SUMMIT POINTE POLICY AND PROCEDURE MANUAL

Section: Customer Services	**Policy Name:** Appeals	**Policy Number:** 11.1.7
Owner: Corporate Compliance Director	**Applies To:** ☒Summit Pointe Staff ☒Summit Pointe Contract Providers ☒Summit Pointe CCBHC Services ☐Summit Pointe CCBHC DCO Providers	
Approved By: [signature]		
Version Number: 4	**Revised Date: 07/29/2024**	**First Effective Date: 03/01/2019**

I. PURPOSE:

To outline the requirements to ensure that there is a system for customers receiving Summit Pointe services to request an Appeal of service actions.

II. DEFINITIONS: Refer to the "Summit Pointe Policy and Procedures Definitions Glossary."

III. POLICY:

It shall be the policy of Summit Pointe that all customers have access to a fair and efficient process for resolving complaints regarding the services and supports provided by Summit Pointe or any agency under contract with them for the provision of mental health treatment and supports.

IV. PROCEDURE:

The Due Process Clause of the U.S. Constitution guarantees that Medicaid enrollees must receive "due process" whenever benefits are denied, reduced, suspended, or terminated. Due Process includes prior written notice of the adverse action, a fair hearing before an impartial decision maker, continued benefits pending a final decision and a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements. The Medicaid Enrollee Grievance and Appeal System provides a process to help protect Medicaid Enrollee due process rights.

According to 42 CFR 438.408, Summit Pointe must resolve each grievance and Appeal, and provide notice as quickly as the customers health condition requires, within State established timeframes that may not exceed the timeframes specified in 42 CFR 438.408.

All customers have various avenues available to them to resolve disagreements or complaints. There are several processes under authority of the Social Security Act and its federal regulations that outline the requirements regarding grievances and Appeals for Medicaid enrollees who participate in managed care: (1) State Fair Hearings through authority of 42 CFR 431.200 et seq, (2) PIHP Appeals through authority of 42 CFR 438.400 et seq., (3) Local grievances through authority of 42 CFR 438.400 et seq. Medicaid enrollees, as public mental health consumers, have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, Chapters 2, 7, 7A, 4, and 4A, including: Mediation through authority of the Mental Health Code (MCL 330-1206a et seq.), Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.), Second Opinion through authority of the Mental Health Code (MCL 330.1705 et seq.).

All customers have the right to request and have previously authorized services continued with an internal CMHSP Appeal and/or State Fair Hearing is pending.

Service Authorization Decision Timeframes:

For a Service Authorization decision that denies or limits services, notice must be provided to the customer within 14-days following receipt of the request for service for standard authorization decisions, or within 72-

hours after receipt of a request for an expedited authorization decision. *42 CFR 438.210(d) (1)-(2); 42 CFR; 438.404(c)(3)* & *(6*).

When a Medicaid service authorization is processed (initial request or continuation of service delivery) Summit Pointe must provide the customer with a written service authorization decision within specified time frames and as expeditiously as the customer's health condition requires. Summit Pointe cannot delay the service authorization decision based upon the availability of providers.

For Service Authorization decisions not reached within 14-days for standard request, or 72-hours for an expedited request, (which constitutes a denial and is thus an adverse benefit determination), notice must be provided to the customer on the date that the relevant timeframes expire. 42 CFR 438.404(c) (5).

If a customer requests an extension, or if Summit Pointe justifies (to the State agency upon request) a need for additional information and how the extension is in the customers best interest, Summit Pointe may extend the 14 calendar days to an additional 14 calendar days (for a standard request). For expedited requests, Summit Pointe may extend the 72-hour time period up to 14 calendar days.

NOTE, however, when a standard or expedited authorization decision timeframe is extended (not at the request of the customer), Summit Pointe must do the following:

- Make a reasonable effort to give the customer oral notice of the delay.
- Within two calendar days, provide the customer with written notice of the reason for the decision to extend the timeframe and inform the customer of the right to file a grievance if he/she disagrees with that decision.
- Issue and carry out its determination as expeditiously as the customer's health condition requires and no later than the date the extension expires. *42 CFR 438.404(c)(4).*

Notice Requirements:

Notice of Benefit Determination requirements include:

- The requesting provider, in addition to the customer, must be provided notice of any decision by Summit Pointe to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice of action to the provider is not required to be in writing.
- If the customer or representative requests an Appeal or a beneficiary requests a state fair hearing not more than 10 calendar days from the date of the notice of action, Summit Pointe must reinstate with customer approval the services until resolution of the Appeal.
- If the customer's services were reduced, terminated, or suspended without advance notice, Summit Pointe must reinstate with customer approval the services to the level before the action.
- If the utilization review function is not performed within an identified organization, program, or unit (access centers, 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 adverse benefit determination, and requires a written Notice of Benefit Determination.

