Policy Section	Advocacy	Policy Number	VIII-001-001
Subject	Grievance & Appeal Process	Issue Date	09/26/2008
		Revision Date	11/22/2022
		Approved By	
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POLICY

It is the policy of Tuscola Behavioral Health Systems (TBHS) to adhere to all state, federal, and regional regulations for grievance and appeals.

PURPOSE

This policy has been established to ensure that all recipients have access to options to exercise their grievance and appeal rights. Individuals served are to be notified of their options any time Tuscola Behavioral Health Systems renders a decision to deny, suspend, terminate, or reduce services. Individuals served are also to be notified of all grievance and appeal options at various stages of treatment, including phone screening through the Bay Arenac Behavioral Health Access Center, during intake evaluations, at the time of person-centered planning activities, and anytime as requested by the individual served. The intent of this policy is to provide individuals served with options that are timely, objective, fair, accessible and understandable.

APPLICATION

This policy shall apply to staff of all TBHS programs, direct operated and contractual.

DEFINITIONS

Adverse Benefit Determination (ABD) (Note: Adverse Benefit Determination is also referred to as "Action" in this policy) – A decision that adversely impacts an individual's claim for services due to:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
- Failure to make an expedited authorization decision within **72 hours** from the time of a beneficiary's request for expedited service authorization.
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning process and as authorized by TBHS.
- Failure of BABH to resolve standard appeals and provide notice within **30 calendar days** from the date of a request for a standard appeal for individuals with Medicaid / Healthy Michigan Plan (HMP) and 45 calendar days for individuals without Medicaid / HMP.

- Failure of BABH to resolve expedited appeals and provide notice within **72 calendar hours** from the time of a request for an expedited appeal for individuals with Medicaid / HMP and 3 business days for individuals without Medicaid / HMP.
- Failure of BABH to resolve grievances and provide notice within **90 calendar days** of the date of the request for individuals with Medicaid / HMP and 60 calendar days for individuals without Medicaid / HMP.
- For a resident of a rural area with only one MCO, the denial of an individual's request to exercise his or her right to obtain services outside of the network.
- Denial of a request by an individual served to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other individual's financial responsibility.

Adequate Notice of Adverse Benefit Determination (ABD) – Written statement advising the individual served of a decision to deny or limit authorization of services requested. Notice is provided to the individual served on the same date the action takes effect

Advance Notice of Adverse Benefit Determination (ABD) – Written statement advising the individual served of a decision to reduce, suspend or terminate services **currently provided. For an individual on Medicaid / HMP, a notice must be** provided/mailed to the individual at least **10 calendar days prior** to the proposed date the action is to take effect. **For an individual NOT on Medicaid, a notice must be** provided/mailed to the individual at least **30 calendar days prior** to the proposed date the action is to take effect.

Appeal – A request from the individual served for a review of an "action" as defined above.

Authorization of Services – The processing of requests for initial and continuing service delivery.

Bay Arenac Behavioral Health (BABH) – A community mental health contracted provider providing Access and customer services for TBHS.

Beneficiary – An individual who has been determined eligible for Medicaid/Healthy Michigan Plan and who is receiving or may qualify to receive Medicaid services through TBHS.

Individuals Served – Broad, inclusive reference to an individual requesting or receiving mental health services and/or substance use disorder services delivered and/or managed by TBHS and/or Mid-State Health Network (MSHN) Pre-Paid Inpatient Health Plan (PIHP), including Medicaid beneficiaries, and all other recipients of TBHS/MSHN services.

Expedited Appeal – The expeditious review of an action, requested by an Individual served or the provider for the individual served, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the Individual's life or health or ability to attain, maintain, or regain maximum function. If the Individual served requests the expedited review, TBHS determines if the request is warranted. If the provider for the individual makes the request, or supports the request of the individual served, TBHS must grant the request.

Grievance – An expression of dissatisfaction by an individual served about TBHS service issues, **other than an action**. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationship between a service provider and the Individual served, failure to respect the individual's rights regardless of whether remedial action is requested, or an individuals' dispute regarding an extension of time proposed by TBHS to make a service authorized decision.

