writing of the decision. The written notification will include the signature of the Associate Director and Medical Director, or other verification that the decision was made in conjunction with the Medical Director. 4. Sends a copy of the decision to the originating program and to the Local Appeals Administrator or Affiliation Fair Hearings Officer.
ACCESS/Crisis/ Psychiatric Emergency Services Staff	1. Arranges for hospitalization if this was the outcome of the second opinion, or makes appropriate referrals(s) if the outcome of the second opinion was denial of hospitalization.
Local Appeals Administrator	1. Logs request for second opinion and outcome. If the applicant/legal representative was not told of his/her right to a second opinion or if the request for a second opinion was denied, s/he may file a local appeal or a recipient rights complaint. 2. If the request for hospitalization is denied and the individual is a current consumer, the consumer or someone on behalf of the consumer may file a rights complaint alleging a violation of the right to treatment suited to condition. 3. If the second opinion supports the initial denial of hospitalization and the individual is a current consumer, and if a recipient rights complaint has not been filed already on behalf of the individual, the consumer/someone on behalf of the consumer may file a rights complaint for treatment suited to condition.

EXHIBIT E

Community Mental Health Partnership of Southeast Michigan
(Local Affiliate Name Here)

ADEQUATE ACTION NOTICE
Denial of Service to a Medicaid Recipient

(Mailed or given at the time of the action)

☐ Denial of public mental health services for an applicant or denial of hospitalization
☐ Denial of requested Medicaid service to a current Medicaid consumer

_____
(Applicant/Recipient Name and I.D.#) (Date)

☐ The services for which you a*pplied*, specifically_____, were denied because_____

OR

☐ Services you requested as a current consumer, specifically_____, were denied because_____

The legal basis for this decision is 42CFR440.230(d)

If you don't agree with this action you may:

- Speak with your worker or his/her supervisor. They will be happy to talk about this with you and try to resolve your concerns, or help you with any of the following options:
- Ask for a second opinion if you are applying for public mental health services and they have been denied, or if you have been denied hospitalization, by signing, dating and returning the enclosed form within 30 days.
- Ask for a review by the Local Dispute Resolution Committee by calling your local Appeals Officer, Customer Services, or your local Office of Recipient Rights at ***local number here*** within 90 days of the date of this Notice. In an emergency, an LDRC may be held within 24 hours of receiving the necessary information.
- Ask the Michigan Department of Community Health for a hearing. You or your authorized hearing representative have 90 days from the date of this Notice to ask for a hearing. If you want to know more about how a hearing works, call toll-free (877) 833-0870. To ask for a hearing, complete the enclosed Hearing Request form and mail it to:

Administrative Tribunal
MI Department of Community Health
P.O. Box 30763
Lansing, Michigan 48909

You can also contact the Affiliation Fair Hearings Officer at 734-544-3000 for help with your appeal.
If you ask for a hearing, you can have another person represent you at the hearing.

- This person can be anyone you want.
- This person may ask for a hearing for you and/or speak for you at a hearing.
- You must give this person written permission to speak for you. Or you may provide a letter or a copy of a court order naming this person as your guardian or conservator.
- You do not need written permission if the person who speaks for you is your spouse.

You may use one or more of the above options and they can happen at the same time. If you would like more information, or if you need help with the appeal process, you can contact your local Appeals Officer, Customer Services, or your local Office of Recipient Rights at: ***local number here***.

EXHIBIT F

Community Mental Health Partnership of Southeast Michigan
(Local Affiliate Name Here)

NOTICE OF DENIAL OR CHANGE OF SERVICES FOR NON-MEDICAID RECIPIENTS

_____ _____
(Recipient Name and I.D.#) (Date)

Following a review of the services that you are currently receiving, it has been determined that the following service(s) must be denied or changed as follows:

Service(s) Action to be Taken Effective Date

_____
_____
_____
_____

Reason(s) why action is taken::_____
_____
_____
_____

If you do not agree with this action you may:

- Speak with your worker or his/her supervisor. They will be happy to discuss this with you and try to resolve your concerns. They can also help you access any available conflict resolution mechanisms.

