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# **Maryland's Public Mental Health System**

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## **Chapter 9 Grievances and Appeals (Pre-service)**

## Chapter 9

### Grievances and Appeals

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The grievance procedure is set forth in Maryland Law (COMAR 10.09.70.08). This chapter of the provider manual describes the process for complying with COMAR regulations. A *grievance* is a request made for re-review of a previous medical necessity determination that resulted in non-authorization of a service request. A consumer or a provider/advocate may also request a grievance with the consumer's consent. MAPS-MD provides for two levels of grievance following an initial medical necessity determination that resulted in non-authorization of a service request. Consumers may appeal to the CSA at any point in the process, except in circumstances when the CSA is the provider of service. Medical Assistance (MA) recipients may have the state of Maryland Office of Administrative Hearings (OAH) review the decision for MA services, at any stage, as the final authority. The Mental Hygiene Administration (MHA) is the final authority for consumers who are uninsured eligible.

#### Definitions

A **consumer** is a Maryland Medicaid (MA) recipient, uninsured eligible individual or the consumer's legal guardian who requests mental health services. For this chapter of the provider manual, a parent of the child is considered the consumer.

A **complaint** is an expression of dissatisfaction with some aspect of the Public Mental Health System (PMHS).

A **grievance** is a process available to MA recipients and uninsured eligible individuals to request a re-review of a non-authorization of requested services.

An **appeal** is a formal process available to MA recipients to request the CSA, MHA and/or the Office of Administrative Hearings (OAH) to review the decision.

A **Care Manager (CM)** is a mental health professional responsible for reviewing, coordinating, and approving the mental health treatment of individuals served by the Maryland PMHS.

A **Physician Advisor (PA)** is a board-certified psychiatrist who reviews authorization requests and performs medical necessity determinations.

**Clinical service non-authorization** is defined as a determination by a MAPS-MD PA that the mental health services requested are not medically necessary.

An **administrative or technical denial** is based on the failure to meet administrative requirements set forth by the PMHS and the MHA, such as following the rules for pre-authorization of services or requesting continued authorization of existing services on or before the last authorized day or service.

An **urgent request** is defined as a request for pre-authorization for admission to an acute inpatient facility, or a service level in which the consumer, or provider of service believes that waiting 24 hours for a decision would potentially be harmful to the consumer.

A **non-urgent request** is defined as a request for continued acute inpatient services or any other service level other than a request for pre-authorization of an acute inpatient admission.

### **Level I – MAPS-MD Grievance - Summary**

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The initial review of an authorization request submitted by a provider on behalf of a consumer is completed by a MAPS-MD CM. A CM may only authorize service requests. When a CM cannot authorize services based on the information submitted via APS CareConnection®, or submitted telephonically, the CM may ask the provider for additional information. When this occurs, the CM will enter “Holding for Provider Information” in APS CareConnection®. This will be communicated to the provider via the provider download and will outline the additional information needed and the timeframe for the response. When the additional information is received, the CM will authorize the services requested or suggest an alternative level of care. If the CM is not able to authorize the requested services or negotiate an alternative level of care, the CM will refer the case to the MAPS-MD Medical Director or PA.

A non-authorization of services results when the MAPS-MD Medical Director or PA reviews a service request, and cannot approve the request because it does not meet the medical necessity criteria established for that level of service. Following the initial non-authorization of service, a consumer, or a provider or advocate with the consumer’s consent, may file a Level I Grievance to have the service request reviewed by another MAPS-MD PA. If the decision to non-authorize the service request is upheld, MAPS-MD forwards a non-authorization letter to the consumer and provider. If the consumer continues to disagree with the continued non-authorization decision, a Level II Grievance may be requested.

### **Level I Grievance: Pre-certification of Inpatient Admissions and Urgent Requests**

A Level I Grievance must be filed within 10 business days of the initial non-authorization of service. The Level I Grievance is completed telephonically between a MAPS-MD PA and the provider. The Level I Grievance will be completed within one hour of receiving the request.

- Direct contact with the provider is required in order to make timely decisions.
- If the provider is not available within the time frame allotted, the provider or consumer may request that MAPS-MD place the request on hold for up to 24 hours.
- The MAPS-MD PA will make reasonable attempts to reach the provider or designated clinical contact for additional clinical information. If he/she cannot be reached, the MAPS-MD PA will make a decision based on the available information.
- MAPS-MD may request documentation from the medical record when the telephonic information is unclear or incomplete.
- If the MAPS-MD PA concludes that services are medically necessary, MAPS-MD authorizes the requested service and forwards a Level I Grievance authorization letter to the consumer and the provider within two business days. The authorization is also entered in APS CareConnection® and is available to the provider via download.

- If the MAPS-MD PA concludes that the non-authorization or partial non-authorization is appropriate, MAPS-MD informs the provider of the decision and grievance rights during the telephonic review. A Level I Grievance non-authorization letter that includes the next level of grievance available to the consumer is sent to the provider and consumer within two business days.

### **Level I Grievance: Other Services or Non-Urgent Requests**

Level I Grievances for all other services in which the *consumer is actively in care* will be completed within 24 hours of the grievance being filed. A Level I Grievance must be filed within 10 business days following the initial non-authorization of service. The Level I Grievance is completed telephonically between a MAPS-MD PA and the provider.

