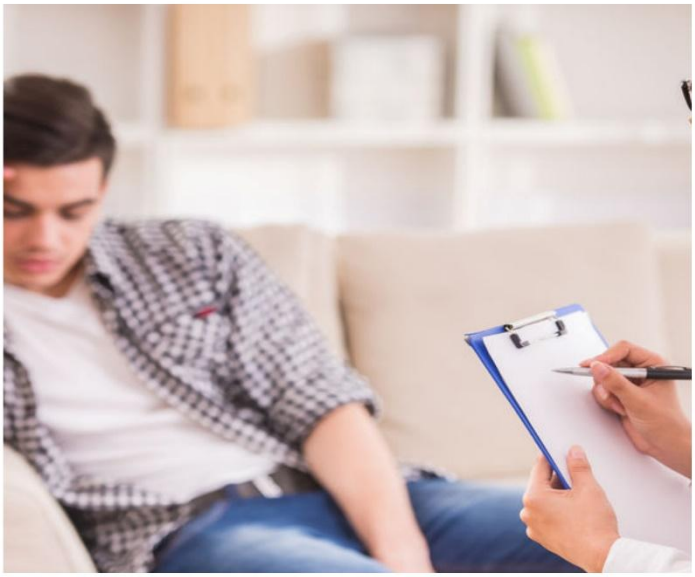
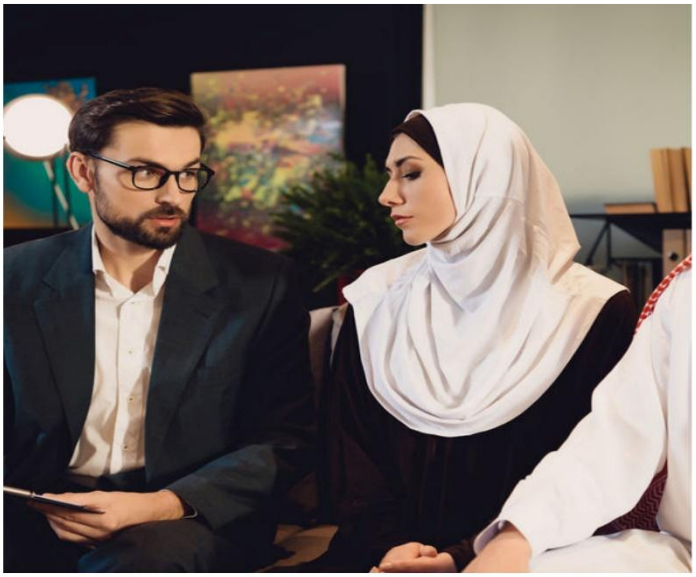
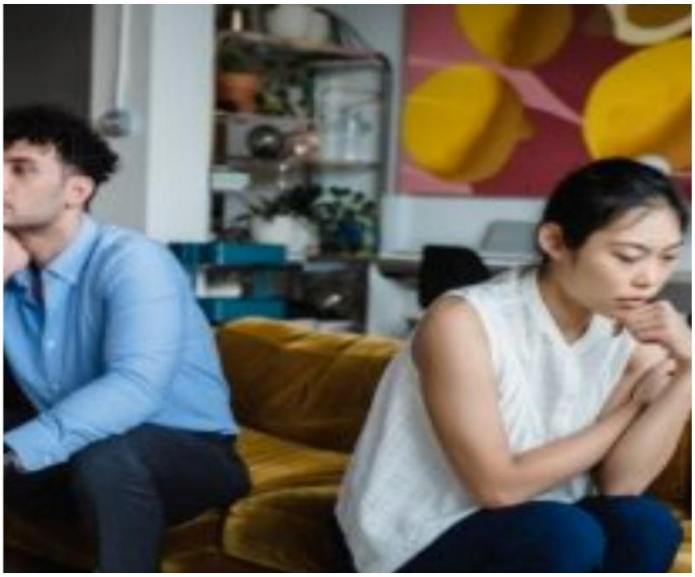
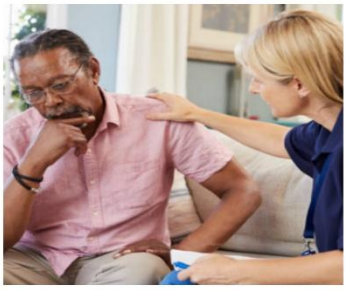
YOUR RIGHTS

When Receiving Mental Health Services in Michigan


Rights Is Everybody's Business

MDHHS 2025

MDHHS
Michigan Department of Health & Human Services

Office of Recipient Rights

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SECTION I: GENERAL INFORMATION

When you receive mental health services your rights are protected by Michigan's Mental Health Code and by many Federal and State Laws. Staff are responsible to act in a manner that protects your rights when they provide services to you. If you do not understand your rights, or if you have questions about your treatment, you should ask staff. If you believe that your rights have been violated, you should tell the Rights Advisor/Officer at the location where you are receiving services. This booklet provides information about the rights granted to you by the Mental Health Code when you are receiving mental health services.

Notice

Mental Health Code Sections 706, 706a

When you make a request for, or begin to receive, mental health services, you are to be given information about the rights guaranteed in Chapters 7 and 7A of the Code. This booklet meets that requirement and provides you a summary of the information and rights contained in those chapters. A complete copy of Chapters 7 and 7A will be available for review at each service site.

If you receive services from a community mental health services program, you, or your family, should also be given a pamphlet containing information regarding available resources, advocacy and support groups, and other relevant information, including how to contact Disability Rights Michigan (DRM).

Competency

Mental Health Code Section 702

Just because you receive mental health treatment or services does not mean that you are incompetent. You still have the right to have a driver's license, marry and divorce, make a will, buy, and sell property, manage your own affairs, and decide most things about your life. You will be treated as competent unless a court has decided that you are legally incompetent and has appointed a guardian for you.

A guardian is authorized by a judge to make certain decisions for you. For some people, a guardian makes major decisions; for others, the guardian decides only those specific things listed in a court order. If you have a guardian and you think you should be able to make more decisions for yourself, or if you think you don't need a guardian, or that you need a different guardian, then you, or someone on your behalf, may go to the court and ask (petition) for a change of guardianship.

Consent

Mental Health Code Section 100 a [17]; Administrative Rule 330.7003

You must give **INFORMED CONSENT** in order to receive treatment or to have confidential information about you

provided to others by the agency from which you are receiving services. In order to be able to give informed consent you must have:

- **COMPETENCY** (see pg. 2)
- **COMPREHENSION**
  You must be able to understand what the personal implications of providing consent will be based upon the information given to you.
- **KNOWLEDGE**
  You must be told about the risks, benefits, and available alternatives to a course of treatment or medication.
- **UNDERSTANDING**
  You must be able to reasonably understand the information you are given including the risks, benefits, available options or alternatives, or other consequences.

Your decision to provide consent must be **VOLUNTARY**. You should not be forced or pressured into a decision. Unless you are a minor or have a guardian, the choice you make should be your and yours only. This consent must either:

- Be in writing and signed by you, your legal representative, or
- Be your verbal agreement which is witnessed and documented in your record by someone who is not the person asking for your consent at the time. Only you (the recipient) can give verbal consent.

Dignity and Respect

Mental Health Code Section 708, 711

The law requires all mental health service providers to assure that you are treated with dignity and respect. Examples of staff not showing respect include calling you names, making fun of you, teasing, or harassing you.

Your FAMILY MEMBERS also have the right to be treated with dignity and respect. In addition, they must be given:

- An opportunity to provide information about you to your treating professionals.
- An opportunity to request, and receive, general education information about the nature of mental disorders, medications, and their side effects, and information about available support services, advocacy groups, financial assistance, and coping strategies.

Freedom from Abuse and Neglect

Mental Health Code Section 722; Administrative Rule 330.7001, 7035

WHEN RECEIVING MENTAL HEALTH SERVICES YOU HAVE THE RIGHT NOT TO BE PHYSICALLY, SEXUALLY, OR OTHERWISE ABUSED AND YOU HAVE THE RIGHT NOT TO BE NEGLECTED.

ABUSE AND NEGLECT MAY TAKE MANY FORMS. SOME EXAMPLES:

- IF A STAFF PERSON MAKES ANY PHYSICAL CONTACT WITH YOU FOR SEXUAL PURPOSES.

- IF YOU ARE SEXUALLY HARASSED.
- IF STAFF CAUSE YOU TO BE INJURED IN ANY WAY, OR USE UNREASONABLE FORCE IN A PHYSICAL MANAGEMENT SITUATION, OR CAUSE YOU EMOTIONAL HARM.
- IF YOUR FUNDS ARE MISUSED.
- IF YOUR FUNDS/POSSESSIONS ARE USED BY STAFF OR USED FOR SOMEONE ELSE.
- IF STAFF ARE VERBALLY ABUSIVE TO YOU.
- IF STAFF FAIL TO DO SOMETHING THEY ARE SUPPOSED TO DO WHEN THEY ARE CARING FOR YOU, OR IF THEY DO SOMETHING THEY SHOULDN'T DO AND IT RESULTS IN HARM TO YOU OR HAS THE POTENTIAL TO HARM YOU.

IF YOU FEEL THAT YOU HAVE BEEN ABUSED OR NEGLECTED, OR IF YOU THINK ANOTHER RECIPIENT HAS BEEN SUBJECTED TO ABUSE OR NEGLECT, YOU SHOULD REPORT IT IMMEDIATELY TO THE RIGHTS OFFICE AND TO A STAFF PERSON.

Fingerprints, Photographs, Audiotape, Videotape, and Use of One-Way Glass

Mental Health Code Section 724

You have the right not to be fingerprinted, photographed, recorded on audio or video, or viewed through a one-way glass unless you or your legal representative agree in writing.

- If someone wants to photograph, or record (via video or audio) you for educational, informational, social or treatment purposes, that person must obtain your permission. If you object, it will not be done.
- When they are no longer needed, or upon discharge, any fingerprints, photographs, audio, or video recordings in your record must either be destroyed or given to you.
- Video surveillance may be conducted **in a psychiatric hospital** for purposes of safety, security, and quality improvement. Video surveillance may only be conducted in common areas such as hallways, nursing station areas, and social activity areas within the psychiatric unit. Video surveillance recordings taken in common areas shall not be used for treatment or therapeutic purposes. You be notified if surveillance is being used.

While doing an investigation to determine if your rights were violated, the Rights Officer/Advisor may need to take your picture. This will be kept in your confidential records maintained in the Rights Office.

Confidentiality

Mental Health Code Section 748, 946

You have the right to have information about your mental health treatment kept private. Information about you and your treatment cannot be given to anyone except as required or allowed by law. Listed here are examples of when confidential information may be released:

- If a law or a court order requires your records be released.
- If you, or your legal representative, consents.
- If needed to get benefits for you, or to get reimbursement for cost of treatment.
- If you need follow up care, or in order to provide care to you
- If it is needed for research or statistical purposes, with certain safeguards regarding identification.

- If you die and your surviving spouse or other close relative needs the information to apply for and receive benefits.
- If you tell your mental health professional that you are going to harm another person, he/she may have to notify the police and the person who you threaten to harm.

Access to Your Record

Mental Health Code Section 748

You have the right to see your treatment record. Upon request, you or your legal representative may read or get a copy of all or part of your record. There may be a charge for the cost of copying.

If you are an adult and the court has not judged you incompetent (appointed a guardian for you), information entered in your record may not be withheld from you *under any circumstances.*

If you are denied access to your record, you, or someone on your behalf, may appeal the decision to withhold information. Contact your rights officer/advisor for information about the agency's appeal process.

If you (or your legal representative) believe(s) your record contains incorrect information, you or they may place a statement in your record which corrects that information. You may not remove what is already in the record.