- Ask for a second opinion if your application for services has been denied, or if hospitalization has been denied, by signing, dating and returning the enclosed Request for Second Opinion form to your local CMH within 30 days.

- Ask for a review by the CMH Local Dispute Resolution Committee by contacting your local Appeals Officer, Customer Services, or your local Office of Recipient Rights at ***local number here*** within 90 days of the date of this Notice. In an emergency situation, an LDRC meeting may be held within 24 hours of receiving the necessary information.

- Once you receive a written decision from the Local Dispute Resolution Committee, if you are not satisfied with the outcome, you may then ask for a review by the Michigan Department of Community Health Alternative Dispute Resolution Process.

If you would like further information or if you want help in pursuing your appeal options, please contact your local Appeals Officer, Customer Services, or your local Office of Recipient Rights at ***local number here***. You can also contact the Affiliation Fair Hearings Officer at 734-544-3000 for help with your appeal.

E

EXHIBIT G

Community Mental Health Partnership of Southeast Michigan
(Local Affiliate Name Here)

ADVANCE ACTION NOTICE

Suspension, Reduction or Termination of Service(s) to Medicaid Recipient

_____ _____
(Recipient Name and I.D.#) (Date)

Service(s): Effective Date:
☐ Reduction of Service _____ _____
☐ Suspension of Service _____ _____
☐ Termination of Service _____ _____

Specifically,

☐ The Medicaid covered service you were receiving (described above) was reduced, suspended, or terminated for the following reasons:_____
_____
The legal basis for this decision is 42CFR440.230(d).

If you do not agree with this action, you may speak with your worker or his/her supervisor. They will be happy to talk about this with you and try to resolve your concerns, or help you with any of the following options.

You may ask for a review through the Local Dispute Resolution Committee by calling your local Appeals Officer, Customer Services, or your local Office of Recipient Rights at ***local number here*** within 90 days of the date of this Notice. You can also call the Affiliation Fair Hearings Officer for help at 734-544-3000. In an emergency situation, an LDRC may be held within 24 hours of receiving the necessary information.

You may ask the Michigan Department of Community Health for a hearing. You must request a hearing within 90 days of the date of this notice. If you want to know more about how a hearing works, call toll-free (877) 833-0870. To request a hearing, complete the enclosed Hearing Request form and mail it to:

Administrative Tribunal
Michigan Department of Community Health
P.O. Box30763
Lansing, Michigan 48909

If you send in your Hearing Request form before the "effective date" of action listed above, you can continue to receive the service, in most circumstances, until we receive the Judge's hearing decision.

If you keep receiving the service because you asked for a hearing, you may have to repay the cost of the service. This will happen if:
The proposed suspension, reduction or termination of services is upheld in the hearing decision.
You withdraw your hearing request.
You, or the person you asked to represent you, do not attend the hearing.
NOTE: You can ask for both a Michigan Department of Community Health hearing and a review through the Local Dispute Resolution Committee, and these can happen at the same time.

- If you ask for a hearing, you may have another person speak for you at the hearing.
- This person can be anyone you want.
- This person may ask for a hearing for you and/or speak for you at a hearing.
- You must give this person written permission to speak for you. Or you may provide a letter or a copy of a court order naming this person as your guardian or conservator.
- You do not need any written permission if the person who represents you is your spouse.

You can call your local Appeals Officer, Customer Services, or your local Office of Recipient Rights at ***local number here*** if you need help in the appeal process, or if you need help filling out the Hearing Request form. The Affiliation Hearings Officer can also help you and can be reached at 734-544-3000. You can also call the Office of Recipient Rights if you want to make a rights complaint.