- Direct contact with the provider is required in order to make timely decisions.
- If the provider is not available within the time frame allotted, the provider or consumer may request that MAPS-MD place the request on “Holding for Provider Information” status for up to 24 hours.
- The MAPS-MD PA will make reasonable attempts to reach the provider or designated clinical contact for additional clinical information. If he/she cannot be reached, the MAPS-MD PA will make a decision based on the available information.
- MAPS-MD may request documentation from the medical record when the telephonic information is unclear or incomplete.
- If the MAPS-MD PA concludes that services are medically necessary, MAPS-MD authorizes the requested service and forwards a Level I Grievance authorization letter to the consumer and the provider within two business days. The authorization is also entered in APS CareConnection® and is available to the provider via download.
- If the MAPS-MD PA concludes that the non-authorization or partial non-authorization is appropriate, MAPS-MD informs the provider of the decision and grievance rights during the telephonic review. The provider and consumer will be forwarded a Level I Grievance non-authorization letter, within two business days, that includes the next level of grievance available to the consumer.

### **Level II Grievance: Pre-certification of Inpatient Admissions and Urgent Requests**

A Level II Grievance must be filed within three business days following the Level I Grievance non-authorization of service. The Level II Grievance is completed telephonically between a MAPS-MD PA and the provider. The Level II Grievance will be completed by MAPS-MD within one hour of receiving the request when a consumer is waiting for admission to an acute inpatient service level.

- Direct contact with the provider is required in order to make timely decisions.
- If the provider is not available within the time frame allotted, the provider or consumer may request that MAPS-MD place the request on hold for up to 24 hours.
- The MAPS-MD PA will make reasonable attempts to reach the provider or designated clinical contact for additional clinical information. If he/she cannot be reached, the MAPS-MD PA will make a decision based on the available information.

- MAPS-MD may request documentation from the medical record when the telephonic information is unclear or incomplete.
- If the MAPS-MD PA concludes that services are medically necessary, MAPS-MD authorizes the requested service and forwards a Level II Grievance authorization letter to the consumer and the provider within two business days. The authorization is also entered in APS CareConnection® and is available to the provider via download.
- If the MAPS-MD PA concludes that the non-authorization or partial non-authorization is appropriate, MAPS-MD informs the provider of the decision and grievance rights during the telephonic review. A Level II Grievance non-authorization letter that includes the next level of grievance available to the consumer is forwarded to the provider and consumer within two business days.

### **Level III - CSA Appeals**

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When the consumer does not agree with the determination made by the MAPS-MD PA following the Level II Grievance, the consumer may contact the CSA Director of his/her county of residence to appeal the decision.

#### **Pre-authorization of Inpatient Admissions and Urgent Requests**

A review of Level III appeals for inpatient admissions or urgent care will be completed and the decision communicated to the consumer, provider and MAPS-MD by the CSA within five business days of the request.

#### **All Other Services**

Appeals for all other services will be completed and the decision communicated to the consumer and provider by the CSA within 10 business days of the request.

#### **Process for Level III Appeals:**

- Within 10 business days of the Level II non-authorization, a Level III appeal may be submitted to the CSA of the county in which the consumer resides.
- When requested, MAPS-MD will forward to the CSA all the documentation regarding the decision within one business day.
- The CSA may contact the appropriate provider for any additional information needed to re-evaluate medical necessity.
- The CSA may request that the consumer or provider follow the grievance process with MAPS-MD if he/she has not already done so.
- When the CSA authorizes services, they will inform the consumer and the provider, telephonically, of the determination within one business day. The CSA will notify MAPS-MD, MHA, and the provider, in writing, within two business days of the decision, using the approved form letter which must be signed by the CSA Director.
- When the CSA upholds MAPS-MD's non-authorization, the CSA must inform the consumer and provider by phone or fax within one business day of the decision. The CSA will notify MAPS-MD, MHA, and the provider, in writing within two business days of the decision, using the approved form letter which must be signed by the CSA Director.

- Consumers must also be informed by the CSA of their right to appeal to the Mental Hygiene Administration.

### **Level IV - MHA Appeal**

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Regarding appeals submitted for MHA review:

- Appeals must be requested in writing to MHA within 5 business days after receipt of a CSA's decision.
- MHA may perform an investigation of the appeal which must be accomplished within 10 business days.
- MHA may refer the appeal to either MAPS-MD or the CSA for re-review when grievance levels have not been utilized.
- MHA must make its determination and provide written notification to the consumer within 15 business days.
- Medical Assistance (MA) recipients will be informed by the MHA of their right to appeal to the OAH.
- The MHA is the final authority for consumers who are uninsured eligible.
- MHA will notify MAPS-MD, in writing, of any appeal that results in an authorization.

**To file a Level IV Appeal with the MHA via mail:**

Attn: Grievances and Appeals  
Mental Hygiene Administration  
Spring Grove Hospital Center-Dix Building  
55 Wade Avenue, Catonsville, MD 21228

### **Level V – OAH Appeals**

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If a consumer with MA wishes to appeal the MHA's decision, he/she must file a notice, in writing, to the Office of Administrative Hearings (OAH) within 45 business days of MHA's decision to not authorize services.

**Requests for appeal hearings should be submitted via mail to:**

Office of Administrative Hearings  
11101 Gilroy Road  
Hunt Valley, Maryland 21031-1301  
Voice: (410) 229-4100, Fax: (410) 229-4111