Privileged Information

Mental Health Code Section 750

Information that is shared between you and a mental health professional (your psychiatrist, psychologist or social worker) cannot be shared in court, or any proceedings related to court, unless you indicate that it is okay, or if the mental health professional tells you in advance that the information could be used in court (i.e., for guardianship proceedings or for hearings related to involuntary treatment).

Environmental Rights

Mental Health Code Section 708

You have the right to treatment in a place which is clean and safe

If you are receiving services from a residential program, the place where you live must have good lighting, enough heat, fresh air, hot and cold water, a bathroom with privacy, and personal storage space. It should also be free from unpleasant smells.

Civil Rights

Mental Health Code Section 704; Administrative Rule 330.7009

Your civil rights are protected even though you are receiving mental health services. You have the right to an education, the right register and to vote*, and the right not to be discriminated against because of age, color, height, national origin, sex, religion, race, weight or due to a physical or mental disability. Michigan law prohibits discrimination: based on race, religion, color, national origin, age, sex, disability, genetic information, marital status, familial status, height, weight, and arrest record.

**** If you are receiving treatment in an inpatient psychiatric facility, or are a resident of a group home, the staff must inquire if you wish to vote and, if you do, they must make arrangements for you to be transported to a voting location or make it possible for you to get an absentee ballot.***

If you believe that your civil rights have been violated during the course of your treatment, you can file a complaint with the Office of Recipient Rights. You may also file a complaint with the Michigan Department of Civil Rights. If you feel that any of your civil rights have been violated *by an employer, landlord, or business*, you may file a discrimination complaint with either the Michigan Department of Civil Rights, or the U.S. Office for Civil Rights. *Note: To file with either of these agencies you must write to them within 180 days of the time the alleged discrimination occurred. If you are still not satisfied, you may also sue in the State Circuit Court or Federal District Court.*

Michigan Department of Civil Rights

Capital Tower Building 110 W. Michigan Avenue, Suite 800, Lansing, MI 48933 VOICE: 800-482-3604, FAX: 517-241-0546, TTY: 517-241-1965, or email: MDCR-INFO@michigan.gov To file a complaint online: https://dtmb.state.mi.us/MDCRRequestforService/RequestComplaint.

Office for Civil Rights, U.S. Department of Health and Human Services

233 N. Michigan Ave., Suite 240, Chicago, IL 60601 Chicago, IL 60601 VOICE 800-368-1019, FAX 202-619-3818, TDD 800-537-7697 or email: ocrmail@hhs.gov or file a complaint online: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Note: To file with either of these agencies you must write to them within 180 days of the time the alleged discrimination occurred. If you are still not satisfied, you may also sue in the State Circuit Court or Federal District Court.

FEDERAL LAWS

As a person with a mental disability, you may have additional protections under the following laws:

Americans with Disabilities Act (ADA)
Fair Housing Amendments Act
Individuals with Disabilities Act (IDEA)
Elliot Larsen Civil Rights Act
Civil Rights of Institutionalized Persons Act (CRIPA)
Health Insurance Portability & Accountability Act (HIPAA)
Section 504 of the Rehabilitation Act
Michigan Disability Civil Rights Act

Title II of the Americans with Disabilities Act (ADA)

Title II of the ADA prohibits discrimination on the basis of disability by public entities. It states that people with disabilities cannot be denied services or participation in programs or activities that are available to people without disabilities. If you feel your rights under Title II have been violated by state or local governmental agencies, you may file a complaint with the Department of Justice. This must be done within 180 days from the date of discrimination. For more information, or to file a complaint, contact the U.S. Department of Justice, Civil Rights Division, Disability Rights Section, 950 Pennsylvania Avenue, NW, 4CON 9th Floor, Washington, D.C. 20530. You may also call VOICE: 800-514-0301, TTY: 800-514-0383, or file a complaint online at https://civilrights.justice.gov/report/ , or email: ADA.complaint@usdoj.gov.

Title III of the Americans with Disabilities Act (ADA)

Title III of the ADA requires that public accommodations such as restaurants, hotels, grocery stores, retail stores, etc., as well as privately owned transportation systems, be accessible to individuals with disabilities. If

you feel your rights under Title III have been violated, you may file a complaint with the Department of Justice. In certain circumstances cases may be referred to a mediation program sponsored by the Department. See the address and phone numbers given above. Title III may also be enforced through a private lawsuit.

Civil Rights of Institutionalized Persons Act

Under the Civil Rights of Institutionalized Persons Act, the Attorney General may initiate a civil rights lawsuit when there is reasonable cause to believe that the conditions are significant enough to subject residents to serious harm and they are part of a pattern or practice of denying residents' constitutional or federal rights including Title II of the ADA and Section 504 of the Rehabilitation Act. To bring a matter to the attention of the Department of Justice, contact the U.S. Department of Justice, Civil Rights Division, 950 Pennsylvania Ave NW, Washington, D.C. 20530, VOICE: 877-218-5228 FAX: 202-514-0212, or email: Special.Litigation@usdoj.gov

Fair Housing Amendments Act

The Fair Housing Amendments Act prohibits discrimination by direct providers of housing, such as landlords and real estate companies as well as other entities, such as municipalities, banks or other lending institutions and homeowners' insurance companies. If you feel your rights under this Act have been violated, you may file a complaint with the U.S. Department of Housing and Urban Development, Office of Fair Housing and Equal Opportunity (FHEO). For more information on filing a complaint, contact the Office of Fair Housing and Equal Opportunity, Detroit Field Office, McNamara Federal Building, 477 Michigan Avenue, Detroit, Michigan 48226. VOICE: 313-226-5611, FAX: 313-226-5611, TTY: 313-226-6899, or file a complaint online: https://portalapps.hud.gov/FHEO903/Form903/Form903Start.action

Health Insurance Portability & Accountability Act (HIPAA)

The HIPAA Privacy Rule regulates the use and disclosure of the information your provider gathers and retains regarding your condition and treatment. Protected Health Information (PHI) is any information held by the provider that concerns health status, provision of health care, or payment for health care that can be linked to an individual. Providers must disclose PHI to the individual within 30 days upon request. They also must disclose PHI when required to do so by law such as reporting suspected child abuse to state child welfare agencies. A provider may disclose PHI to facilitate treatment, payment, or health care operations without a patient's expressed written authorization. Any other disclosures of PHI require the provider to obtain written authorization from the individual for the disclosure. In some instances, the mental health code is more protective of health information than HIPAA. Please see your Rights Advisor for more information.

If you feel that your HIPAA rights have been violated you may file a complaint with the U.S. Department of Health and Human Services by sending your complaint to: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg. Washington, D.C. 20201 or sending an email to: OCRComplaint@hhs.gov. You will need to submit a Health Information Privacy Complaint Form Package available online at: https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html. You may also use the online complaint portal by going online to: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

MICHIGAN LAWS

Individuals with Disabilities Education Act

Under the Individuals with Disabilities Education Act, a parent who disagrees with the proposed IEP, can request a due process hearing from the Michigan Department of Education. To make this request contact the Michigan Department of Education, Office of Special Education, 608 West Allegan Street Lansing, Michigan 48933, VOICE: 517-241-7075, FAX: 517-241-7075, TTY: 517-241-7142 or email mde-ose@michigan.gov. Assistance with disputes about and IEP can also be obtained from the Michigan Department of Education Office of Special Education Mediation Services by calling 833-543-7178, by going online at www.MIKIDS1st.org or email: info@miKids1st.org. The state agency's decision can also be appealed to a state or federal court. For more information about this act and your rights, contact the Office of Special Education and Rehabilitative Services, U.S. Department of Education, 400 Maryland Ave., SW, Washington, DC 20202-7100, VOICE: 202-245-7459.

Section 504 of the Rehabilitation Act

Under Section 504 of the Rehabilitation Act, no qualified individual with a disability in the United States shall be excluded from, denied the benefits of, or be subject to discrimination under any program or activity that either receives federal financial assistance or is conducted by any executive agency or the U.S. Postal Service. If you feel that you have been discriminated against by an agency receiving federal money based on disability, you can file a 504 complaint with an appropriate agency by contacting the Office of Civil Rights, U.S. Department of Education, 400 Maryland Ave. SW, Washington, DC 20202-1100, VOICE: 800-421-3481, FAX: 202-245-8392, TDD: 800-877-8339, or email: OCR@ed.gov. You may file a complaint online at https://ocrcas.ed.gov/. Additional information is available online at: www.ed.gov/ocr.

Elliott Larsen Civil Rights Act and Persons with Disabilities Civil Rights Act

- If you are a recipient who believes that you have been discriminated against in your job because of your race, gender, marital status, etc., you are protected under Michigan's "Elliott Larsen Civil Rights Act".
- If you believe you have been discriminated against based upon disability, you are protected under Michigan's "Persons with Disabilities Civil Rights Act".

For information regarding either of these laws, or to file a complaint, contact the Michigan Department of Civil Rights, 110 W. Michigan Avenue, Suite 800, Lansing, Michigan 48933, VOICE: 1-800-482-3604, or email: MDCR-INFO@michigan.gov. Online information is available at: www.michigan.gov/mdcr.

SECTION II: TREATMENT RIGHTS

Treatment and Support

Mental Health Code Section 705, 707- 719, 744; Administrative Rule 7029, 7135

You have the right:

- To be told why you are being treated and what your treatment is.
- To participate in the development of your plan of service and to involve family members, friends, advocates, and professionals of your choice in the development process. Justification for the exclusion of a person of your choice must be documented in your case record.

- To have your plan of service developed within seven days of commencement of services or before discharge or release if you are hospitalized less than seven days.
- To choose, within certain limitations, the physician or other mental health professionals to provide services for you, if you receive services from a community mental health services program or a licensed hospital.
- To be informed of your progress, both orally and in writing, at reasonable intervals and in a manner appropriate to your condition.
- To not have surgery unless consent is obtained from at least one of the following:
    - You, if you are over 18 years old and do not have a guardian for medical purposes,
    - If you are under 18 years of age, your parent with legal and physical custody,
    - Your guardian who has legal authority to consent to surgery,
    - A representative authorized to give consent under a durable power of attorney or another advance directive.

    OR

    - If your life is threatened and there is not time to obtain consent, surgery may be performed without consent after the medical necessity for the procedure has been documented and the documentation has been entered into your record.
    - Surgery is necessary, no appropriate person can be found to give consent, and the probate court consents to the surgery.
- To be given notice of available family planning and health information services and, if you ask, to have staff provide referral assistance to providers of these services. Your receipt of mental health services does not depend in any way on requesting or not requesting family planning or health information services.
- To have staff help you get treatment by spiritual means if you request it.
- To receive treatment in a place where you have as much freedom as your condition allows.
- To not have electroconvulsive therapy (ECT) or other procedures intended to produce convulsions or coma, unless consent is obtained from:
    - You, if you are over 18 years old and do not have a guardian for medical purposes,
    - If you are under 18 years of age, your parent with legal and physical custody,
    - Your guardian who has legal authority to consent to ECT,
    - A representative specifically authorized to consent to ECT under a durable power of attorney or another advance directive.
- To receive a second opinion if you have been denied services by making a request to the Executive Director of the Community Mental Health Services Program.

Person-Centered Planning

Mental Health Code Section 712

The Mental Health Code requires a person-centered approach to the planning, selection, and delivery of the supports, services, and/or treatment you receive from the public mental health system (community mental health programs, their service providers, and licensed psychiatric hospitals.

What is person-centered planning?

Person-centered planning means the treatment you receive will be made up of activities which you think will help you, or which you assist in developing, and which meet your goals. This process will determine the supports you want or need to achieve your desired future. The staff involved in your treatment will encourage feedback from you about these supports, the progress you have made, and any changes you think would make your treatment more effective.

There are four basic parts in the person-centered process:

- **Identifying the future you desire.**
  It is up to you to choose the individuals who will help identify your future and help you plan for it. You will be a part of deciding what information is, or is not, shared at the meeting. You will be able to choose, within reason, the times and place you want to have meetings to plan your treatment, to decide the content of the meetings and how long they will be.