Grievance Process – Impartial local level review of a grievance by an individual served presided over by individuals who were not involved in the previous level review or decision-making and who are healthcare professionals with appropriate clinical expertise in treating the condition of the individual served or disease when the grievance involves clinical issues or involved the denial of an expedited resolution of an appeal.

Healthy Michigan Plan (HMP) – A special Michigan Medicaid program that provides healthcare benefits (including some mental health and substance use disorder benefits) to adults who are 19-64 years of age; have income at or below 133% of the federal poverty level under the Modified Adjusted Gross Income methodology; do not qualify for standard Medicaid; are not pregnant at the time of application; and are residents of the State of Michigan.

Legal Representative – An individual who has legal authority to act on behalf of an individual served (i.e. guardian, parent of a minor child and/or durable power of attorney).

Local Appeal Process – Impartial local level TBHS review of an appeal by an individual served presided over by individuals who were not involved in the previous level review or decision-making and who are healthcare professionals with appropriate clinical expertise in treating the Individual 's condition or disease when the appeal is of a denial based on lack of medical necessity or involved other clinical issues.

Medicaid Fair Hearing – An impartial state level review of a Medicaid /HMP beneficiary's appeal of an action presided over by a MDHHS Michigan Office of Administrative Hearings and Rules (MOAHR) Judge (also referred to as "Administrative Hearing" in this policy).

Medicaid Services – Services provided to a beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Support Waiver, and/or Section 1915(b)(3) of the Social Security Act.

Mid-State Health Network (MSHN) – the Pre-Paid Inpatient Health Plan (PIHP) region in which TBHS is a member.

Notice of Resolution – Written statement by TBHS of the resolution for each local appeal and/or grievance, provided to the Individual served.

Recipient Rights Complaint – Written or verbal statement by an Individual served, or anyone acting on behalf of the Individual served, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in

Chapter 7A. The recipient rights for individuals with substance use disorders is protected by the MDHHS substance abuse program licensing rules R325.14301-325.14306.

Service Authorization: The process of identifying, defining, and specifying the amount, duration, and scope of service.

Second Opinion – Whenever initial access to Tuscola Behavioral Health Systems' services or supports or inpatient hospitalization are denied, the Individual served, his/her guardian, or in the case of a minor, his/her parent must be informed of their right to a second opinion consistent with Sec. 705 of the Michigan Mental Health Code. The second opinion for inpatient hospitalization denials must be performed within 3 calendar days excluding Sundays and holidays, at no cost to the Individual served.

STANDARDS

Medicaid and Healthy Michigan Plan Beneficiaries

All Medicaid and HMP beneficiaries have the right to request an Appeal followed by a Medicaid Fair Hearing anytime TBHS or BABH proposes a denial, suspension, termination, or reduction in services or takes other actions as defined in the Michigan Department of Health and Human Services (MDHHS) Grievance and Appeal Technical Requirement, 42 CFR 438 Subpart F – Grievance and Appeal System, and Mid-State Health Network (MSHN)-TBHS contract

BABH manages all Local Appeals for Medicaid and HMP Individuals served requesting and/or receiving services. If such a request for Appeal has been made, the beneficiary shall have the option of requesting an Expedited Appeal. Beneficiaries shall be informed of the availability of this process.

Non-Medicaid Individuals served

All non-Medicaid Individuals served have the right to request an Appeal followed by Alternative Dispute Resolution any time TBHS or BABH proposes a denial, suspension, termination, or reduction in services. BABH manages all local appeals for Non-Medicaid Individuals served requesting and/or receiving services. If such a request for Appeal has been made, the beneficiary shall have the option of requesting an Expedited Appeal. Individuals served shall be informed of the availability of this process.

All Individuals served/Applicants

All Individuals served and applicants have the right to request and/or file a Local Grievance, Second Opinion, and/or a Recipient Rights Complaint. TBHS and BABH cannot interfere with communication between Individuals served and his/her CMHSP service provider(s). Further, Individuals served, as well as providers acting on behalf of Individuals served in the grievance system process, should be free from discrimination or retaliation. All Individuals served also have the right to be provided timely written notices of adverse benefit determinations related to TBHS services.