Notice of Adverse Benefit Determination:

- Summit Pointe is required to provide timely and "adequate" notice of any Adverse Benefit Determination. *42 CFR 438.404(a)*.
- The notice is a written statement advising the customer of a decision to deny or limit authorization of Medicaid services requested (or denial of payment) and the reasons why. Summit Pointe must mail the notice within the timeframes identifies in the Code of Federal Regulations (CFR).
- ***Content & Format:*** The notice of Adverse Benefit Determination must meet the following requirements: *42 CFR 438.404(a)-(b).*
    - Customer notice must be in writing, and must meet the requirements of 42 CFR 438.10 (i.e., "…manner and format that may be easily understood and needs of those with limited English proficiency and or limited reading proficiency);

- Notification that *42 CFR 440.230(d)* provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.
- Description of Adverse Benefit Determination.
- The reason(s) for the Adverse Benefit Determination, and notification of the right of the customer to be provided upon request, and free of charge, reasonable access to and copies of all documents, records and other information relevant to the customer's Notice of Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);
- Notification of the customer's right to request an Appeal of the Adverse Benefit Determination, including information on exhausting Summit Pointe's single Appeal process, and the right to request a State Fair Hearing thereafter.
- Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal.
- Notification of the customer's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the Customer may be required to pay the costs of the continued services (only required when providing "Advance Notice of Adverse Benefit Determination").
- Description of the procedures that the customer is required to follow to exercise any of these rights; and
- An explanation that the customer may represent himself/herself or use legal counsel, a relative, a friend or other spokesman.

Advance Notice of Adverse Benefit Determination:

- Required for reductions, suspensions, or terminations of previously authorized/currently provided services.
- Must be provided to the customer at least ten (10) calendar days prior to the proposed effective date the Adverse Benefit Determination takes effect. *42 CFR 438.404(c)(1); 42 CFR 431.211.*

Limited Exceptions:

Summit Pointe may mail an adequate Notice of Benefit Determination, not later than the date of action to terminate, suspend or reduce previously authorized services, IF: *42 CFR 431.213; 42 CFR 431.214*

- Summit Pointe has verified information confirming the death of a Customer.
- Summit Pointe receives a clear and written statement signed by a customer that s/he no longer wishes services (per 42 CFR 321.213(b)(1));, or that gives information that requires termination or reduction of services and indicates that the customer understands that this must be the result of supplying that information.
- The customer has been admitted to an institution where s/he is ineligible under the plan for further services.
- The customer's whereabouts are unknown, and the post office returns agency mail directed to the customer indicating no forwarding address.
- Summit Pointe establishes that the customer has been accepted for services by another local jurisdiction, State, territory, or commonwealth.
- A change in the level of medical care is prescribed by the customer's physician.
- The notice involves an adverse determination made regarding the preadmission screening requirements of section 1919(e)(7) of the SSA.
- The Adverse Benefit Determination effective date will occur in less than 10 calendar days.
- Summit Pointe has facts (preferably verified through secondary sources) indicating that the Adverse Benefit Determination should be taken because of probable fraud by the customer (in this case, Summit Pointe may shorten the period of advance notice to 5 days before the Adverse Benefit Determination effective date).

The Adverse Benefit Determination must be mailed within the following timeframes:

- At least 10 calendar days before the proposed effective date to terminate, suspend, or reduce previously authorized or currently provided Medicaid services (Advanced).
- For denial of payment for services requested but not currently provided, notice must be provided to the customer at the time of action affecting the claim (Adequate).
- Within 14 calendar days of the receipt of request for a standard service authorization decision to deny or limited services (Adequate).
- Within 72 hours of the receipt of request for an expedited service authorization decision to deny or limit services (Adequate).
- Summit Pointe is able to extend the standard (14 calendar days) or expedited (72-hour) service authorization timeframes for up to an additional 14 calendar days if either the customer requests the extension, or Summit Pointe can show that there is a need for additional information and how the extension is in the customers best interests.
- For service authorization decisions not reached within the specified timeframe above, on the date that the timeframes expire.

