RAINBOW CENTER OF MICHIGAN, INC.
APPEAL POLICY

Title: Appeal Policy	Chapter: Rights and Responsibilities
	Approved by: _____ Winnifred Griffin Chief Executive Officer
December 1, 2000 Date of Inception	May 1, 2022 Updated

Policy

It is the policy of Rainbow Center of Michigan that all recipients of service at this agency have the right to file an appeal if they do not wish to accept the findings and or action plan proposed by the Program Director subsequent to the filing of a complaint/grievance. Punitive action may not be taken by the Rainbow Center of Michigan against a staff member or DWIHN against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so.

Procedure

When the recipient has received the recipient rights investigation report he/she has 60 working days to decide as to whether he/she accepts the findings of the proposed action plan by the program or wishes to file an appeal within 60 working days after he/she have received the report.

You will be given notice when a decision is made that denies your request for services or reduces, suspends or terminates the services you already receive. This notice is called an "Adverse Benefit Determination". You have the right to file an "appeal" when you do not agree with such a decision. If you would like to ask for an appeal, you will have to do so within 60-calendar days from the date on the Adverse Benefit Determination.

If the decision is to file an appeal the recipient must be provided with a recipient rights appeal form or request one from the Michigan Department of Consumer and Industry Services, Lansing Michigan. A recipient may also file a new complaint if/when it is discovered that an action plan is not being put into place as described in the report. An appeal may be at the coordinating agency level and or the state level. See further Appeal Rights Form/Instructions.

If you request and meet the requirements for an “expedited appeal”, your appeal will be decided within 72-hours after we receive your request.In all cases, Rainbow Center of Michigan may extend the time for resolving your appeal by 14 calendar days if you request an extension. If the Rainbow Center of Michigan denies a request for expedited resolution of an appeal, it must:

a. Transfer the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2).
b. Follow the requirements in 42 CFR §438.408(c)(2), including:
    i. Make reasonable efforts to give the member prompt oral notice of the delay.
    ii. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if the member disagrees with that decision.

Rainbow Center of Michigan will resolve standard appeals and send notice to the affected parties as expeditiously as the member’s health condition requires, but no later than thirty (30) calendar days from the day the appeal is received.

Rainbow Center of Michigan defines an appeal as a review by the provider of an ABD. Rainbow Center of Michigan may have only one level of appeal for members.

The provider must establish and maintain an expedited review process for appeals, when the provider determines (for a request from the member) or the provider indicates (in making the request on the member’s behalf or supporting the member’s request) that taking the time for a standard resolution could seriously jeopardize the member’s life,
physical or mental health, or ability to attain, maintain, or regain maximum function.

a. The provider must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member’s appeal.

Following receipt of a notification of an ABD by a provider, the member has sixty (60) calendar days from the date on the ABD notice in which to file a request for an appeal to the provider.

The member may file an appeal orally or in writing.

a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member.

If the Provider denies a request for expedited resolution of an appeal, it must:

a. Transfer the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2).
b. Follow the requirements in 42 CFR §438.408(c)(2), including:
    i. Make reasonable efforts to give the member prompt oral notice of the delay.
    ii. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if the member disagrees with that decision.

The provider must acknowledge receipt of each appeal.

The provider must ensure that the individuals who made decisions on appeals are individuals:

a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual.
b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease:
    i. An appeal of a denial that is based on lack of medical necessity.
    ii. An appeal that involves clinical issues.
c. Who takes into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial ABD.

The Provider must provide that oral inquiries seeking to appeal an ABD are treated as appeals.

The Provider must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

a. The Provider must inform the member of the limited time available for this sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution.

The Provider must provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the provider (or at the direction of the provider) in connection with the appeal of the ABD. This information must be provided free of charge and sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c).

The Provider must resolve standard appeals and send notice to the affected parties as expeditiously as the member's health condition requires, but no later than thirty (30) calendar days from the day of receipt of the appeal. The Provider must resolve expedited appeals and send notice to the affected parties no later than seventy-two (72) hours after the Provider receives the appeal.

The Provider may extend the standard or expedited appeal resolution timeframes by up to fourteen (14) calendar days if:

a. The member requests the extension; or
b. The provider shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member's interest.

If the Provider extends the standard or expedited appeal resolution timeframes not at the request of the member, it must complete all of the following:

a. Make reasonable efforts to give the member prompt oral notice of the delay.
b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.
c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

In the case that the Provider fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the Providers appeals process, the member may initiate a State fair hearing.

For all appeals, the provider must provide written notice of the resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. The written notice of the appeal resolution includes:

a. The results of the resolution process and the date it was completed.
b. For appeals not resolved wholly in favor of the member:
i. The right to request a State fair hearing, and how to do so.
ii. The right to request and receive benefits while the hearing is pending, and how to make the request.
iii. That the member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the PROVIDER's ABD related to the appeal.

For notice of an expedited appeal resolution, the Provider must make reasonable efforts to provide oral notice.

The member may request a State fair hearing only after receiving notice that the provider is upholding the ABD related to the appeal. A State Fair Hearing may be requested by the consumer if Rainbow Center of Michigan fails to adhere to the appeal notice and timing requirements. Consumers may also request a State fair hearing only after receiving notice that the agency is upholding the ABD related to the appeal. The consumer is given one hundred twenty (120) calendar days from the date of the notice of appeal resolution to request a State fair hearing.

The provider must continue the member's benefits if all of the following occur:

a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice).
b. The appeal involves the termination, suspension, or reduction of previously authorized services.
c. The services were ordered by an authorized provider.
d. The period covered by the original authorization has not expired.
e. The member timely files for continuation of benefits.

If, at the member's request, the provider continues or reinstates the member's benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of following occurs:

a. The member withdraws the appeal or request for State fair hearing.
b. The member fails to request a State fair hearing and continuation of benefits within ten (10) calendar days after the provider sends the notice of an adverse resolution to the member's appeal.
c. A State fair hearing office issues a hearing decision adverse to the member.
d. The authorization expires or authorization service limits are met.

If the provider or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the provider must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. If DWIHN or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the provider must pay for those services.

In handling grievances and appeals, the Provider/PIHP must give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance. 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.

The Provider must provide information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.

The Provider must include as parties to the appeal and State fair hearing:

a. The member and his or her representative.
b. The legal representative of a deceased member's estate.
c. For State fair hearings, the PROVIDER.

Grievance and appeal records must be accurately maintained in a manner accessible to the State and available upon request to CMS, and contain, at a minimum, all of the following information:

a. A general description of the reason for the appeal or grievance.
b. The date received.
c. The date of each review or, if applicable, review meeting.
d. Resolution at each level of the appeal or grievance, if applicable.
e. Date of resolution at each level, if applicable.
f. Name of the member for whom the appeal or grievance was filed.

Rainbow Center of Michigan must continue the member's benefits if all of the following occur:

a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice).
b. The appeal involves the termination, suspension, or reduction of previously authorized services.
c. The services were ordered by an authorized provider.
d. The period covered by the original authorization has not expired.
e. The member timely files for continuation of benefits.

Grievance and appeal records must be retained for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.