- **Planning the future you desire.**
  Meetings which are held to plan for your future will attempt to discover what is important to you, to share information about your abilities, strengths, and skills, to learn about your needs and to decide which of your desired goals will be achieved in the short term and which will need to be long-term. Then, you and the support team will determine the strategies for achieving these goals.

- **Finding the supports and services it will take to achieve your desired future.**
  You will be able to use the resources in your network of family, friends, your community, and the public mental health system which might be available to assist in achieving your desired outcomes. You will be able to choose, from available resources, the supports and services to be delivered, and help decide who will do what, when, and how.

- **Getting regular feedback on your treatment.**
  It is important for you to receive feedback on your progress. This should be done on a regular basis (weekly or monthly). Your case manager (supports coordinator) should review how services are being delivered, ask about your satisfaction with their delivery, and tell you about your progress toward your desired outcomes. The information you provide should be used to make any necessary changes in the supports and services you receive.

You should also have the opportunity to formally express your opinion about supports and services you receive so that improvements in service delivery can be made for everyone.

In addition, you always have the right to make formal complaints about how your supports and services were delivered or about any of the people who might have provided them. Contact your Rights Officer/Advisor if you would like to do this.

Questions You May Want to Ask About Person-Centered Planning

Who must attend the person-centered planning meeting?

You, and your supports coordinator (case manager).

Who also might be included?

You may want to invite family members, co-workers, friends, a teacher, coach, staff, and other people who know you well and with whom you feel comfortable sharing personal information. Your supports coordinator (case manager) may also suggest inviting a nurse, physical therapist, or direct care staff, who has information to help in planning and decision making.

What kinds of outcomes are discussed?

"Outcomes" may include:

Having positive relationships with family members,
Participating in community activities and events,
Doing what you find meaningful and productive with your day, (such as going to school, work, volunteering),
Living in a place alone or having assistance from people you choose.

Are there limits to person-centered planning?

Person-centered planning does not guarantee that the supports, services, and/or treatment nor the amount of them you might like to have can be provided by the public mental health system. What is actually provided by the public mental health system will depend upon the available resources (such as funding and staffing), rules and regulations that govern the program or funding system, and/or the judgment of the program administrator(s) as to feasibility, appropriateness, and safety of such support, service, or treatment.

Questions You May Want to Ask About Your Medication

If you are given medication by your doctor, you will need to take it according to their instructions. Listed below are some questions you may want to ask of the doctor or nurse so that you can have the information you need to make it as effective as possible.

- Why do I have to take this medicine?
- What will happen if I do not take it?
- Can I be treated without medication?
- Before I begin taking any medicine or even if I am not taking medicine, can I have a second opinion?
- What is the name of the medicine prescribed for me?

- How is it supposed to make me feel? What are the side effects of the medicine? Will it affect any other medical or physical problems I have?
- Are there side effects I should report immediately?
- Is it similar to or different from the medicine I was taking before this?
- How much should I take? How many times a day? What time of day? Before or after meals?
- What would happen if I took too much?
- Is it all right if I drink alcohol or beer when taking this medicine? Is there any food or drink I should avoid?
- Are there other medicines I should avoid when taking this medicine?
- Will this medicine affect my interest and/or my ability to participate in sex?
- How long will I need to take this medicine?
- If I take this medicine for a long time, what can it do to me?
- What is tardive dyskinesia (TD)? Can I get TD from taking this medicine? Can something be done to avoid this?

For women in childbearing years:

- Will this affect my menstrual periods?
- Should I take birth control pills while taking this medicine?
- If I get pregnant while taking this medicine, could it have any effect on my baby?
- Should I take it while nursing?
- Should I drive or operate machinery while taking this medicine?
- Is there anything else I should know about this medicine?
- How often will you review with me what the medicine is doing?
- How soon will I need to take this medicine?

Mediation (This section applies only to persons receiving services from a CMH)

Mental Health Code Section 206a

If you have a dispute related to your service planning or the services provided by a Community Mental Health Services Program (CMHSP) or a contracted service provider of a CMHSP, you have the right to mediation.

- You have the right to request mediation at any time.
- You or your individual representative must be notified of your right to request and access mediation at the time services or supports are initiated and at least annually after that.
- If you have requested a local dispute resolution, a local appeal, or a state Medicaid fair hearing, you also have the right to request mediation at the same time.
- Mediation is handled by a mediation agency, not the CMHSP.
- The CMHSP and its contracted service providers are required to participate in mediation.

Michigan Behavioral Health Mediation Services offers free, statewide mediation services for persons receiving services from a CMH or a pre-paid inpatient health plan (PIHP). Assistance with disputes can be obtained by calling 1-844-363-3428, by going online at MiBehavioralHealthMediationServices.com or by email behavioralhealth@mediation-omc.org.

SECTION III: YOUR RIGHTS WHEN YOU ARE BEING ADMITTED OR DISCHARGED FROM A PSYCHIATRIC HOSPITAL OR UNIT

Admission Process

If you are admitted to a psychiatric hospital or unit, **you have the right:**

- To make at least two phone calls.
- To have a physical and mental examination within 24 hours after you are admitted, and again at least once a year.

VOLUNTARY: *Mental Health Code Sections 410-420*

If you present yourself at a place for screening, the staff of that unit must complete their examination of you within two (2) hours unless there is a documented medical reason for the delay. If the screening unit denies your request for hospitalization, you may request a second opinion from the community mental health services program.

If you are admitted to a psychiatric hospital or unit on a **VOLUNTARY BASIS** (you admit yourself), or you are admitted by application of your guardian (if they have been granted that authority and with your agreement) you have the right:

- To have all of your rights verbally explained, including the right to object to treatment and to have a copy of your application for hospitalization.
- To give written notice of your intent to leave the hospital.
  After you put your request in writing, you must be discharged within 72 hours (excluding Sunday and holidays). However, if the hospital director determines you require treatment and petitions the court for your involuntary admission you must remain in the hospital until a determination is made about your treatment by the court.
- To be discharged when treatment is complete or when you no longer need the services.

INVOLUNTARY: *Mental Health Code Sections 423-450; 498*

If the police take you into protective custody and bring you to a place for screening or if you present yourself, the staff of that unit must complete their examination of you within two (2) hours unless there is a documented medical reason for the delay. If the screening unit denies the request, you may request *a second opinion from the community mental health services program.*

Once you are brought to the hospital, you have the following rights:

- To be asked if you wish to be admitted as a voluntary patient.
- To a copy of the petition saying you require treatment and to copies of reports by the doctors who examine you.
- To a written statement explaining that you will be examined by a psychiatrist within 24 hours after you are admitted and explaining all of your rights, including the right to:
  - A full court hearing.
  - Be represented by an attorney.

- Be present at the hearing.
- A jury trials.
- An independent clinical examination.

- To have staff, if you wish, notify your family of your admission to the hospital.
- To be examined by a psychiatrist who will determine whether you need to remain hospitalized. (Second certification).
- To refuse medication before your court hearing unless a physician decides you are in immediate risk of harming yourself or others. If you agree to medication or treatment before the court hearing, this does not mean that you are agreeing to the hospitalization.

Within 72 hours (this does not include Sundays and holidays) after a petition and clinical certification have been filed with the court, you have:

- The right to a deferral conference with the following:
  - your appointed legal counsel,
  - a treatment team member assigned by the hospital director,
  - a designated community mental health worker,
  - an individual of your choice.

This conference will be scheduled by the hospital. At this conference, the team (some members may participate remotely) will share the plan, including:

- The proposed plan of service in the hospital.
- The proposed plan of service in the community.
- The nature and possible consequences of the involuntary hospitalization process.
- The right to request that your court hearing be "deferred" (delayed) temporarily for 60 or 180 days. You will be treated as a voluntary patient during this time; however, you have the right to demand a hearing at any time during the "deferral" period.
- If you are brought back to the hospital during the deferral period, you *will not* be offered a voluntary application upon arrival at the hospital. A demand for hearing will be filed with the court.

COURT HEARINGS: *Mental Health Code Sections 452; 463*

If you are the subject of a petition, you have the following rights regarding court hearings:

- To have your court hearing promptly, but not more than seven days (this does not include Sundays or holidays) after the court receives the petition and two certifications.
- To be present at all court hearings. During this hearing, you have the right to be represented by an attorney. If you cannot afford an attorney, the court will appoint one for you. Your attorney must consult with you, in person, at least 24 hours before the time set for your court hearing. (You may choose to waive the right to attend your hearing by signing a waiver witnessed by your legal counsel and filed with the court.)
- To have the hearing held at the hospital whenever possible, rather than court *(Sec. 456)*
- To demand a jury trial.
- To present documents and witnesses and to cross examine witnesses.

- To obtain, at public expense, if necessary, an independent clinical evaluation by a physician, psychiatrist, or licensed psychologist of your choice. (You must request this before the first scheduled hearing or at the first scheduled hearing before the first witness`s has been sworn.)
- To a copy of the court order.

As a court-ordered recipient, **YOU DO NOT HAVE THE RIGHT TO REFUSE TREATMENT.** However, you do have the right to ask questions about your treatment, participate in the development of your plan of service, and discuss it with your doctor or other mental health professionals. If you think your treatment is not helping, you may ask for a review of your treatment plan.

PERIODIC REVIEW: *Mental Health Code Sections 482; 485a*

If you have a court order for continuing involuntary treatment, whether in a hospital or as an outpatient, you have the right to regular, adequate, and prompt reviews of your status. These reviews must be done six (6) months from the date of the court order and every six (6) months from there on. Results of these reviews must be provided to you within five days from the time they are made part of your record and you must be informed of your right to petition for discharge.

If you object to the conclusions of the periodic review, you have the right to a hearing. In addition to that hearing, you may petition the court for discharge from the program once within each 12-month period from the date of the original order. If, after any of these hearings, the court determines that you no longer require treatment, you will be discharged.

Rights of Minors

Mental Health Code Section 498m

If you are a minor, between 14 and 17, you have the right to ask for, and receive, outpatient mental health services (not including psychotropic medication or pregnancy termination referral services) without the consent or knowledge of your parent or guardian. These services are limited to 12 sessions or 4 months for each request.

If you are a minor between 14 and 17, you may write to the court within 30 days of your admission to object to your being hospitalized. You may do so again within 30 days from the time you receive a written review from the clinical staff regarding your need for continued hospitalization.

If you are a minor <u>of any age</u> and have been hospitalized for more than 7 days, you may inform a hospital staff person of your desire to object to your hospitalization. Staff are required to assist you in properly filing your objection to the hospitalization. If no one does this, then ask to see the Rights Advisor who will help get someone to assist you. If you are re-hospitalized for longer than 10 days under a combined hospitalization/alternative treatment order, you must

LIMITATIONS

The Mental Health Code guarantees that persons receiving services in a hospital or residential setting shall be assured that some basic rights will be protected. These rights may be limited due to the nature of your treatment. If limitations are imposed, you (or your legal representative) must agree to them as part of your plan of service. General restrictions (visiting hours, telephone usage, access to property) can be established for inpatient settings. Revised HCBS rules do not allow restrictions to be enforced in residential settings.

be notified of your right to file an objection to your hospitalization. If you do object, the court must schedule a hearing to determine whether you continue to require treatment.

SECTION IV: ACCESS RIGHTS

Mail

Mental Health Code Section 726

You have the right to receive and send mail without anyone else opening or reading it. If you have no income, and if you ask, you will be given writing materials and a reasonable number of stamps.

Telephone

Mental Health Code Section 726

You have the right to talk on the phone in private. If you have no income, a reasonable amount of funds will be provided so that you can use the telephone.

Visitors

Mental Health Code Section 715, 726, 748; Administrative Rule 7135

You have the right to see visitors of your choice. You can ask to see your own doctor (if you have one) or visit with your minister, priest, rabbi, or spiritual counselor at reasonable times. You have the right to talk with your attorney, a court, or others, about legal matters without any limitations and at any time.

