

RULES AND BENEFITS STATEMENT
FOR PERSONS ENROLLED IN BEHAVIORAL HEALTH PLANS UNDER THE AUSPICES OF
THE MENTAL HEALTH AND RECOVERY BOARD OF WAYNE AND HOLMES COUNTIES

TOPIC: Appeals Process for MACSIS Claims

NUMBER: 3.8

DATE: Adopted January 17, 2002

1. Enrollees and providers who may wish to dispute the manner in which the Board adjudicated and paid a MACSIS claim shall be afforded an opportunity to do so.
 - a. The provision shall be limited to disputes/appeals involving whether a claim should or should not be paid and at what level or what party ought to be responsible.
 - b. This MACSIS claims-appeals mechanism is not intended to address complaints or grievances alleging poor quality services, discrimination, etc., nor policy-level questions (which might typically deal with what level of benefits the Board ought to include in its plans or who should be eligible for these benefits). Other, more appropriate, alternative avenues are available and are to be used to deal with such issues.
2. The application of this appeals process shall be governed by the following procedures:
 - a. For Medicaid claims, Medicaid appeals rules shall take precedence, although the parties shall have the option of voluntarily agreeing to make use of the provisions of these procedures.
 - b. For those provider agencies which have a direct contract with the Board, the provider agency shall be afforded the option to use either the grievance procedure referenced in the Board-Agency contract or, by mutual agreement, the provisions of this MACSIS claims-appeals mechanism.
3. Appeals must be submitted in writing to be considered. Unless there are extenuating circumstances, this is to be done within 45 calendar days of the time the affected party had occasion to learn of the matter which is to be subject to dispute.
4. Appeals will be dealt with through a three-tier process:
 - a. Level 1: There shall be an informal local process that attempts to resolve the issue through good faith discussions among the parties involved. Consideration shall be given to including a mediator in these efforts.
 - b. Level 2: If the dispute is not resolved at Level 1, it shall be submitted to a review committee drawn from a regional panel of Board and agency representatives (and perhaps some outside parties, possibly including family member or consumers). The members of a review committee will be selected by the Board, with the assistance of Heartland East staff and in consultation with the other parties to the dispute. A typical committee would have a minimum of two members, among whom there would be both Board and agency personnel. Review committee members would need to have appropriate credentials, expertise in the issue being considered and no affiliation with

1-99A-83 111422

the parties to the dispute or prior involvement with the case in question. The review committee would be expected to make a non-binding ruling on the dispute (i.e., to provide non-binding arbitration) and to provide a rationale for its decision.

- c. Level 3: If the dispute is not resolved at Level 2, it shall be submitted to an independent external party comparable to that which would be utilized by a private managed care organization. The decision of this external party would be final and binding on all parties (i.e., binding arbitration), except that that the affected party would still have the option of turning to the courts if a decision were felt to be particularly egregious or inconsistent with statutory/regulatory provisions.
5. At each stage of the process those involved would have 30-days after that level of the process was initiated to come to some decision at that level and officially communicate it to the affected parties. The affected parties would have an additional 30-days to consider whether to appeal to the next tier.
6. While the appeal was under consideration, the costs of any on-going services that were provided would be at the risk of the client/enrollee and provider. Should the final decision be in favor of the client/enrollee or provider, it is expected that the outcome would be made retroactive.
7. Throughout the appeals process, to the extent issues of "clinical necessity," "levels of care" and "treatment protocols" may be involved, standards promulgated by ODMH/ODADAS and established and accepted industry/professional guidelines are to be followed. The Rules and Benefits Statements adopted by the Board are also to govern the decision-making process, although these are not to be interpreted as establishing any "entitlement" program, but as good faith attempts to establish the guidelines and principles through which the Board intends to appropriately, fairly and impartially manage the public resources entrusted to it.
8. The Board shall call upon the support and assistance of the Heartland East ASO in the administration of this MACSIS claims appeals process. The amount of time and effort to be devoted to establishing the framework for implementation of the process shall be proportional to the volume of cases which need to be addressed.
9. Underwriting the costs associated with this appeals process shall be a Board responsibility.