Continuation or Reinstatement of Services:
If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, Summit Pointe MUST continue the customer's benefits if all of the following occur: *42 CFR 438.420:*

- The customer files the request for Appeal timely (within 60 calendar days Medicaid) from the date on the Adverse Benefit Determination Notice; *42 CFR 438.402(c)(2)(ii).*
- The customer files the request for continuation of benefits timely (on or before the latter of) 10 calendar days from the date of the notice of Adverse Benefit Determination, the intended effective date of the proposed Adverse Benefit Determination). *42 CFR 438.420(a)*.
- The period covered by the original authorization has not expired.
- The services were ordered by an authorized provider.

Duration of Continued or Reinstated Benefits (42 CFR 438.420(c)):
If Summit Pointe continues or reinstates the customer's benefits, at the customer's request, while the Appeal or State Fair Hearing is pending, Summit Pointe must continue the benefits until one of following occurs:

- The customer withdraws the Appeal or request for State Fair Hearing.
- The customer fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after Summit Pointe sends the customer notice resolution to the customer's Appeal.
- A State Fair Hearing office issues a decision adverse to the customer.
- The authorization expires or authorization service limits are met.

If Summit Pointe or the State Fair Hearing Administrative Law Judge reverses a decision to deny authorization of services, and the customer received the disputed services while the appeal was pending, Summit Pointe, or the State must pay for those services in accordance with State policy and regulations.

If Summit Pointe, or the State Fair Hearing Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, Summit Pointe must authorize or provide the disputed services promptly, and as expeditiously as the customer's health condition requires, but no later than 72 from the date it received notice reversing the determination.

If the final resolution of the Appeal or State Fair Hearing upholds Summit Pointe's Adverse Benefit Determination, Summit Pointe may, consistent with the state's usual policy on recoveries and as specified in Summit Pointe's contract, recover the cost of services furnished to the customer while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements. 42 CFR 438.420(d).

Local Appeals Process:
Upon receipt of an adverse benefit determination notification, federal regulations 42 CFR 400 et seq., provide customers the right to Appeal the determination. Upon receiving the request for Appeal, Summit Pointe will conduct an internal review process. Summit Pointe may only have one level of Appeal. The internal review by Summit Pointe will be completed before the customer files for a State Fair Hearing. The internal Appeal process is the first of two Appeal levels under the following conditions:

- The customer has 60 calendar days from the date of the notice of Adverse Benefit Determination to request an Appeal. 42 CFR 438.402(c)(2)(ii).
- The customer may request an Appeal either orally or in writing. NOTE: Oral inquiries seeking to Appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal). 42 CFR 438.406(b)(3).
- In the circumstances described above under the Section entitled “Continuation or Reinstatement of Benefits,” Summit Pointe will be required to continue/reinstate Medicaid Services while the Appeal or state fair hearing is pending, until one of the events described in that section occurs.

When a customer requests an Appeal, designated Summit Pointe staff will:

- Provide the customer reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)*
- Acknowledge receipt of a standard Appeal within five (5) business days and an expedited Appeal within 72 hours of receipt.
- Enter the Appeal request into the Grievance/Appeals/CS module in SPOT.
- Customer Service Coordinator/designee identifies individual to review the Appeal and ensures that the individual(s) who make the decisions on Appeals: *42 CFR 438.406(b)(2).*
  - Who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual.
  - Who when deciding an Appeal that involves either (i) clinical issues, or (ii) a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the customer’s condition or disease.
  - Who consider all comments, documents, records, and other information submitted by the customer or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
- Provide the customer and his/her representative the customer’s case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of Summit Pointe in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for Appeals. *42 CFR 438.406(b)(5)*.
- Provide the customer and/or his/her representative with a reasonable opportunity to present evidence, testimony and allegations of fact or law, in person and in writing. Summit Pointe shall inform its customers of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals.
- Provide opportunity to include as parties to the Appeal the customer and his or her representative, or the legal representative of a deceased customer’s estate; 42 CFR 438.406(b)(6).
- Provide the customer with information regarding the right to request a State Fair Hearing and the process to be used to request one. The customer can request a State Fair Hearing only after receiving notice that Summit Pointe is upholding the Adverse Benefit Determination. In the case of Summit Pointe failing to adhere to the notice and timing requirements of 30 (thirty) days, the customer is deemed to have exhausted the local Appeal process. The customer may initiate a State Fair Hearing.
- Reviewer documents the decision and sends it to Customer Service Coordinator/designee with a copy to the Corporate Compliance Director within the required time frame.