Entertainment Materials, Information and News

Mental Health Code Section 704; Administrative Rule 7139

You have the right to watch television, have a newspaper provided, buy magazines, and books of your own choice, unless limited by your plan of service or as generally restricted by program rules.

Religion

Mental Health Code Section 704

You have the right to practice your religion or faith. You cannot be forced to go to a religious event if you do not want to, nor can you be required to listen to or watch religious programs on radio or TV.

Personal Property

Mental Health Code Section 728; Administrative Rule 7009

You have the right to:

- Wear your own clothes and keep your own things.

- Inspect your personal property at reasonable times.
- Have a receipt given to you, and to a person you designate, for your property held by the facility. Unless it is illegal, this property must be returned to you when you are discharged.
- Have a reasonable amount of space to store your personal belongings.
- Not have your belongings searched unless this is part of your plan of service or unless there is a good reason; to watch if your belongings are searched; and to have the reason for the search written in your record.

Your plan of service may further limit this right for the following reasons:

- To protect property, you may have brought with you from theft, loss, or destruction.
- To prevent you from physically hurting yourself or others.

You (and your legal representative) should be given the reason for the limitation and the date it expires.

Labor

Mental Health Code Section 736

You have the right to:

- Be paid for work you agree to do if you are offered work. However, you will not be paid for personal housekeeping chores (such as making your own bed) or work which is part of a small group living arrangement.
- Not have more than half of any money you earn used to pay for your treatment.

These rights may be limited:

- If the U.S. government says you need someone to handle money you receive from Social Security and has assigned you a representative payee, or
- If you have a conservator or guardian who has the authority to limit how you spend your money.

Freedom of Movement

Mental Health Code Sections 740, 742, 744

Freedom of movement is a right, not a privilege. This right cannot be limited or restricted more than is necessary to provide mental health services to you, to prevent you from injuring yourself or others, or to prevent substantial property damage. If you are admitted by order of a criminal court or are transferred from a jail or prison, appropriate security precautions may be taken. If there are limitations on your freedom of movement, the expected length and the reasons for them must be written into your record. The limitations must be removed when the reasons for them no longer exist.

If you are in a psychiatric hospital or licensed child caring institution, you may only be put in a locked room (seclusion) to keep you from physically hurting others. If you are a resident in an inpatient or residential setting, you may only be physically restrained if facility licensure rules allow in order to keep you from physically hurting yourself or others.

SECTION V: THE RECIPIENT RIGHTS COMPLAINT AND APPEAL PROCESS

Filing a Recipient Rights Complaint

Mental Health Code Section 776

If you believe that **any right listed in this booklet has been violated**, you, or someone on your behalf, should file a recipient rights complaint. You may do this by calling or visiting the Rights Office, or by completing a recipient rights complaint form and returning it to the Rights Office. Copies of the rights complaint form are available wherever you receive services, from your local rights office, or online at the Office of Recipient Rights website: www.michigan.gov/recipientrights; click on the link "Recipient Rights Complaint Form". The name and telephone number of the Rights Officer/Advisor for this agency can be found on the back of this booklet and on the ORR website. This information must also be clearly posted in the place you are receiving treatment.

If you need help writing your complaint your Rights Officer/Advisor can assist you; however, you may also contact one of the advocacy organizations listed in Section VI of this book for assistance. Staff at the place where you receive service may assist you.

Investigating Your Complaint

Mental Health Code Section 776

Within five (5) business days after receiving your complaint, the Rights Office will send you a letter indicating that your complaint was received and will also provide a copy of your complaint. This letter will also tell you what the Rights Office will do with your complaint.

If the Rights Office investigates your complaint, a decision will be made whether your rights have been violated and, recommendations will be given as to appropriate action the Agency/Hospital should take to correct the violation. This process should take no longer than 90 days after your complaint was received. You will get a written status report every 30 days until completion of the investigation. When the investigation is complete, the Rights Office will submit a Report of Investigative Findings to the Agency/Hospital Director. Within 10 business days after receiving this report, the Director must provide you with a written Summary Report.

The Summary Report will tell you about the investigation, let you know if the Rights Office determined your rights were violated, and tell you about any recommendations made by the Rights Office. If it is determined that there was a rights violation, this report will also tell you what action the Director has taken, or will take, to resolve your complaint. It will also provide you with information regarding the appeal process. If the action has not been completed when you receive the Summary Report, a follow-up letter will be provided indicating either the action was completed or that a different action was taken.

Appeal Rights

Mental Health Code Sections 784-786

Local Appeals Committee Review

Upon receipt of the Summary Report, you may file an appeal if:

- You are not satisfied with the **findings of the Rights Office**

- You disagree with the **action taken or proposed by the provider.**
- You think the Rights Office **did not start or finish** the investigation in a **timely** manner.

Your appeal must be in writing and received by the local appeals committee within 45 days from the time you receive the Summary Report. Information on how to file your appeal will be given to you in the Summary Report. If you want help writing your appeal, your Rights Officer/Advisor can assist you; you may also contact one of the advocacy organizations listed in Section VII of this book for assistance. Within five (5) business days after receiving your appeal, the appeals committee will review it to see if it meets the requirements, and will notify you, in writing, whether or not your appeal was accepted. The committee has 30 days to review the case file provided by the Rights Office and make a decision on your appeal. You will receive their written decision within 10 business days after their meeting.

Second Level Appeal - Findings

If your appeal was based upon your belief that the investigative findings of the Rights Office were not consistent with the facts or relevant laws, rules, policies, or guidelines, and you are not satisfied with the decision of the local appeals committee, you have 45 days to file a written appeal to the next level. This should be sent to: MDHHS -Level 2 Appeal, DHHS-Appeals, PO Box 30807, Lansing, MI 48909. Information on this process will be provided in the response from the local appeals committee. If you are not satisfied with the answer from the Level 2 Appeal, you may file an appeal with the Circuit Court in the county where you live (or with the Ingham County Circuit Court). You only have 21 days to do this and may need to hire an attorney to help you. Your appeal to the Circuit Court will be based on the entire record of your appeal which was put

SECTION VI: ADVISORY ORGANIZATIONS THAT CAN ASSIST YOU

together by the Second Level Appeal reviewer.

Second Level Appeal – Action Taken

There is no second level of appeal if your appeal to the local committee had to do with the action taken, or not taken, as a result of your complaint. In this case, if you are not satisfied with the decision of the local appeals committee, you may file a new complaint against the person who issued the Summary Report.

The following organizations are available to assist you in protecting your rights as a recipient of mental health services:

Michigan Disability Rights Coalition https://mymdrc.org/
3498 East Lake Lansing Road, Suite #100,
East Lansing, MI 48823
VOICE: 800-578-1269 or 517-333-2477 FAX: 517-333-2677 email: info@mymdrc.org

Disability Rights Michigan (formerly Michigan Protection & Advocacy Service) www.drmich.org
4095 Legacy Parkway
Lansing, MI 48911
VOICE: 800-288-5923 or 517-487-1755 FAX: 517-487-0827 TTY: 517-374-4687

Deaf C.A.N. (Deaf Community Advocacy Network) www.deafcan.org

2111 Orchard Lake Road, #101
Sylvan Lake, MI. 48320
VOICE: 248-332-3331 FAX: 248-332-7334 TTY: 248-332-3323

SECTION VII: INFORMATION FOR PERSONS RECEIVING TREATMENT UNDER THE FORENSIC PROVISIONS OF THE MENTAL HEALTH CODE.

Incompetent to Stand Trial (IST)

Mental Health Code Sections 1020 -1044

If you are admitted to a hospital on an IST (Incompetent to Stand Trial) Order you are under the jurisdiction of the criminal court, not the probate court system. The IST order means that the court has determined that, due to your mental condition, you are unable to understand the nature and object of the proceedings against you or of assisting in your defense in a rational manner. This order may be valid for up to 15 months during which time you will receive psychiatric treatment. Reevaluation of your competence will be done by your treating psychiatrist every 90 days and a report will be submitted to the criminal court.

Not Guilty by Reason of Insanity (NGRI)

Mental Health Code Section 1050

If you are found to be not guilty of a criminal charge due to reasons of insanity (Not Guilty by Reason of Insanity (NGRI), you will be sent to the Center for Forensic Psychiatry, for a period of not more than 60 days, so that you can be evaluated, and a determination made as to whether you are a person who requires mental health treatment. If the Center determines that you do require mental health treatment, the court may direct the prosecutor to file a petition for involuntary hospitalization. If this occurs, you will have a hearing in a probate court to determine if you will be involuntarily hospitalized (See Section III of this book). You will have to stay at the Forensic Center until the probate court hearing. If a petition for involuntary hospitalization is not filed, the prosecutor will notify the Center and you shall be discharged.

To deny people their rights is to challenge their very humanity.

Nelson Mandela

TO LEARN MORE ABOUT YOUR RIGHTS ASK YOUR RIGHTS ADVISOR:

Michigan Department Health and Human Services Office of Recipient Rights

235 South Grand Building
Suite 216
PO Box 30037
Lansing, MI. 48909

1-800-854-9090

MDHHS
Michigan Department of Health & Human Services
Office of Recipient Rights

Michigan Department Health and Human Services Office of Recipient Rights
South Grand Building
Lansing, MI. 48909
Authorized by: P.A. 258 of 1974, as amended

RECIPIENT RIGHTS COMPLAINT

COMPLAINT NUMBER

INSTRUCTIONS

If you believe that one of your rights has been violated, you (or someone on your behalf) may use this form to make a complaint. A rights officer/advisor will review the complaint and may investigate. Send this form to the rights office at the Community Mental Health (CMH) or hospital (LPH) where you are receiving (or received) services at:

Enter your agency address here…

If you send your complaint to Michigan Department of Health and Human Services, Office of Recipient Rights (MDHHS-ORR), it will be forwarded to the appropriate rights office. The MDHHS-ORR address is, Office of Recipient Rights, 235 South Grand, Suite 216, PO Box 30037, Lansing MI 48909.

Complainant's Name	Recipient's Name (if different from complainant)
Complainant's Address	Where did the alleged violation occur? (Address or Name of Hospital/Agency)
Complainant's Phone Number	When did the alleged violation happen?

What right was violated?

Describe what happened

What would you like to see happen in order to correct the violation?

Complainant's Signature	Date

Name of person assisting complainant

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

Authority: PA 258 of 1974 as amended.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral & Physical Health & Aging Services Administration

APPEAL AND GRIEVANCE RESOLUTION PROCESSES TECHNICAL REQUIREMENT

TABLE OF CONTENTS

I. PURPOSE AND BACKGROUND

This Technical Requirement is intended to facilitate the Prepaid Inpatient Health Plans (PIHPs) compliance with the Appeal and Grievance Resolution Process requirements contained in the Medicaid Managed Specialty Supports and Services Contract with the Michigan Department of Health and Human Services (MDHHS). The requirements can be found in Schedule A, Statement of Work; 1. General Requirements; Section L. Grievance and Appeals Process for Beneficiaries. These requirements are applicable to all the PIHPs, the Community Mental Health Services Programs (CMHSPs), and their provider networks.

Although this Technical Requirement specifically addresses the federal Grievance and Appeal System Processes required for Medicaid enrollees, other dispute resolution processes available to all mental health consumers are identified and referenced.

Under the Due Process Clause of the U.S. Constitution, Medicaid enrollees are entitled to "Due Process" whenever their Medicaid benefits are denied, reduced, or terminated. Due Process requires that enrollees receive:

1. Prior written notice of the adverse action.
2. A fair hearing before an impartial decision maker.
3. Continued benefits pending a final decision; and
4. A timely decision measured from the date the complaint is first made.