This form was mailed on _____ (at least 12 days prior to the effective date of action) and copied for the case record. If a Medicaid covered service is affected, a Hearing Request form (and envelope, if the state has made them available) was included. _____
Initial Here

EXHIBIT H

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
(Local Affiliate Name Here)

LOCAL DISPUTE RESOLUTION COMMITTEE
REQUEST FOR REVIEW OF LOCAL APPEAL

Instructions to the requestor:

1. Please complete the form below. Assistance is available by calling your local Appeals Officer, Customer Services, or you local Office of Recipient Rights at ***local number here***.
2. The review will occur within ten business days.
3. You will receive written notification of the decision of the LDRC and subsequent avenues if you are not satisfied with the results.
4. After you have completed the form, please mail it to:

(Local Affiliate address/contact information here)
ATTN: Local Appeals Officer

To be completed by the Requestor:

I WANT TO REQUEST A REVIEW OF MY APPEAL. Following are my reasons for this request:

_____ _____ _____
Requestor's Signature Date Recipient's Name

Requestor's Address _____
_____

Requestor's Telephone Number: _____

LOCAL DISPUTE RESOLUTION COMMITTEE (LDRC) PROCEDURES

1. The purpose of the LDRC is to review a local appeal of an adverse action taken by the WCHO or the local CMH, and to reach a resolution that is acceptable to all parties. An LDRC may be requested by a consumer, a consumer's legal representative, a parent of a minor consumer, or an authorized hearing representative with written permission to represent the consumer (hereafter referred to as "Appellant").

2. Membership of the LDRC shall be determined by the local CMH Board designee and will vary depending on the appeal. Membership will always include staff with the appropriate clinical expertise in treating the consumer's condition and an administrator with the authority to require corrective action, who were not involved in the initial determination of adverse action.

3. When a Request for Review of Local Appeal form is received by the local CMH, or when the Appellant verbally requests a local appeal, the local CMH Board designee shall convene the LDRC to review and attempt to resolve the dispute. Verbal requests should be confirmed in writing unless an expedited resolution is requested (see #7 below).

4. Requests for a local appeal will be acknowledged in writing by the local CMH within 5 days of receipt of the request.

4. The local Board designee will contact the Appellant/legal representative to explain the LDRC process and schedule the meeting. All local appeals will be disposed of within 45 calendar days of receipt of the appeal. If the consumer is a Medicaid beneficiary, the board designee will inform the Appellant that a Medicaid beneficiary appealing an adverse action may access a DCH Administrative Hearing at the same time as requesting a review by the LDRC. (A Non-Medicaid consumer may only access the DCH Alternative Resolution Process after receiving a Resolution Notice with which s/he does not agree.)

5. The Appellant/legal representative will have the opportunity to present evidence and allegations of fact or law, in personas well as in writing, to the LDRC. Before and after the LDRC meets, the Appellant may examine the consumer's record and any other documents considered during the LDRC process.

6. Within 10 calendar days of the LDRC meeting, a Resolution Notice will be mailed to the Appellant legal representative. A Resolution Notice is written notification of the decision reached by the LDRC. The Resolution Notice will include: the names of everyone present at the LDRC meeting, the date of the meeting, the issue under dispute, and the result of the LDRC process. Subsequent avenues of appeal that are available to the Appellant if s/he is not satisfied with the result shall be included (e.g., consumer rights complaint, DCH Administrative Hearing for Medicaid consumers, or DCH Alternative Dispute Resolution Process for non-Medicaid consumers).

LOCAL DISPUTE RESOLUTION COMMITTEE (LDRC) PROCEDURES (Continued)

If the local appeal was resolved wholly in favor of the Appellant, and an Administrative Hearing Request has already been filed, the Resolution Notice will include an explanation of, and an offer to assist in, the process for withdrawing the request. A copy of the Resolution Notice will be provided to the Affiliation Fair Hearings Officer and filed in the clinical record.

7. An **expedited appeal review** will be conducted if an urgent situation exists and the standard timeframe for resolution would seriously jeopardize the consumer's life or health**.** If the consumer/ legal representative requests the expedited review, the WCHO/affiliate determines if the request is warranted. If the consumer's provider makes the request, or supports the consumer's request, the WCHO/affiliate must grant the request.