- Customer Service Coordinator/designee logs results of Appeal into the Grievance/Appeals/CS module in SPOT.
- Customer Service Coordinator/designee sends the notice of resolution letter to the customer and copies the Corporate Compliance Director.

Notice of Resolution Timeframes:
Standard Resolution:

- Summit Pointe must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the customer's health condition requires, but not to exceed 30 calendar days from the day Summit Pointe receives the written or oral request for Appeal.

Expedited Appeal Resolution:

- Available where Summit Pointe determines (for a request from the customer) or the provider indicates (in making a request on the customer's behalf or supporting the customer's request) that the time for a standard resolution could seriously jeopardize the customer's life, physical or mental health, or ability to attain, maintain, or regain maximum function. *42 CFR 438.410(a)*
- Summit Pointe may not take punitive action against a provider who requests an expedited resolution or supports a customer's Appeal. *42 CFR 438.410(b).*
- If granted, Summit Pointe must resolve the appeal and provide written notice of resolution to the affected parties no longer than 72 hours after Summit Pointe receives the request for an expedited resolution of the appeal.
- ***If a request for expedited resolution is denied, Summit Pointe must:***
    - Transfer the Appeal to the timeframe for standard resolution. *42 CFR 438.410(c)(1)*
    - Make reasonable efforts to give the customer prompt oral notice of the denial if Summit Pointe extends the timeframe not at the request of the customer. *42 CFR 438.408(c)(2), 438.410(c)(2)*.
    - Within 2-calendar days, give the customer written notice of the reason for the decision to extend the timeframe and inform the customer of the right to file a Grievance if they disagree with the decision. *42 CFR 438.408(c)(2), 438.410(c)(2), and:*
    - Resolve the Appeal as expeditiously as the customer's health condition requires but not to exceed 30 calendar days.

Extension of Timeframes:
Summit Pointe may extend the resolution and notice timeframe by up to 14 calendar days if the customer requests an extension, or if Summit Pointe shows to the satisfaction of the State (upon request) that there is a need for additional information and how the delay is in the customer's interest *42 CFR 438.408(c).* If Summit Pointe extends resolution/notice timeframes, not at the request of the customer, it must complete all the following: *42 CFR 438.408(c)(2)*:

- Make reasonable efforts to give the customer prompt oral notice of the delay.
- Within 2-calendar days, give the customer written notice of the reason for the decision to extend the timeframe and inform the customer of the right to file a Grievance if they disagree with the decision.
- Resolve the Appeal as expeditiously as the customer's health condition requires and not later than the date the extension expires.

Appeal Resolution Notice Format:
Summit Pointe must provide customers with written notice of the resolution of their Appeal and must also make reasonable efforts to provide oral notice in the case of an expedited resolution. *42 CFR 438.408(d)(2)*. Customer notice must meet the requirements of 42 CFR 438.10 (i.e., "…in a manner and format that may be easily understood and is readily accessible by such Consumers and potential Consumers," meets the needs of those with limited English proficiency and or limited reading proficiency).

42 CFR 438.416 indicates the State must require Summit Pointe maintain records with (at minimum) the following information:

- A general description of the reason for the Appeal or grievance.
- The date received.
- The date of each review or, if applicable, review meeting.
- Resolution at each level of the Appeal or grievance if applicable.
- Date of resolution at each level, if applicable.
- Name of the covered person for whom the Appeal or grievance was filed.
- Further this recordkeeping must be "accurately maintained in a manner accessible to the state and available upon request to Centers for Medicare and Medicaid Services."

Appeal Resolution Notice Content: 42 CFR 438.408(e):

- The notice of resolution must include the results of the resolution and the date it was completed.
- When the Appeal is not resolved wholly in favor of the customer, the notice of resolution must also include notice of the customer's:
    - Right to request a State Fair Hearing
    - Right to request to receive benefits while the state fair hearing is pending, and how to make the request.
    - That the customer may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the Adverse Benefit Determination.