Nothing about managed care changes these Due Process requirements. The Medicaid enrollee Appeal and Grievance Resolution Process provides a process to help protect the Medicaid enrollee Due Process rights.

According to 42 CFR 438.408, each PIHP must resolve each grievance and appeal, and provide notice, as quickly as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in 42 CFR 438.408.

Consumers of mental health services, who are Medicaid enrollees eligible for specialty supports and services, have various avenues available to them to resolve disagreements or complaints. There are three (3) processes under the authority of the Social Security Act (SSA) and its federal regulations that articulate federal requirements regarding appeals and grievances for Medicaid beneficiaries who participate in managed care:

- State Fair Hearings through authority of 42 CFR 431.200 et seq.
- The PIHP appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid enrollees, as public mental health consumers, also have rights and dispute resolution protections under authority of the Michigan Mental Health Code (MMHC), Chapters 7,7A, 4, and 4A, including:

- Recipient Rights complaints through authority of the MMHC *MCL 330.1772 et seq.*
- Medical Second Opinion through authority of the MMHC *MCL 330.1705.*

This guide does not describe the recipient rights process.

II. DEFINITIONS

The following terms and definitions are utilized in this Technical Requirement.

Adverse Benefit Determination: A decision that adversely impacts the Medicaid enrollee's claim for services due to *42 CFR 438.400:*

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (*42 CFR 438.400(b)(1))*
- Reduction, suspension, or termination of a previously authorized service. (*42 CFR 438.400(b)(2))*
- Denial, in whole or in part, of payment for a service. (*42 CFR 438.400(b)(3))*
- Failure to make a standard Service Authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service. (*42 CFR 438.210(d)(1*))
- Failure to make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization. (*42 CFR 438.210(d)(2))*
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning (PCP) meeting and as authorized by the PIHP. (*42 CFR 438.400(b)(4); 42 CFR 438.20).*
- Failure of the PIHP to resolve standard appeals and provide notice within **30 calendar days** from the date the standard appeal request is received by the PIHP. (*42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2))*
- Failure of the PIHP to resolve expedited appeals and provide notice within **72 hours** from the date the expedited appeal request is received by the PIHP. (*42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3))*
- Failure of the PIHP to resolve grievances and provide notice within **90 calendar days** of the date the grievance is received by the PIHP. (*42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1)).*
- For a resident of a rural area with only one Managed Care Organization (MCO), the denial of the enrollee's request to exercise the enrollee's right under 438.52(b)(2)(ii), and to obtain services outside the network. (*42 CFR 438.400(b)(6))*
- Denial of the enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial responsibility. (*42 CFR 438.400(b)(7))*

Adequate Notice of Adverse Benefit Determination: Written statement advising the enrollee of a decision to deny or limit authorization of Medicaid services requested and the reasons why. The PIHP must mail the notice within timeframes identified in the Code of Federal Regulations (CFR) and written in an easily understood manner. (*42 CFR 438.404; 42 CFR 438.10)*

Advance Notice of Adverse Benefit Determination: Written statement advising the enrollee of a decision to reduce, suspend, or terminate Medicaid services currently provided, which notice must be provided to the Medicaid enrollee at least **10 calendar days prior** to the proposed date the Adverse Benefit Determination takes effect. (*42 CFR 438.404(c)(1); 42 CFR 431.211)*

Appeal: A review at the local level by the PIHP of an Adverse Benefit Determination. (*42 CFR 438.400(b)*).

Authorization of Services: The processing of requests for initial and continuing service delivery. (*42 CFR 438.210(b))*

Community Mental Health Services Program (CMHSP): A CMHSP is a program that contracts with the State to provide comprehensive behavioral health services in specific geographic service areas, regardless of an individual's ability to pay. (*Michigan Mental Health Code 330.1100a, 330.1206*)

Enrollee: A Medicaid beneficiary who is currently enrolled in a PIHP, Entity managed care program. *(42 CFR 438.2)*

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by the enrollee or the enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the enrollee requests the expedited review, the PIHP determines if the request is warranted. If the enrollee's provider makes the request, or supports the enrollee's request, the PIHP must grant the request. (*42 CFR 438.410(a); 42 CFR 438.210)*

Grievance: The enrollee's expression of dissatisfaction with the PIHP and/or the CMHSP about any matter other than an adverse benefit determination grievance may include, but are not limited to, any aspect of the operations, activities, or behavior of PIHP or its Provider Network, regardless of whether remedial action is requested. Specific examples include the quality of care or services provided, problems getting an appointment or having to wait a long time for an appointment, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's right to dispute an extension of time proposed by the PIHP to make a service authorization decision. (*42 CFR 438.400(b))*

Grievance Process: Impartial local level review of the enrollee's Grievance.

Grievance and Appeal System: The processes the PIHP implements to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them. (*42 CFR 438.400*)

Medicaid Services: Services provided to the enrollee under the authority of the Medicaid State Plan, 1115 Behavioral Health Demonstration Waiver, Healthy Michigan Plan, MIChild, 1915(i) Waiver, 1915(c) Waivers, and/or Section 1915(b)(3) of the Social Security Act (SSA).

Notice of Resolution: Written statement from the PIHP of the resolution of an Appeal or Grievance, which must be provided to the enrollee as described in *42 CFR 438.408*.

Prepaid Inpatient Health Plan (PIHP): A PIHP is an organization as defined in *42 CFR Part 438* and meets the requirements of *MCL 330.1204b*.

Provider: An individual or entity engaged in the delivery, ordering, or referring of services.

Recipient Rights Complaint: Written or verbal statement by the enrollee, or anyone acting on behalf of the enrollee, 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. *MHC 330.1776*

Service Authorization: The PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to *42 CFR 438.210.*

State Fair Hearing: Impartial state-level review of the Medicaid enrollee's appeal of an Adverse Benefit Determination presided over by a MDHHS Administrative Law Judge. Also referred to as an "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of *42 CFR Part 431 (431.200 – 431.246).*

Substantiated – The decision that there is sufficient evidence to support the enrollee's expression of dissatisfaction and merit for the grievance.

Unsubstantiated – The decision that there is not sufficient evidence to support the enrollee's expression of dissatisfaction and merit for the grievance.

III. GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS

Federal regulation *(42 CFR 438.228)* requires the State to ensure through its contracts with the PIHPs, that the PIHP has a Grievance and Appeal System in place for the enrollees that complies with *Subpart F of Part 438*.

The Grievance and Appeal System must provide enrollees:

- An Appeal process (one level only) enables enrollees the right to challenge Adverse Benefit Determinations made by the PIHP or its agents.
- A Grievance process.
- The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other services complaints.
- Access to the State Fair Hearing process to further appeal an Adverse Benefit Determination, after receiving notice that the Adverse Benefit Determination has been upheld by the PIHP level Appeal.
- Information that if the PIHP fails to adhere to notice and timing requirements as outlined in the PIHP Appeal process, the enrollee is deemed to have exhausted the PIHPs Appeal process. The enrollee may initiate a State Fair Hearing.

- The right to request and have Medicaid covered benefits continued while the PIHP Appeal and/or the State Fair Hearing is pending.
- With the written consent from the enrollee, the right to have a provider or other authorized representative acting on the enrollee's behalf file an Appeal or Grievance to the PIHP or request a State Fair Hearing. The provider may file a Grievance or request a State Fair Hearing on behalf of the enrollee since the State permits the provider to act as the enrollee's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the enrollee's behalf with the enrollee's written consent to do so.

IV. RECORDKEEPING REQUIREMENTS

The PIHP is required to maintain records of enrollee Appeals and Grievances, which will be reviewed by the PIHP as part of its ongoing monitoring procedures, as well as by State staff as part of the State's quality strategy. (*42 CFR 438.416(a))*

A PIHPs record of each Appeal and/or Grievance must contain, at a minimum *(42 CFR 438.16(b)):*

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, the review meeting.

D. The resolution at each level of the Appeal or Grievance, if applicable.

E. The date of the resolution at each level, if applicable.

F. Name of the covered enrollee for whom the Appeal or Grievance was filed.

PIHPs must maintain such records. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS. (*42 CFR 438.16(c))*

V. NOTICE OF ADVERSE BENEFIT DETERMINATION

The PIHP is required to provide timely and adequate notice of any Adverse Benefit Determination. (*42 CFR 438.404(a))*

A. Content and Format: The notice of Adverse Benefit Determination must meet the following requirements:

1. The enrollee 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 is readily accessible by such enrollees and potential enrollees" and meets the needs of those with limited English proficiency and/or limited reading proficiency).

2. 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.

3. Description of Adverse Benefit Determination the PIHP has been made or intends to make. (*42 CFR 438.404(b)(1))*

4. The reason(s) for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. *(42 CFR 438.404(b)(2))*

5. Notification of the enrollee's right to request an appeal of the PIHPs adverse benefit determination, including information on exhausting the PIHPs one level of appeal, and the right to request a State Fair Hearing thereafter. (*42 CFR 438.404(b)(3))*

6. Description of the circumstances under which an Appeal can be expedited, and how to request an expedited Appeal.

7. Notification of the enrollee's right to have benefits continue 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 enrollee may be required to pay the costs of the continued services (only required when providing "Advance Notice of Adverse Benefit Determination"). **(***42 CFR 438.404(b)(6))*

8. Description of the procedures that the enrollee is required to follow to exercise any of these rights. (*42 CFR 438.404(b)(4))*

9. An explanation that the enrollee may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman. (*45 CFR 155.505(e))*

B. Timing of Notice *(42 CFR 438.404(c))*:

1. Adequate Notice of Adverse Benefit Determination:

   a. For a denial of payment for services requested but not currently provided, notice must be provided to the enrollee at the time of the action affecting the claim. (*42 CFR 438.404(c)(2))*

   b. For a Service Authorization decision that denies or limits services, notice must be provided to the enrollee within **14 calendar 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) and (6))*

c. For Service Authorization Decisions not reached within **14 calendar days** for standard request, or **72 hours** for an expedited request, (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire. (*42 CFR 438.404(c)(5))*

NOTE: the PIHP may be 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 enrollee requests the extension, or if the PIHP can show that there is a need for additional information and the extension is in the enrollee's best interest (*42 CFR 438.210(d)(1)(ii)).* If the PIHP extends the time **NOT** at the request of the enrollee, the PIHP must: (i.) make reasonable efforts to give the enrollee prompt oral notice of the delay; (ii.) within **2 calendar days**, provide the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if he/she disagrees with that decision; and (iii.) issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (*42 CFR 438.404(c)*(4*); 42 CFR 438.408(c)(2); 438.410(c)(2))*

2. Advance Notice of Adverse Benefit Determination:

a. Required for reductions, suspensions, or terminations of previously authorized/currently provided Medicaid Services. Must be provided to the enrollee at least **10 calendar days** prior to the proposed effective date. (*42 CFR 438.404(c)(1); 42 CFR 431.211)*

b. Exceptions from advance notice:

The PIHP may mail an adequate notice of action not later than the date of action to terminate, suspend, or reduce previously authorized services, **IF:**

i. The PIHP has verified information confirming the death of the enrollee. *(42 CFR 431.213(a))*

ii. The PIHP receives a clear and written statement signed by the enrollee that he/she no longer wishes services per 42 CFR 431.213(b)(1); or that gives information that requires termination or reduction of services, and indicates the enrollee understands this must be the result of supplying that information. *(42 CFR 431.213(b)(2))*

iii. The enrollee has been admitted to an institution where he/she is ineligible under the plan for further services. (*42 CFR 431.213(c))*

iv. The enrollee's whereabouts are unknown, and the post office returns agency mail directed to the enrollee indicating no forwarding address. *(42 CFR 431.213(d))*

v. The PIHP establishes that the enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth. *(42 CFR 431.213(e))*

vi. A change in the level of medical care is prescribed by the enrollee's physician. *(42 CFR 431.213(f))*

vii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the SSA. *(42 CFR 431.213(g))*

viii. The date of action will occur in less than **10 calendar days**. *(42 CFR 431.213(h))*

ix. The PIHP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the enrollee (in this case, the PIHP may shorten the period of advance notice to **5 calendar days** before the date of action). (*42 CFR 431.214*)