PROCEDURES

APPEAL (All Individual served)

Individuals served may file an Appeal verbally or in writing within 60 calendar days from the date of the Notice of ABD by BABH, TBHS or a contracted provider if they have Medicaid / HMP and 30 calendar days if they do not have Medicaid / HMP. Upon receipt of a request for a ***standard*** appeal, BABH Customer Service Department shall complete the standard local appeal process, including the written Local Appeal Resolution Letter, within 30 calendar days of the request for an appeal if they have Medicaid / HMP and 45 calendar days if they do not have Medicaid / HMP. Upon receipt of a request for an ***expedited*** appeal, BABH Customer Service Department shall complete the expedited local appeal process, including the written Local Appeal Resolution Letter, within 72 hours if they have Medicaid / HMP or 3 business days if they do not have Medicaid / HMP. If request for an expedited appeal is denied, BABH Customer Services Department shall transfer the appeal to the standard resolution timeframe and provide reasonable efforts to provide prompt oral notice of the denial. A follow-up written notice of this decision to deny expedited appeal shall be provided to the beneficiary within two (2) calendar days. For individuals with Medicaid / HMP, BABH Customer Service Department may extend the notice of resolution timeframe for those with Medicaid / HMP by up to 14 calendar days.

BABH shall review appeal information in conjunction with TBHS administrative staff and shall render a decision regarding the appeal. The determination will be provided in writing to the individual served and/or the legal representative of the individual served and to pertinent providers as applicable. The BABH Customer Services Department shall provide the individual served with additional grievance and appeal options as well as information regarding appropriate avenues to exercise those options.

Local appeals shall be processed as follows:

- The individual served shall be notified of his/her grievance and appeal rights at screening, at intake, at least annually at the time of his/her PCP, and upon receiving a notice of ABD.
- The individual served will be given reasonable assistance in completing forms and in taking other procedural steps.
- The individual served will be provided:
    a. Reasonable opportunity to present evidence and allegations of fact or law in person or in writing.
    b. Opportunity, before and during the appeal process, to examine case file of the individual served.
- The individual served shall make a verbal or written request for an Appeal to BABH Customer Services Department. If an appeal is requested verbally, attempts will be made to obtain a written appeal request from the individual served / guardian.
- BABH Customer Services Department shall send a letter to the individual served acknowledging receipt of the Local Appeal, copying TBHS administrative staff, within 5 business days of receiving the request for a standard appeal. For expedited appeals, the acknowledgement and resolution letters will be sent no later than 72 hours for Medicaid/HMP

after receipt of such request and 3 business days for Non-Medicaid after receipt of such request.

- BABH Customer Services Department shall log the appeal for reporting to the PIHP and QA/Compliance Program.
- BABH Customer Services Department shall consult with the TBHS Chief Operating Officer and other relevant staff to address the appeal, none of whom shall have been involved in the initial determination.
- BABH Customer Services Department shall ensure that the individual(s) involved in making decisions regarding the appeal are not involved in the decision leading to the adverse action and are health care professionals with appropriate clinical expertise in treating the individual's condition or disease if the appeal:
  - Involves clinical issues, or
  - Involves the denial of an expedited resolution of an appeal
- For Medicaid / HMP appeals, BABH Customer Services Department may extend the resolution timeframe by up to 14 calendar days if the individual served requests an extension, or if BABH Customer Services shows to the satisfaction of the state that there is a need for additional information and how the delay is in the best interests of the individuals served. In this situation, BABH Customer Service must make reasonable efforts to give the individual served prompt oral notice of a delay and give the individual served a written notice of the reason for the decision to extend the timeframe within 2-calendar days. This letter should inform the individual served that he/she is able to request a grievance if he/she disagrees with the extension.
- BABH Customer Services Department shall provide the individual served a written **notice of resolution** not to exceed **30 calendar days** from the day of receipt of the appeal request for those with Medicaid / HMP and 45 calendar days for those that do not have Medicaid/HMP…. unless it is an expedited appeal, or an extension has been requested. In an expedited appeal, written notice of resolution is not to exceed 72 calendar hours for those with Medicaid/HMP or 3 business days for those without Medicaid/HMP. The content of the notice of resolution shall include required elements as defined by MDHHS and MSHN:
  - The results of the appeal process
  - The date the appeal process was concluded
  - The individual served has the right to request a Medicaid Fair Hearing (Medicaid and HMP beneficiary) within 120 calendar days of the appeal resolution letter or Michigan Alternative Dispute Resolution (Non-Medicaid) within 10 calendar days of the appeal resolution letter. If the request for hearing is within 10 calendar days of appeal resolution letter, the individual served may receive benefits while the hearing is pending but may be liable for cost of these services if the hearing upholds TBHS
  - How to access the respective state appeal process