State Fair Hearing Appeal Process:
Federal regulations provide an Enrollee the right to an impartial review by a state level administrative law judge (a State Fair Hearing), of an Adverse Benefit Determination of a local agency or its agent, in certain circumstances:

- After receiving notice that Summit Pointe is, after Appeal, upholding an Adverse Benefit Determination. *42 CFR 438.408(f)(1).*
- When Summit Pointe fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals, as described in 42 CFR 438.408.

The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the customer, free to customer, independent of State and Summit Pointe, and not extend any timeframes or disrupt continuation of benefits). *42 CFR 438.408(f)(1)(ii).*

Summit Pointe may not limit or interfere with an Enrollee's freedom to make a request for a State Fair Hearing.

Customers are given no more than 120 calendar days from the date of the applicable notice of resolution to file a request for a State Fair Hearing. 42 CFR 438.408(f)(2).

Summit Pointe is required to continue benefits, if the conditions described under the heading 'Continuation or Reinstatement of Services' are satisfied, and for the durations described therein.

If the customer's services were reduced, terminated, or suspended without advance notice, Summit Pointe must reinstate services to the service level before the Adverse Benefit Determination.

The parties to the State Fair Hearing include Summit Pointe, the customer and his or her representative, or the representative of a deceased customer's estate. A Recipients Rights Officer shall not be appointed as the Summit Pointe Hearings Officer due to the inherent conflict of roles and responsibilities.

Expedited hearings are available. Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at:

http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html
OR Department of Licensing and Regulatory Affairs

Michigan Office of Administrative Hearings and Rules
State Fair Hearing
http://www.michigan.gov/lara/0,4601,7-154-10576_61718_77732---,00.html

Appointment of an Authorized Representative:
A customer may appoint any individual (such as a relative, friend, advocate, attorney, or any physician) to act as his or her representative when pursuing an Appeal or fair hearing.

With written consent from the customer, the customer has the right to have a provider or other authorized representative to act on his or her behalf, file an Appeal to Summit Pointe or request a State Fair Hearing.

In the event the customer appoints a representative, the Appeal request must include:

- A statement that the customer is authorizing the representative to act on his or her behalf, and a statement authorizing the disclosure of individually identifiable information to the representative.
- The customer's signature and date of making the appointment.
- A signature and date of the individual being appointed as a representative, accompanied by a statement that the individual accepts this appointment.

Punitive action may not be taken against a provider who acts on the customer's behalf with the customer's written consent to do so or who supports the customer's Appeal.

If an Appeal is submitted by a third party but does not include a signed document authorizing the third party to act as an authorized representative for the customer, the 30 days' time frame will start once a signed document is received. Summit Pointe must notify the customer that an authorized representative form or document is required and that the request will not be considered until the appropriate documentation is received. The third party includes health care providers.

When a request for an Appeal is filed by a person claiming to be a representative, but the representative does not provide appropriate documentation upon Summit Pointe's request, Summit Pointe will not undertake a review until or unless documentation is obtained.

For expedited requests, Summit Pointe will ensure that these requests are not inappropriately delayed due to missing documentation for an appointment of a representative.

Notice Regarding Grievance, Appeal, and Second Opinion Processes (Mediation):
The customer or his/her legal guardian or personal representative are entitled to information regarding mediation services. Information on mediation will be given to the customer or his/her legal guardian or personal representative at the start of services and annually thereafter. If a grievance, Appeal, or second opinion is requested, notification of the right to request mediation will also be provided to the customer and his/her legal guardian or personal representative. Mediation will be facilitated by a State appointed mediation organization. Participation in the mediation process will be attended by a Summit Pointe (or applicable service provider). Mediation proceedings must begin within 10 business days after recording the request and complete within 30 days after the date the mediation was recorded. An extension of up to 30 days can be given if all parties agree in writing. The entire mediation process cannot exceed 60 days.

V. REFERENCES:

Balanced Budget Act 42 CFR
Michigan Mental Health Code, Chapter 7

Michigan Department of Health and Human Services Administrative Tribunal Policy and Procedure Manuals
The Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs Agreement with Southwest Michigan Behavioral Health PIHP
Michigan Department of Health and Human Services (MDHHS)/Pre-paid Inpatient Health Plan (PIHP) Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program Contract
Michigan Department of Health and Human Services (MDHHS)/Community Mental Health Service Program (CMHSP) Managed Mental Health Support and Services Contract
MDHHS Medical Services Administration Bulletin, Beneficiary Eligibility Manual, Beneficiary Hearings Chapter 1, Section 2

VI. **ATTACHMENTS:**
None