C. Required Recipients of Notice of Adverse Benefit Determination:

1. The enrollee must be provided written notice. (*42 CFR 438.404(a); 42 CFR 438.210(c))*

2. The requesting provider must be provided notice of any decision by the PIHP to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested. Notice to the provider does NOT need to be in writing. (*42 CFR 438.210(c))*

3. 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 PCP process still constitutes an adverse benefit determination and requires a written notice of action. *(42 CFR 438.210(e))*

VI. MEDICAID BENEFITS AND SERVICES CONTINUATION OR REINSTATEMENT

A. Continuation of benefits:

The PIHP must continue the enrollee's benefits if all the following occur (*42 CFR 438.420(b)*):

1. The enrollee files the request for an appeal timely within **60 calendar days** from the date on the Adverse Benefit Determination Notice. (*42 CFR 438.420(b)(1); 42 CFR 438.402(c)(ii))*

2. The enrollee files for continuation of benefits timely (on or before the latter of within ten (10) calendar days of the PIHP sending the notice of Adverse Benefit Determination; or the intended effective date of the proposed Adverse Benefit Determination. (*42 CFR 438.420(b)(5); 42 CFR 438.420(a) "Timely files*");

3. The Appeal involves the termination, suspension, or reduction of previously authorized services (*42 CFR 438.420(b)(2));*

4. The services were ordered by an authorized provider (*42 CFR 438.420(b)(3)*);

5. The period covered by the original authorization request has not expired (*42 CFR 438.420(b)(4)**);*** and

B. Duration of Continued or Reinstated Benefits *(42 CFR 438.420(c)*):

If the PIHP continues or reinstates the enrollee's benefits, at the enrollee's request, while the Appeal or State Fair Hearing is pending, the PIHP must continue the benefits until one of following occurs:

1. The enrollee withdraws the Appeal or request for State Fair Hearing. *(42 CFR 438.420(c)(1))*

2. The enrollee fails to request a State Fair Hearing and continuation of benefits within **10 calendar days** after the PIHP sends the enrollee notice of an adverse resolution to the enrollee's Appeal under 42 CFR 438. 408(d)(2). (*42 CFR 438.420(c)(2))*

3. The State Fair Hearing office issues a decision adverse to the enrollee. *(42 CFR 438.420(c)(3))*

C. Enrollee responsibility for services furnished while the appeal or state fair hearing is pending:

If the final resolution of the Appeal or State Fair Hearing upholds the PIHPs Adverse Benefit Determination, the PIHP may, consistent with the State's usual policy on recoveries under *42 CFR 431.230(b),* and as specified in the PIHP contract, recover the cost of services furnished to the enrollee 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))*

D. Reinstating services:

If the enrollee's services were reduced, terminated, or suspended without an advance notice, the PIHP must reinstate services to the level before the action. *(42 CFR 431.231(c))*

E. Services furnished while the appeal is pending:

If the PIHP or the State Fair Hearing Administrative Law Judge reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations. (*42 CFR 438.424(b))*

F. Services not furnished while the appeal is pending:

If the PIHP 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, the PIHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. (*42 CFR 438.424(a))*

VII. PIHP APPEAL PROCESS

A. Upon receipt of an adverse benefit determination notification, federal regulations 42 CFR 400 et seq. provides the enrollee the right to Appeal the determination through an internal review by the PIHP. Each PIHP may only have one level of appeal. The enrollee may request an internal review by the PIHP, which is the first of two Appeal levels, under the following conditions:

1. The enrollee 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))*

2. The Appeal can be requested orally or in writing. (*42 CFR 438.402(c)(3)(ii))*

   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))*

3. In the circumstances described above under the Section entitled "Continuation of Benefits," the PIHP 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. (*42 CFR 438.420(c))*

B. PIHP Responsibilities when the Enrollee Requests Appeals:

1. The PIHP must provide the enrollee any reasonable assistance to complete forms and 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))*

2. The PIHP must acknowledge receipt of an expedited Appeal within 72 hours of receipt. The PIHP must acknowledge receipt of each standard Appeal within five (5) business days. (*42 CFR 438.406(b)(1); 42 CFR 438.408(b)(3))*

3. The PIHP must maintain a record of appeals for review by the State as part of its quality strategy. *(42 CFR 438.416(a))*

4. The PIHP must ensure that the individual(s) who make the decisions on appeals are individuals:

a. Who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual (*42 CFR 438.406(b)(2)(i)*);

b. Who when deciding an Appeal that involves either involves clinical issues, or 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 enrollee's condition or disease *(42 CFR 438.406(b)(2)(ii))*; and

c. Consider all comments, documents, records, and other information submitted by the enrollee and/or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination. *(42 CFR 438.406(b)(2)(iii))*

5. The PIHP must provide the enrollee a reasonable opportunity to present evidence, testimony, and allegations of fact or law, in person and in writing. The PIHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals. (*42 CFR 438.406(b)(4))*

6. The PIHP must provide the enrollee and the enrollee's representative the enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP, 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))*

7. The PIHP must provide opportunity to include as parties to the Appeal the enrollee and the enrollee's representative or the legal representative of a deceased enrollee's estate. (*42 CFR 438.406(b)(6*))

8. The PIHP must provide the enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one. The enrollee can request a State Fair Hearing only after receiving notice that the PIHP is upholding the Adverse Benefit Determination (*42 CFR 438.408(f)(1)).* In the case of a PIHP that fails to adhere to the notice and timing requirements of **30 days,** the enrollee is deemed to have exhausted the PIHP's appeals process. The enrollee may initiate a State fair hearing *(42 CFR 438.408(c)(3)).*

C. Appeal Resolution Timing and Notice Requirements:

1. Standard Appeal Resolution (timing):

The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the enrollee's health condition requires, but not to exceed **30 calendar days** from the day the PIHP receives the Appeal. (*42 CFR 438.408(b)(2)*

2. Expedited Appeal Resolution (timing):

a. Each PIHP must establish and maintain an expedited review process for appeals when the PIHP determines (for a request from the enrollee) or the provider indicates (in making a request on the enrollee's behalf or supporting the enrollee's request) that the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (*42 CFR 438.410(a))*

b. The PIHP may not take punitive action against a provider who requests an expedited resolution or supports the enrollee's Appeal. (*42 CFR 438.410(b))*

c. If a request for expedited resolution of an appeal is denied, the PIHP must:

   i. Transfer the Appeal to the timeframe for standard resolution. (*42 CFR 438.410(c)(1))*

   ii. Make reasonable efforts to give the enrollee prompt oral notice of the denial if the PIHP extends the timeframes not at the request of the enrollee. (*42 CFR 438.408, 438.410(c)(2))*

   iii. Within **two (2) calendar days**, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if they disagree with the decision. (*42 CFR 438.408(c)(2); 438.410(c)(2))*

   iv. Resolve the Appeal as expeditiously as the enrollee's health condition requires, but not to exceed **30 calendar days**. (*42 CFR 438.408(c)(2)(iii))*

d. If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than **72 hours** after the PIHP receives the request for expedited resolution of the Appeal. *(42 CFR 438.408(b)(3))*

3. Extension of Timeframes:

The PIHP may extend the resolution and notice timeframe by up to **14 calendar days** if the enrollee requests an extension; or if the PIHP shows (to the satisfaction of the State, upon its request) that there is a need for additional information, and how the delay is in the enrollee's interest. (*42 CFR 438.408(c)(1))*

a. If the PIHP extends resolution/notice timeframes not at the request of the enrollee, it must complete **all** the following (*42 CFR 438.408(c)(2)):*

   i. Make reasonable efforts to give the enrollee prompt oral notice of the delay. *(42 CFR 438.408(c)(2)(i))*

   ii. Within **2 calendar days**, give the enrollee written notice of the reason for the decision to extend the timeframe, and inform the enrollee of the right to file a Grievance if they disagree with the decision. (*42 CFR 438.408(c)(2)(ii))*

iii. Resolve the Appeal as expeditiously as the enrollee's health condition requires, and not later than the date the extension expires. *(42 CFR 438.408(c)(2)(iii))*

4. Appeal Resolution Notice Format:

The PIHP must provide enrollees 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))*

a. Attached to this agreement are required notice templates for Appeals and Grievances. They are titled, "Exhibit A - Notice of Adverse Benefit Determination", "Exhibit B - Notice of Receipt of Grievance", "Exhibit C - Notice of Grievance Resolution, "Exhibit D – Notice of Receipt of Appeal", "Exhibit E, Notice of Appeal Approval," and "Exhibit F – Notice of Appeal Denial.". These templates incorporate the information needed to meet the requirement of Appeals and Grievances recordkeeping in *42 CFR 438.416*, and section IV. Recordkeeping Requirements of this technical requirement.

b. The enrollee notices must meet the requirements of *42 CFR 438.10(c)(1) that states "each PIHP entity must provide all required information* in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," and meets the needs of those with limited English proficiency and/or limited reading proficiency.

5. Appeal Resolution Notice Content:

a. The notice of resolution must include the results of the resolution process and the date it was completed. (*42 CFR 438.408(e)(1))*

b. When the Appeal is not resolved wholly in favor of the enrollee, the notice of disposition must also include:

i. The enrollee's right to request a State Fair Hearing, and how to do so. *(42 CFR 438.408(e)(2)(i))*

ii. The enrollee's right to request to receive benefits while the State Fair Hearing is pending, and how to make the request *(42 CFR 438.408(e)(2)(ii))*; and

iii. That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the PIHP's adverse benefit determination. (*42 CFR 438.408(e)(2)(iii))*

VIII. GRIEVANCE PROCESS

A. Federal regulations provide the enrollee the means of expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of

interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the PIHP to make an authorization decision. (*42 CFR 438.400(b) "Grievance")*

B. Generally:

1. The enrollee must file a Grievance with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances.

2. A Grievance may be filed at any time by the enrollee, guardian, or parent of a minor child, or the enrollee's authorized representative. *(42 CFR 438.402(c)(1)(ii); 42 CFR 438.402(c)(2)(i))*

C. PIHP Responsibility when Enrollee Files a Grievance:

1. The PIHP must provide the enrollee any reasonable assistance to complete forms and 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))*

2. Acknowledge receipt of the Grievance **within five (5) business days**. (*42 CFR 438.406(b)(1))*

3. Maintain a record of Grievances for review by the State as part of its quality strategy. (42 CFR 438.416(a))

4. Ensure that the individual(s) who make the decisions on the Grievance are individuals:

   a. Who were neither involved in any previous level review or decision-making, nor a subordinate of any such individual. (*42 CFR 438.406(b)(2)(i))*

   b. Who are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease; for a grievance regarding denial of expedited resolution of an appeal and/or a grievance that involves clinical issues. (42 CFR 438.406(b)(2)(ii))

   c. Who consider all comments, documents, records, and other information submitted by the enrollee and/or the enrollee's representative without regard to whether such information was submitted or considered previously. (42 CFR 438.406(b)(2)(iii))

D. Grievance Resolution Timing and Notice Requirements

1. Timing of Grievance Resolution:

   Provide the enrollee a written notice of resolution not to exceed **90 calendar days** from the day the PIHP received the Grievance. (42 CFR 438.408(b)(1))

2. Extension of Timeframes:

   The PIHP may extend the Grievance resolution and notice timeframe by up to **14 calendar days** if the enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the enrollee's interest. (*42 CFR 438.408(c))*

   a. If the PIHP extends resolution/notice timeframes not at the request of the enrollee, it must complete **all** the following:

      i. Make reasonable efforts to give the enrollee prompt oral notice of the delay. (*42 CFR 438.408(c)(2)(i))*

      ii. Within **2 calendar days**, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if they disagree with the decision. (*42 CFR 438.408(c)(2)(ii))*

3. Format and Content of Notice of Grievance Resolution:

   a. The enrollee notices must meet the requirements of *42 CFR 438.10(c)(1)* that states *"each PIHP entity must provide all required information in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees,"* and meets the needs of those with limited English proficiency and/or limited reading proficiency.

   b. The notice of Grievance resolution must include:

      i. The results of the Grievance process.

      ii. The date the Grievance process was concluded.