SECOND OPINION (All individuals served)

If an initial applicant for public mental health services is denied such services, the applicant or his/her legal representative, must be informed in writing of the right to request a second opinion of the TBHS Chief Executive Officer (CEO). The request shall be processed in compliance with

Section 705 of the Michigan Mental Health Code and must be resolved within **five (5) business days**.

The applicant or his/her legal representative, may not file a recipient rights complaint, as he/she does not have standing as a recipient of mental health services. However, the applicant and/or his/her legal representative may file a rights complaint if the request for second opinion is denied.

If an individual is established in services or is new to services and is denied eligibility for inpatient psychiatric hospitalization, he/she or his/her legal representative may request a second opinion in writing of the TBHS CEO. Such a second opinion review will be completed within **three (3) business days**, not including Sundays and holidays.

Individuals initially denied eligibility for public mental health services and individuals denied eligibility for inpatient psychiatric hospitalization also have access to the local appeal process, as well as the respective Medicaid Fair Hearing or Michigan Alternative Dispute Resolution process if they are not satisfied with the local appeal resolution.

MEDICAID FAIR HEARING (Medicaid and HMP Beneficiaries)

Medicaid Fair Hearing requests will be processed in accordance with MDHHS MOAHR Policies. All Medicaid Fair Hearing requests must be submitted in writing to the MDHHS MOAHR and must be signed by the Medicaid or HMP beneficiary and/or the beneficiary's representative within 120 calendar days of receiving the appeal resolution letter.

Expedited hearings can be requested by an individual if it is felt the adverse action is an immediate threat to his/her health and safety.

Upon notification that a hearing request has been submitted, the BABH Customer Services Department and/or TBHS staff shall notify the TBHS Chief Operating Officer (COO) who also serves as the designated hearing representative for TBHS. The COO shall work collaboratively with appropriate staff to prepare the Hearing Summary and shall forward the completed summary to the Administrative Tribunal.

If BABH is responsible for the decision to deny, suspend, terminate or reduce services, the BABH Customer Services Department shall serve as the designated Hearing Representative and shall prepare and submit required documentation.

The hearing shall commence and an Administrative Law Judge (ALJ) shall render a decision and order. The decision and order are final, and all orders are to be implemented. The BABH Customer Services Department and TBHS administrative staff will monitor the implementation of all decisions and orders.

Requests for Hearing shall be processed as follows:

- The beneficiary or beneficiary's representative shall be notified of his/her grievance and appeal rights upon receiving notice of ABD.
- A beneficiary must exhaust the local appeal process before requesting a hearing. A beneficiary will also be notified of his/her rights to a Medicaid Fair Hearing in a notice of appeal denial letter.
- TBHS cannot limit or interfere with an individual's freedom to file a Medicaid Fair Hearing.
- The beneficiary or beneficiary's representative shall make a written request to MOAHR. Requests for Medicaid Fair Hearing are to be submitted to:

Michigan Office of Administrative Hearings and Rules
Michigan Department of Health and Human Services PO Box 30763
Lansing, MI 48909