The review shall be completed within three working days of receipt of the appeal. . In emergent situations, the timeframe to make expedited decisions will be made on an immediate basis where applicable; based on clinical judgment on consumer clinical need. As with appeals other adverse actions, the consumer's services will continue until a decision is made. The consumer/ legal representative will immediately be notified orally of the LDRC outcome; a written Resolution Notice will be mailed within two calendar days.

A. If a request for an expedited appeal is denied, staff shall transfer the appeal to the timeframe for standard resolution and give consumer/legal representative prompt oral notice of the denial for an expedited appeal. Staff shall send written notice of the denial for an expedited appeal within two (2) calendar days and inform the consumer/legal representative of their right to file a grievance for denial of an expedited appeal.

EXHIBIT J

REQUEST for an ADMINISTRATIVE HEARING
INSRUCTIONS
Michigan Department of Community Health

Use this form to request an administrative hearing. An administrative hearing is an impartial review of a decision made by the Michigan Department of Community Health (or one of its contracted agencies) that the appellant (beneficiary, resident, patient, consumer, or responsible party) believes is inappropriate.

AUTHORIZED HEARING REPRESENTATIVE:
You may choose to have another person represent you at a hearing.

- This person can be anyone you choose.
- This person may request a hearing for you.
- This person may also represent you at the hearing.
- You MUST give this person written permission to represent you.
- You may provide a letter or a copy of a court order naming this person as your guardian or conservator.
- You DO NOT need any written permission if this person is your spouse or attorney.

GENERAL INSTRUCTIONS:

- Read ALL Instructions FIRST, then remove this instruction sheet before completing the form.
- Complete **Sections I and 2 ONLY. Do NO**T complete Section 3.
- Please use a PEN and PRINT FIRMLY.
- Remove the BOTTOM (**Pink**) copy and save with the Instruction Sheet for your records.
- If you have any questions, please call toll free **1 (877) 833-0870.**
- After you complete this form, mail it in the enclosed postage paid envelope to:

ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30195
LANSING MI 48909

IMPORTANT:
After the Administrative Tribunal receives your request for a hearing, your hearing will be scheduled and a notice will be mailed to you and/or your representative within 30 days.

Authority: MCL 330.114; MCL 333.5451; MCL 400.9; Executive Order No. 1996-1; Executive Order No.1996-4; 42 CFR 431.200; 7CFR 246.18; MAC R 325.910, etseq.; MAC. R 330.4011; MAC R330.5011; MAC R 330.8005, etseq.; MAC R 400.3401, etseq.; and relevant Interagency Agreements.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Department of Community Health

If you do not understand this, call the Department of Community Health at **(877) 833-0870**.
Si usted no entiende esto, llame a la oficina del Departamento de Salud Comunitaria**.**

REQUEST FOR AN ADMINISTRATIVE HEARING

EXHIBIT K

Michigan Department of Community Health **1 (877) 833-0870**

IMPORTANT:

Read the instruction sheet first.

See the instruction sheet for **non-discrimination** and **PA 431** information

ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30195
LANSING MI 48909 **1 (877) 833-0870**

Your Name			Your Telephone Number	Your Social Security Number
Your Address (No. & Street, Apt. No., etc.)			Your Signature	Date Signed
City	State	Zip Code		
What Agency took the action or made the decision that you are appealing.				Case Number

I WANT TO REQUEST A HEARING: The following are my reasons for requesting a hearing. ***Use Additional Sheets if Needed.***

Do you have Physical or other Conditions requiring Special Arrangements for you to Attend or Participate in a Hearing?