IX. STATE FAIR HEARING PROCESS

A. Federal regulations provide the enrollee the right to an impartial review by a State-level Administrative Law Judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances:

1. After receiving notice that the PIHP is upholding an Adverse Benefit Determination after Appeal. *(42 CFR 438.408(f)(1));*

2. When the PIHP fails to adhere to the notice and timing requirements for resolution of appeals as described in *42 CFR 438.408(f)(1)(i).*

B. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if the following conditions are met:
   1. The review must be at the enrollee's option and must not be required before or used as a deterrent to proceed to the State Fair Hearing. (*42 CFR 438.408(f)(1)(ii)(A)*)
   2. The review must be independent of both the State and the PIHP. (*42 CFR 438.408(f)(1)(ii)(B)*)
   3. The review must be offered without any cost to the enrollee. (*42 CFR 438.408(f)(1)(ii)(C)*)
   4. The review must not extend any of the timeframes specified above and must not disrupt the continuation of benefits. (*42 CFR 438.408(f)(1)(ii)(D)*)

C. The PIHP may not limit or interfere with the enrollee's freedom to make a request for a State Fair Hearing.

D. The enrollee is 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)*)

E. The PIHP is required to continue benefits if the conditions described in *Section VII - Medicaid Services Continuation or Reinstatement* are satisfied and for the duration described therein.

F. If the enrollee's services were reduced, terminated, or suspended without advance notice, the PIHP must reinstate services to the level before the Adverse Benefit Determination. (*42 CFR 431.231(c)*)

G. The parties to the State Fair Hearing include the enrollee and the enrollee's representative, or the representative of a deceased enrollee's estate, and the PIHP. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities. (*42 CFR 438.408(f)(3)*)

H. Expedited hearings are available.

Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Office of Administrative Hearings and Rules 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

Exhibit A

LETTER OF ADVERSE BENEFIT DETERMINATION

Adverse Benefit Determination is a decision made by a health plan that:

- denies a request for a service(s);
- denies payment;
- reduces or stops a benefit; or
- does not provide services in time.

Appeal is a request you can make to ask that a decision that you do not agree with is looked at again.

Important: This letter explains your Appeal rights. Read this letter carefully. If you need help with this letter or disagree with the decision that was made, you can call one of the numbers listed on the last page under "Get help and more information."

Mailing Date: **Member ID:**

Name: **Beneficiary ID:**

This is to tell you about our decision:

This decision is based on the following:

There is a law [42 CFR §440.230(d)] that allows us to place appropriate limits on service requests based on the reason for the medical need.

You can share a copy of this letter with your provider so you and your provider can discuss next steps. If your provider asked for these services to be provided to you, we have sent a copy of this letter to your provider.

If you do not agree with our decision, you have the right to an Appeal.
You must ask the [CMHSP/PIHP] for an Appeal within **60 days** of the date of this letter. You can name a relative, friend, attorney, provider, or another person to speak for you with your permission. If you already have a person approved to make legal health care decisions for you, you do not have to do anything else. The Appeal can be requested either verbally or in writing.

There are two (2) types of Appeals:

Standard Appeal:

You will be provided with a written decision on a Standard Appeal within **30 days** after your Appeal is received. Our decision might take longer than 30 days if you ask for more time, or if we need more information about your case. We will tell you if we are taking extra time and we will explain why more time is needed.

Fast Appeal:

You will be provided with a decision on a Fast Appeal within **72 hours** after your Appeal is received. You or your provider can ask for a Fast Appeal if you or your provider believe your health could be seriously harmed by waiting up to 30 days for a decision. [CMHSP/PIHP] will decide if your request is considered a Fast Appeal. If you are not provided a Fast Appeal, you will be called as soon as possible to tell you and then you will be given a decision within **30 days**. To ask for a Fast Appeal, you must call: **[telephone number] [TTY telephone number]** right away.

Next steps if you want to file an appeal:

When asking for an Appeal, you must tell us the following:

- Your Name.
- Your Address.
- Your Member Number.
- Your Reason for the Appeal.
- Whether you want a Standard or Fast Appeal.
- If you want someone to speak for you. Both you and the person you want to speak for you must sign and date a letter saying this is what you want.
- Any proof you want us to review, such as medical records, letters from your providers, or other information that explains why you need the item or service. [Note: There is a limited time available if you are asking for a Fast Appeal.]
- If your services were stopped or reduced, if you want your services to continue.

If you would like to continue the services that you are currently receiving, you must follow the below:

If you ask for an Appeal within **10 days** of this letter, in some cases, you may continue to receive your services while your Appeal is being looked at. Your request to continue services can be sent at the same time with your Appeal request.

If your services are continued during your Appeal, you can keep getting the service(s) until one of the following happens: 1) you cancel the Appeal; or 2) all individuals that receive and review your Appeal decide to say “no” to your request; or 3) the original approval request for your services has ended. You may be asked to pay for some of the services you received during the Appeal process if the Appeal is not approved. This is not always the case, but if you do need to pay, you will be notified of the amount.

Access to Documents:

You and/or your approved individual are allowed access to and a free copy of all documents that relate to your appeal any time before or during the appeal. You can ask for these documents either by requesting in writing or by calling Customer Services at the number below or if you have any questions or concerns about this decision.

What happens next:

- If you ask for an Appeal, [CMHSP/PIHP] will review information about the Appeal request and send you a letter with the decision. If [CMHSP/PIHP] does not support your Appeal, the letter will explain why [CMHSP/PIHP] did not approve your request.

- You can ask for a Medicaid State Fair Hearing. The State Fair Hearing process can only be used after [CMHSP/PIHP] does not approve your Appeal. The letter that will be sent to you will give you more information about the State Fair Hearings process and how to file the request.

- If [CMHSP/PIHP] approves your Appeal, you will receive a letter that explains the steps you and [CMHSP/PIHP] will follow to approve the services that are now allowed.

- If you do not receive a letter or decision about your Appeal within **30 days** of the Standard Appeal **or 72 hours** of your Fast Appeal, your appeal is considered finished, and you may file a State Fair Hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR). Please call us to get this information.

Get help and more information:

- If you need help or more information about our decision and the Appeals process, call Customer Services at: {telephone number}; TTY: [TTY telephone number] {hours of operation}. You can also visit our website at [PIHP/CMHSP website].

- MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet-based phone service).

There is a law that does not allow [CMHSP/PIHP] to judge or exclude a person based on race, color, where they are from, gender, age, or different ability.

[CMHSP/PIHP] provides help to people with different abilities so they are able to communicate with us, such as:

- Qualified sign language interpreters for those who are deaf or hard of hearing.
- Written information in other formats (such as large print, audio, and braille).
- Free language services to people whose main language is not English, such as:
    - Someone who speaks your language.
    - Information written in another language.

If you need these services, you can call Customer Service at one of the numbers listed above under “Get help and more information.”

Exhibit B

YOUR LETTER OF GRIEVANCE WAS RECEIVED

Important: Read this letter carefully. If you need help, you can call one of the numbers listed under "Get help and more information."

Mailing Date: **Member ID:**

Name: **Beneficiary ID:**

YOU FILED A GRIEVANCE

Your Grievance was received on [date received], about [subject of grievance]. What you say happened to you matters to us. Thank you for letting us know.

WHAT THIS MEANS

Your Grievance will be looked at, and a letter will be mailed to you within 90 days once the review is completed; telling you what was found and what (if any) steps will be taken or have been taken.

We may contact you for more information or if we have questions. If you have any questions or more information to provide to us, please call {telephone number}.

If you want someone else to speak for you:

At any time during the Grievance process, you can name a relative, friend, attorney, provider, or another person to speak for you. If you want someone to speak for you, you must tell us that in writing. Both you and the person you want to speak for you must sign and date a letter saying this is what you want.

If you already have someone that is approved to make legal health care decisions for you, you do not have to do anything else.

Get help and more information:

- If you need help or more information call Customer Services at: {telephone number}; TTY: [TTY telephone number] {hours of operation}. You can also visit our website at [PIHP/CMHSP website].
- MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet-based phone service).

There is a law that does not allow [CMHSP/PIHP] to judge or exclude a person based on race, color, where they are from, gender, age, or different ability.

[CMHSP/PIHP] provides help to people with different abilities, so they are able to communicate with us, such as:

- Qualified sign language interpreters for those who are deaf or hard of hearing.
- Written information in other formats (such as large print, audio, and braille).
- Free language services to people whose main language is not English, such as:
    - Someone who speaks your language.
    - Information written in another language.

If you need these services, you can call Customer Services at one of the numbers listed above under “Get Help and More Information.”

Exhibit C

LETTER OF GRIEVANCE DECISION

Important: Read this letter carefully.

Mailing Date: **Member ID:**

Name: **Beneficiary ID:**

You Filed a Grievance

Your grievance was about [enter reason]. Thank you again for taking the time to bring this to our attention.

We have reviewed your grievance, which was [enter # of days] from when your grievance was received.

Based on our review, the following action has occurred: [enter decision]

This matter is considered closed at this time.

Get help and more information:

- If you need help or more information about our action and the Grievance process, call Customer Services at: {telephone number}; TTY: [TTY telephone number] {hours of operation}. You can also visit our website at [PIHP/CMHSP website].
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet-based phone service).

There is a law that does not allow [CMHSP/PIHP] to judge or exclude a person based on race, color, where they are from, gender, age, or different ability.

[CMHSP/PIHP] provides help to people with different abilities, so they are able to communicate with us, such as:

- Qualified sign language interpreters for those who are deaf or hard of hearing.
- Written information in other formats (such as large print, audio, and braille).
- Free language services to people whose main language is not English, such as:
    - Someone who speaks your language.
    - Information written in another language.

If you need these services, you can call Customer Services at one of the numbers listed above under “Get help and more information.”

Exhibit D

YOUR LETTER OF APPEAL WAS RECEIVED

Important: Read this letter carefully. If you need help, you can call one of the numbers listed below.

Mailing Date: **Member ID:**

Name: **Beneficiary ID:**

You Filed an Appeal

Your Appeal was received on [date received], about [subject].

WHAT THIS MEANS

Your Appeal will be looked at, and a letter will be mailed to you by [**30 calendar days, or within 72 hours if a fast appeal has been approved**] telling you what our decision is and why we made that decision.

We may contact you for more information or if we have questions. If you have any questions or more information to provide to us, please call: {telephone number}; TTY: [TTY telephone number] {hours of operation}. You can also visit our website at [PIHP/CMHSP website].

If you want someone else to speak for you:

At any time during the Appeal process, you can name a relative, friend, attorney, provider, or another person to speak for you. If you want someone to speak for you, you must tell us that in writing. Both you and the person you want to speak for you must sign and date a letter saying this is what you want.

If you already have someone that is approved to make legal health care decisions for you, you do not have to do anything else.

Access to Documents

You and/or your approved individual are allowed access to and a free copy of all documents that relate to your current appeal. [PIHP/CMHSP] will provide you with this information.

There is a law that does not allow [PIHP/CMHSP] to judge or exclude a person based on race, color, where they are from, gender, age, or different ability.

[PIHP/CMHSP] provides help to people with different abilities so they are able to communicate with us, such as:

- Qualified sign language interpreters for those who are deaf or hard of hearing.
- Written information in other formats (such as large print, audio, and braille).
- Free language services to people whose main language is not English, such as:
  - Someone who speaks your language.
  - Information written in another language.