- MOAHR shall fax and/or mail a copy of the Request for Administrative Hearing to TBHS and/or BABH.
- The BABH Hearing Representative or TBHS Hearing Representative (depending on which entity issues the Notice of ABD) shall contact the beneficiary regarding the Request for Hearing to obtain additional information as necessary. The BABH Hearing Representative or TBHS Hearing Representative shall discuss the request with appropriate staff and if the request for hearing can be resolved, the beneficiary shall be given the opportunity to file a withdrawal of the request for hearing.
- In the event that the request cannot be resolved, the TBHS and/or BABH Hearing Representative shall gather all relevant information and shall prepare the hearing summary. The hearing summary and any corresponding exhibit materials shall be forwarded to MOAHR within the designated timeframe. A copy of the hearing summary shall also be provided to the beneficiary and/or the beneficiary's representative at least 7 calendar days prior to the hearing.
- The hearing shall be presided over by an Administrative Law Judge who shall render a final decision and order. A copy of the decision and order shall be sent to the beneficiary and to the TBHS and/or BABH Hearing representatives.
- The TBHS and/or BABH Hearing representatives shall provide a copy of the decision and order to the TBHS Chief Executive Officer and the TBHS Chief Operating Officer.
- The orders rendered by the Administrative Law Judge shall be implemented.
- The pertinent BABH/TBHS Medicaid Fair Hearing Officer will record the hearing process in the provided log.

MICHIGAN ALTERNATIVE DISPUTE RESOLUTION (Non-Medicaid Only)

A Michigan Alternative Dispute Resolution will be processed in accordance with the MDHHS-CMHSP Contract. Individuals will be informed of the ability to access this process during screening, intake, at least annually in their PCP, with ABD notice provision, and with local appeal resolutions. Only after exhausting the local TBHS appeal process, can an individual request a Michigan Alternative Dispute Resolution of MDHHS if he/she does not agree with the resolution of the local appeal. The individual must place such a request in writing to MDHHS within 10 calendar days from the written Notice of Local Appeal Resolution. MDHHS will review all

requests within 2 business days of receipt If MDHHS representative believes that the denial, suspension, reduction or termination will pose an immediate and adverse impact on the individual's health and safety, the issue will be referred within 1 business day to the Community Services Division within Mental Health and Substance Abuse Services for contractual action consistent with Section 8.0 of the MDHHS/CMHSP Contract. In all other cases, MDHHS representative shall attempt to resolve the issue within 15 business days.

GRIEVANCE (All individual served)

Individuals served, guardians, and/or legal representatives may file a grievance verbally or in writing with the BABH Customer Services Department. The BABH Customer Services Department shall address the grievance within 90 calendar days of receipt of the grievance for those with Medicaid / HMP and 60 calendar days for those without Medicaid/ HMP and shall issue a written notice of resolution. BABH Customer Service can extend the grievance resolution and notice timeframe by up to 14 calendar days for individuals with Medicaid/HMP. If the individual served is not notified of resolution of the grievance within 90 calendar days(or an additional 14 calendar days if an extension occurred), the individual served shall be informed of his/her right to request a Medicaid Fair Hearing (Medicaid and HMP beneficiaries only) to dispute the delay in resolution.

The BABH Customer Services Department shall attempt to resolve all grievances at the level closest to the dispute. The complainant will be provided a written summary of actions taken in the attempt to resolve the grievance, appeal options and information regarding appropriate avenues to exercise these options. The BABH Customer Services Department will coordinate resolution of grievances with the TBHS Chief Operating Officer.

Grievances shall be processed as follows:

- The individual served or his/her legal representative shall be notified of grievance rights at the commencement of services, at the time of person-centered planning activities and upon request.
- The individual served shall file a verbal or written grievance with the BABH Customer Services Department.
- The individual served shall not have access to the Medicaid Fair Hearing process **unless**, the BABH Customer Services Department fails to respond to the grievance **within 90 calendar days unless an extension occurred (only for Medicaid and HMP beneficiaries)**.
- TBHS and the BABH Customer Services Department shall provide the individual served reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. The individual served will be provided reasonable opportunity to present evidence.
- BABH Customer Services Department shall send a letter to the individual served acknowledging receipt of the grievance, copying TBHS administrative staff, within 5 business days of receiving the grievance request.