☐ **NO**
☐ **YES** (Please Explain in **Here**):

SECTION 2 – Authorized Hearing Representative Information: ***Read the information near the top of the instruction Sheet FIRST***

Has Someone Agreed to Represent you at a Hearing?
☐ **NO** ☐ **YES** (If Yes, complete the information below)

Name of Representative			Representative Telephone Number ( )	
Address (No. & Street, Apt. No., etc.)			Representative Signature	Date Signed
City	State	ZIP Code		

SECTION 3 – To be completed by the AGENCY distributing this form to the appellant:

Name of Agency			AGENCY Contact Person Name
AGENCY address (No. & Street, Apt., No., etc.)			AGENCY Telephone Number
City	State	ZIP Code	State Program or Service being provided to this appellant

DCH-0092 (8-99) DISTRIBUTION: WHITE – Administrative Tribunal, YELLOW – Person Requesting Hearing

DCH ADMINISTRATIVE HEARING
INSTRUCTIONS FOR AFFILIATION STAFF

1. The Administrative Hearing process is only available to Medicaid consumers, and is only available when the WCHO or local CMHA has taken an adverse action against the consumer. The consumer has 90 calendar days from the date of the written notice of adverse action to request an Administrative Hearing.

2. A local appeal or Administrative Hearing may be requested by a consumer, a consumer's legal representative, a parent of a minor consumer, or an authorized hearing representative with written permission to represent the consumer (hereafter referred to as "Appellant").

3. When a service is denied, suspended, reduced, terminated, or is not provided in a timely manner, the Medicaid consumer or consumer's legal representative must be given notice of the right to a DCH Administrative Hearing and other available appeal and grievance options (e.g., second opinion, consumer rights complaint, local appeal, and/or grievance process). The local CMH Board designee notifies and involves the Affiliation Fair Hearings Officer when a Request for Administrative Hearing is received.

4. **Advance Notice**: If the adverse action affects a previously authorized or provided service, the notice must be mailed to the consumer at least 12 days prior to the effective date of the adverse action, except in the following situations when notice provided by the effective date of the action is sufficient:
   a. There is factual information confirming the death of the consumer.
   b. The consumer signs a clearly written statement that s/he no longer wishes to receive services or gives information that requires termination or reduction services, understanding that this must be the outcome of supplying the information.
   c. The consumer has been admitted to an institution where s/he is ineligible under Medicaid for services.
   d. The whereabouts of the consumer are unknown and mail to him/her is returned indicating no forwarding address. (NOTE: If a consumer's whereabouts are unknown, any discontinued services must be reinstated if his/her whereabouts become known before the end of the authorization period)
   e. It is established that the consumer has been accepted for Medicaid services by another Community Mental Health Board.
   f. A change in the level of medical care is prescribed by the consumer's physician.

5. The requirement for written notice to be provided within 12 days may be shortened to 5 days prior to the effective date of the action if there is factual information, verified through secondary sources, indicating that the action to suspend, reduce or terminate services should be taken because of probable fraud

6. Continuation of Services: The WCHO/local CMH will continue to provide previously authorized Medicaid services to the consumer while the local appeal and/or Administrative Hearing is pending if:

a. The Appellant requests that services be continued, and

b. The Appellant requests a local appeal or Administrative Hearing within 12 days of the mailing of the notice, and
c. The appeal involves the termination, suspension, or reduction of previously authorized services, and
d. The original period covered by the authorization has not expired.

7. **Duration of Continued or Reinstates Services**: If the WCHO/local CMH continues or reinstates the consumer's benefits/services, these benefits/services must be continued until one of the following occurs:
   a. The consumer withdraws the appeal, or
   b. The consumer does not request an appeal and/or hearing within 12 days of the mailing of the notice, or
   c. The decision from the Administrative Hearing confirms the CMHA decision, or
   d. The authorization expires or authorization service limits are met.

8. Administrative Hearings are conducted by an Administrative Law Judge, members of the DCH Administrative Tribunal, and will take place by telephone conference unless the Appellant requests an "in person" hearing. The Affiliation Fair Hearings Officer will present the WCHO/affiliate's position during the hearing.

9. If the Administrative Law Judge reverses the WCHO/affiliate's decision to deny, terminate, suspend, reduce, or delay services and the service *was not* provided during the appeal process, the WCHO/local CMH will provide the disputed service as promptly and expeditiously as possible and as the consumer's health condition requires, after receiving the Law Judge's decision. If the service *was* provided during the appeal process, the WCHO/local CMH will ensure that the service continues to be provided in accordance with the Law Judge's decision and will assume the cost of that service.