- BABH Customer Services Department shall log the grievance for reporting to the MSHN and TBHS/QA/Compliance Program.
- BABH Customer Services Department shall consult with the TBHS Chief Operating Officer and other relevant staff to address the grievance.
- BABH Customer Services Department ensures that the individual(s) who make the decisions on the grievance were not involved in the initial issue leading to the grievance request and are health care professionals with appropriate clinical expertise in treating the condition or disease of the individual served if the grievance involves clinical issues.
- For Medicaid / HMP grievances, BABH Customer Services Department may extend the resolution timeframe by up to 14 calendar days if the individual served requests an extension, or if TBHS shows to the satisfaction of the state that there is a need for additional information and how the delay is in the best interests of the individual served. In this situation, BABH Customer Service must make reasonable efforts to give the individual served prompt oral notice of a delay and give the individual served a written notice of the extension within 2-calendar days. This letter should inform the individual served that he/she is able to request a grievance if they disagree with the extension
- BABH Customer Services Department shall provide the individual served a written **notice of resolution** within the aforementioned timelines. The content of the notice of resolution must include:
  - The results of the grievance process
  - The date the grievance process was concluded
  - The individual served right to request a Medicaid Fair Hearing (Medicaid and/or HMP beneficiary) only if the notice of resolution is more than 90 calendar days from the date of the request for a grievance, and
  - How to access the Medicaid Fair Hearing process
- Grievances received by the PIHP or BABH Customer Services Department which appear to involve violations of individual rights under the Michigan Mental Health Code shall be forwarded to TBHS Office of Recipient Rights for processing, as required by the Michigan Mental Health Code.

RECIPIENT RIGHTS COMPLAINT PROCESS

Individuals served, as recipients of Mental Health Services, have the right to file Recipient Rights complaints under the authority of the Michigan Mental Health Code. Recipient Rights complaint requirements are articulated in CMHSP Managed Mental Health Supports and Services Contract, Attachment C6.3.2.1.

NOTICE OF ADVERSE BENEFIT DETERMINATION (All individual served)

A Notice of Adverse Benefit Determination (ABD) must be provided to individuals served when a service authorization decision constitutes an **"action"** by authorizing a service in amount, duration or scope less than requested or less than currently authorized, or the service authorization is not made timely. In these situations, TBHS **must** provide a notice of ABD

containing additional information to inform the beneficiary of the basis for the action TBHS has taken, or intends to take, and the process available to appeal the decision.

TBHS Notice of ABD requirements include:

- Notice of ABD to all Individuals served must be in writing and meet language format needs of the individual to understand the content.
- The individual served, and pertinent providers, must be provided notice of any ABD to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. Further, an ABD notice must be provided if a currently authorized service is being suspended, reduced, or terminated.
- If the beneficiary or legal representative requests a local appeal, not more than **10 calendar days** from the date of the notice of ABD for those with Medicaid / HMP and the beneficiary/legal representative requests a continuation of benefits before the 10 calendar days, TBHS must reinstate the Medicaid services until resolution of the appeal.
- If the beneficiary's services were reduced, terminated or suspended without an advance notice of ABD, TBHS must reinstate services to the level before the action.
- If the utilization review function is not performed within TBHS (access center, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce or terminate a service occurring outside of the person-centered planning process still constitutes an action, **and requires** a written notice of ABD.

Content of both adequate and advance notices of ABD must include an explanation of:

- What action TBHS has taken or intends to take and the policy relied upon to make your determination.
- The reason(s) for the action.
- 42CFR 440.230(d) is the basic legal authority for an action to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.
- The 's right of the individual served to file a local appeal, and instructions for doing so.
- The right of the individual served to request a Medicaid Fair Hearing after receiving local appeal resolution letter that indicates the ABD has been upheld by TBHS.
- The circumstances under which expedited resolution can be requested and instructions.
- An explanation that the Medicaid beneficiary may represent him/herself or use legal counsel, a relative, a friend or other spokesperson.
- Notification of the right of the individual served to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information to the ABD.

Content of an advance ABD must also include an explanation of (for Medicaid and HMP only):

- The circumstances under which services will be continued pending resolution of the appeal.
- How to request that benefits be continued, and
- The circumstances under which the beneficiary may be required to pay the cost of these services.

Limited exceptions to the advance notice of ABD requirement - TBHS may mail an adequate notice of ABD, no later than the date of action to terminate, suspend or reduce previously authorized services, **if:**

- TBHS has factual information confirming the death of the individual served.
- TBHS receives a clear written statement signed by the individual served that he/she no longer wishes to receive services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.
- The individual served has been admitted to an institution where he/she is ineligible under Medicaid for further services.
- The whereabouts of the individual served are unknown, and the post office returns TBHS mail directed to him/her indicating no forwarding address.
- TBHS establishes the fact that the Medicaid beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
- A change in the level of medical care is prescribed by the beneficiary's physician.
- The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(3)(7) of the Act
- The date of the action will occur in less than **10 calendar days**.
- TBHS has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the individual served (in this case, TBHS may shorten the period of advance notice to 5 days before date of action).

The Notice of ABD must be mailed within the following timeframes:

- **At least 10 calendar days before** the date of an action to terminate, suspend or reduce previously authorized Medicaid covered service(s) (Advance).
- **At least 30 calendar days before** the date of an action to terminate, suspend or reduce previously authorized services for Non-Medicaid individuals. (Advance)
- **At the time of the decision** to deny payment for a service (Adequate).
- **Within 14 calendar days** of the request for a standard service authorization decision to deny or limit services (Adequate).
- **Within 72-hours** of the request for an expedited service authorization decision to deny or limit services (Adequate).

If TBHS is unable to complete either a standard or expedited service authorization to deny or limit services within the timeframe requirement, the timeframe may be **extended up to an additional 14 calendar days.**

If TBHS extends the timeframe, it must:

- Make reasonable efforts to provide the individual served prompt oral notice of the delay.
- Give the beneficiary written notice, within 2 calendar days of initial due date, of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he/she disagrees with that decision; and
- Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

Medicaid/HMP Services Continuation or Reinstatement (Medicaid and HMP Only)

TBHS **must** continue Medicaid/HMP services previously authorized while TBHS appeal and/or State fair hearing are pending if:

- The beneficiary specifically requests to have the services continued, and
- The beneficiary or provider files the appeal timely, and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, and
- The services were ordered by an authorized provider, and
- The original period covered by the original authorization has not expired.

When TBHS continues or reinstates the Medicaid beneficiary's services while the local appeal is pending, the services must be continued until one of the following occurs:

- The beneficiary withdraws the appeal.
- **Ten calendar** days pass after TBHS mails the notice of resolution providing the resolution of the appeal against the beneficiary, **unless** the beneficiary, within the **10-day** timeframe, has requested a Medicaid fair hearing with continuation of services until a Medicaid fair hearing decision is reached.
- A Medicaid fair hearing office issues a hearing decision adverse to the beneficiary.
- The time period of service limits of the previously authorized service has been met.

If TBHS, or the MOAHR Medicaid fair hearing administrative law judge **reverses a decision** to deny authorization of services, and the beneficiary **received the disputed services** while the appeal was pending, TBHS or the State must pay for those services in accordance with State policy and regulations.

If TBHS, or the MOAHR Medicaid fair hearing administrative law judge **reverses a decision** to deny, limit, or delay services that were **not furnished** while the appeal was pending, TBHS must authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires.

RELATED FORMS & MATERIALS

Local Appeals Process Flowchart-Attachment 1
Grievance Process Flowchart-Attachment 2

REFERENCES/LEGAL AUTHORITY

MSHN Customer Services Policies and Procedures
Michigan Mental Health Code
MDHHS/PIHP Contract
MDHHS/CMHSP Contract
BBA

Revision Dates:
09/30/2010
09/15/2011
09/05/2012
04/24/2014
09/11/2017
10/16/2019
09/22/2020
11/22/2022