10. The Affiliation Fair Hearings Officer shall serve as liaison to the DCH Administrative Tribunal, coordinating the Administrative Hearing process by:
    a. Coordinating the scheduling of the Hearing date and conference telephone or room arrangements.
    b. Notifying all parties of Administrative Hearing.
    c. Reviewing the clinical record.
    d. Determining what regulations, policy, rules, and/or statute were used to deny, reduce, suspend or terminate services.
    e. Identifying staff involved in the decision and other witnesses.
    f. Identifying documents and having copies made.
    g. Determining what is the best evidence.
    h. Preparing a hearing summary and sending a copy to the Tribunal and the Appellant in advance of the hearing with a copy of any documents to be introduced as evidence at the hearing.

11. The local CMH Board designee may be involved in any aspect of this process and will work with the Affiliation Fair Hearings Officer to prepare the case for the Administrative Tribunal.

EXHIBIT M

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

(Local Affiliate Name Here)

REQUEST FOR REVIEW BY DEPARTMENT OF COMMUNITY HEALTH ALTERNATIVE DISPUTE RESOLUTION PROCESS

Instructions to the Requestor:

1. Please complete and mail this form within 10 days from the date you received a decision from the Local Dispute Resolution Committee. Assistance to complete the form is available by calling the Office of Recipient Rights at ***local number here***.
2. The review and decision will be completed no later than 15 business days after your request for review is received, and you will then be notified of the outcome in writing.
3. Mail the completed form to: Kendra
   Michigan Department of Community Health
   Division of Community Services
   Lewis Cass Building
   Lansing, MI 48913

To be completed by Requestor (Use additional sheets if necessary)

Requestor_____ Address _____

Consumer Name_____

Daytime Phone No. _____

Representative/Parent of Minor Child Name (If applicable)_____

I WANT TO REQUEST A REVIEW OF MY DISPUTE WITH A PROGRAM OF_____

Description of the service being denied, suspended, reduced or terminated:

Description of the harm caused by the denial, suspension, reduction or termination of services:

_____ _____

Signature of Requestor Date

EXHIBIT N

DCH ALTERNATIVE DISPUTE RESOLUTION PROCESS INSTRUCTIONS FOR AFFILIATION STAFF

1. The DCH Alternative Dispute Resolution Process shall only be available to non-Medicaid consumers.

2. The Alternative Dispute Resolution Process may only be accessed after the consumer requests a review by the Local Dispute Resolution Committee and receives a written Resolution Notice with which s/he does not agree. The consumer has five (5) business days after receiving the Resolution Notice to appeal to DCH.
    a. Access to the Alternative Dispute Resolution Process does not require agreement by both parties, but may be initiated solely by the consumer or his/her legal representative.
    b. Following a review by the Local Dispute Resolution Committee with which the consumer was not satisfied, the local Board's designee shall give the consumer or legal representative notice of the right to a DCH review. A Request for Review form will be included with the Resolution Notice, and the consumer will be informed that assistance is available as needed.

3. The designated reviewer at DCH will contact, as necessary, the consumer/legal representative to clarify any information which has been received and
    a. to provide an opportunity to express concerns,
    b. the Affiliation Fair Hearings Officer to confirm that the local dispute resolution processes have been fully exhausted and to determine the outcome of the local processes and the rationale of the WCHO,
    c. DCH to obtain necessary consultation from the directors of Psychiatric and Medical Services, the Office of Recipient Rights, and others as appropriate.

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

5. In all other cases, the DCH representative shall attempt to resolve the issue with the individual and local CMH/WCHO within 15 business days of receipt. The recommendations of the area manager are non-binding in those cases where the decision poses no immediate impact to the health and safety of the individual. Written notice of the resolution shall be submitted to the local CMH/WCHO and the consumer or consumer's legal representative.

6. The Affiliation Fair Hearings Officer shall serve as liaison to the DCH Alternative Resolution Process for all affiliates. Local CMH Board staff may be called upon to assist with this process.