If you need these services, you can call Customer Services at {telephone number} [TTY telephone number].

Exhibit E

LETTER OF APPEAL APPROVAL

Important: This letter explains the results of your Appeal. Read this letter carefully. If you need help, you can call one of the numbers listed below under "Get help and more information."

Mailing Date: **Member ID:**

Name: **Beneficiary ID:**

This Letter is in response to the Appeal request that was received on [date appeal received].

Your appeal was approved.
Your appeal was fully considered. This is to let you know that we approved your appeal for the service(s)/item(s) listed below:

What this means:
Because your Appeal was approved, you may receive the following service(s) as of:

If you do not receive the services, or if the services are mistakenly stopped or reduced, contact us **immediately** using the following information:

[CMHSP/PIHP Name]
[Name of Appeals/Grievance Department]
[Mailing Address for Appeals/Grievance Department]

Phone: [Telephone Number] TTY: [TTY Telephone Number]
Fax: [Fax Number]

Get help and more information:

- If you need help or additional information about the decision, call Customer Services at: {telephone number}; TTY: [TTY telephone number] {hours of operation}. You can also visit our website at [PIHP/CMHSP website].

- MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet-based phone service).

There is a law that does not allow [PIHP/CMHSP] to judge or exclude a person based on race, color, where they are from, gender, age, or different ability.

[CMHSP/PIHP/Name] provides help to people with different abilities so they are able to communicate with us, such as:

- Qualified sign language interpreters for those who are deaf or hard of hearing.
- Written information in other formats (such as large print, audio, and braille).
- Free language services to people whose main language is not English, such as:
    - Someone who speaks your language.
    - Information written in another language.

If you need these services, you can call Customer Services at one of the numbers listed above under “Get Help and More Information.”

Exhibit F

LETTER OF APPEAL DENIAL

Important: This letter explains the reason for the decision of your Appeal and your other Appeal rights. Read this letter carefully. If you need help, you can call one of the numbers listed under "Get help and more information."

Mailing Date: **Member ID:**

Name: **Beneficiary ID:**

This Letter is in response to the Appeal request that we received on [date received]

Your Appeal was not approved:
Your Appeal was fully considered. This is to let you know that we did not approve your Appeal for the service(s)/item(s) listed below:

Why did we not approve [or partially approve] your appeal?
Your Appeal was not approved for the service(s)/item(s) listed above because:

You can share a copy of this letter with your provider so you and your provider can discuss next steps. If your provider asked for these services to be provided to you, we have sent a copy of this letter to your provider.

If you have any questions or concerns about this decision, please call Customer Services at the contact information provided below.

If you do not agree with the decision, you have the right to additional appeal options.

You have the right to ask for a State Fair Hearing (a different appeal). The State Fair Hearing is reviewed by another organization that is not a part of [enter PIHP/CMHSP]. You can file a State Fair Hearing yourself or Customer Service is available to help you complete the paperwork to file. Below is the information on how to request a State Fair Hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR).

How to ask for a State Fair Hearing with MOAHR:

To ask for a State Fair Hearing, you must follow the directions on the paper in this envelope that says "**Request for State Fair Hearing"** form. You must ask for a State Fair Hearing within **120 days** from the date listed on this letter for a hearing to be granted. If you need another copy of the form, you can ask for one by calling [CMHSP/PIHP Name] Customer Services at {[telephone number}, TTY: [TTY telephone number] or the MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet-based phone service).

What happens next:

- The MOAHR will schedule a State Fair Hearing. You will get a written "Letter of Hearing" telling you the date and time the hearing is scheduled.
- Most hearings are held by telephone; however, you can ask to have a hearing in person if you make this request. During the hearing, you will be asked to tell a Judge why you disagree with your Appeal not being approved (or partially approved).
- You can ask a friend, relative, provider, or lawyer to help you. You must include this person on the State Fair Hearing request form. You have the right to send information to the judge to review as part of the hearing process.
- After the hearing, you will get a written "Decision and Order" letter within **90 days** from when you asked for the hearing. This letter will include the decision by the Judge and, if not decided in your favor, explain any Appeal rights.

If the timeframe for review would seriously harm your life or health, you may be able to get a fast State Fair Hearing. Your request must be in writing, and you must say that you are asking for a fast State Fair Hearing. Your request can be mailed or faxed to MOAHR (see the enclosed Request for Hearing form for the address and fax number). If you qualify for a fast State Fair Hearing, MOAHR must give you an answer within **72 hours**. However, if MOAHR needs to gather more information that may help you, MOAHR can increase the time by up to **14 days**.

If you have any questions about the State Fair Hearing process, including the fast State Fair Hearing process, you can call MOAHR at 1-877-833-0870.

Ongoing Benefits:

If coverage for a service was previously approved but then the service was changed or stopped before the approval ended, you can continue your benefits during this the State Fair Hearing in some cases.

Your service(s) can continue if you qualified for ongoing benefits during your Appeal with [PIHP/CMHSP] and you ask for a State Fair Hearing from MOAHR within **10 days** from the date of this letter. MOAHR must receive your State Fair Hearing by [insert 10 calendar day date from this letter]. You should let [CMHSP/PIHP Name] know you have requested a State Fair Hearing within 10 days, and you are asking for your service(s) to continue.

If your benefits are continued during your State Fair Hearing, you can keep getting the service(s) until one of the following happens: 1) you cancel the State Fair Hearing; or 2) the State Fair Hearing is held, and the Judge says “no” to your State Fair Hearing request, or 3) the original approval request for your services has expired.

You may be asked to pay for some of the services you received during the Appeal and/or the State Hearing process if the State Hearing outcome is not approved. This is not always the case, but if you do need to pay, you will be told the amount.

Access to Documents

You and/or your approved individual are allowed access to and a free copy of all documents relevant to the State Fair Hearing any time before or during the State Fair Hearing process. You can make a request in writing or by contacting Customer Services at the number below.

Get help and more information:

- If you need help or additional information about our decision, call Customer Services at: {telephone number} TTY: [TTY telephone number], [hours of operation]. You can also visit our website at [Health Plan Website URL].

- MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet-based phone service).

There is a law that does not allow [CMHSP/PIHP] to judge or exclude a person based on race, color, where they are from, gender, age, or different ability.

[CMHSP/PIHP] provides help to people with different abilities so they are able to communicate with us, such as:

- Qualified sign language interpreters for those who are deaf or hard of hearing.
- Written information in other formats (such as large print, audio, and braille).
- Free language services to people whose main language is not English, such as:
  - Someone who speaks your language.
  - Information written in another language.

If you need these services, you can call Customer Services at one of the numbers listed above under “Get Help and More Information.”

MENTAL HEALTH CODE (EXCERPT)
Act 258 of 1974

CHAPTER 7

RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES

330.1700 Definitions.

Sec. 700. As used in this chapter, unless the context requires otherwise:

(a) "Criminal abuse" means 1 or more of the following:

(*i*) An assault that is a violation or an attempt or conspiracy to commit a violation of sections 81 to 90 of the Michigan penal code, Act No. 328 of the Public Acts of 1931, being sections 750.81 to 750.90 of the Michigan Compiled Laws. Criminal abuse does not include an assault or an assault and battery that is a violation of section 81 of Act No. 328 of the Public Acts of 1939, being section 750.81 of the Michigan Compiled Laws, and that is committed by a recipient against another recipient.

(*ii*) A criminal homicide that is a violation or an attempt or conspiracy to commit a violation of section 316, 317, or 321 of Act No. 328 of the Public Acts of 1931, being sections 750.316, 750.317, and 750.321 of the Michigan Compiled Laws.

(*iii*) Criminal sexual conduct that is a violation or an attempt or conspiracy to commit a violation of sections 520b to 520e or 520g of Act No. 328 of the Public Acts of 1931, being sections 750.520b to 750.520e and 750.520g of the Michigan Compiled Laws.

(*iv*) Vulnerable adult abuse that is a violation or an attempt or conspiracy to commit a violation of section 145n of the Michigan penal code, Act No. 328 of the Public Acts of 1931, being section 750.145n of the Michigan Compiled Laws.

(*v*) Child abuse that is a violation or an attempt or conspiracy to commit a violation of section 136b of Act No. 328 of the Public Acts of 1931, being section 750.136b of the Michigan Compiled Laws.

(b) "Health care corporation" means a nonprofit health care corporation operating under the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws.

(c) "Health care insurer" means an insurer authorized to provide health insurance in this state or a legal entity that is self-insured and provides health care benefits to its employees.

(d) "Health maintenance organization" means an organization licensed under part 210 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.21001 to 333.21098 of the Michigan Compiled Laws.

(e) "Money" means any legal tender, note, draft, certificate of deposit, stock, bond, check, or credit card.

(f) "Nonprofit dental care corporation" means a dental care corporation incorporated under Act No. 125 of the Public Acts of 1963, being sections 550.351 to 550.373 of the Michigan Compiled Laws.

(g) "Person-centered planning" means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

(h) "Privileged communication" means a communication made to a psychiatrist or psychologist in connection with the examination, diagnosis, or treatment of a patient, or to another person while the other person is participating in the examination, diagnosis, or treatment or a communication made privileged under other applicable state or federal law.

(i) "Restraint" means the use of a physical device to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support.

(j) "Seclusion" means the temporary placement of a recipient in a room, alone, where egress is prevented by any means.

(k) "Support plan" means a written plan that specifies the personal support services or any other supports that are to be developed with and provided for a recipient.

(*l*) "Treatment plan" means a written plan that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services, that are to be developed with and provided for a recipient.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1702 Receipt of mental health services; rights, benefits, privileges, and competency not affected.

Sec. 702. (1) The receipt of mental health services, a determination that an individual meets the criteria of a person requiring treatment or for judicial admission, or any form of admission to a facility including by

judicial order shall not be used to deprive an individual of his or her rights, benefits, or privileges.

(2) The receipt of mental health services, a determination that an individual meets the criteria of a person requiring treatment or for judicial admission, or any form of admission to a facility including by judicial order does not constitute a determination or adjudication that the individual is incompetent as that term is used in other statutes.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1704 Rights of recipient.

Sec. 704. (1) In addition to the rights, benefits, and privileges guaranteed by other provisions of law, the state constitution of 1963, and the constitution of the United States, a recipient of mental health services shall have the rights guaranteed by this chapter unless otherwise restricted by law.

(2) The rights enumerated in this chapter shall not be construed to replace or limit any other rights, benefits, or privileges of a recipient of services including the right to treatment by spiritual means if requested by the recipient, parent, or guardian.

(3) The provisions of this chapter shall be construed to protect and promote the dignity and respect to which a recipient of services is entitled.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1705 Second opinion.

Sec. 705. (1) If an applicant for community mental health services has been denied mental health services, the applicant, his or her guardian if one has been appointed, or the applicant's parent or parents if the applicant is a minor may request a second opinion of the executive director. The executive director shall secure the second opinion from a physician, licensed psychologist, registered professional nurse, or master's level social worker, or master's level psychologist.

(2) If the individual providing the second opinion determines that the applicant has a serious mental illness, serious emotional disturbance, or a developmental disability, or is experiencing an emergency situation or urgent situation, the community mental health services program shall direct services to the applicant.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1706 Notice of rights.

Sec. 706. Except as provided in section 707, applicants for and recipients of mental health services and in the case of minors, the applicant's or recipient's parent or guardian, shall be notified by the providers of those services of the rights guaranteed by this chapter. Notice shall be accomplished by providing an accurate summary of this chapter and chapter 7a to the applicant or recipient at the time services are first requested and by having a complete copy of this chapter and chapter 7a readily available for review by applicants and recipients.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1706a Pamphlet; preparation; distribution; contents.

Sec. 706a. (1) The department shall prepare and distribute to each community mental health services program copies of a pamphlet containing information regarding resources available to individuals with serious mental illness and their families. The information shall include a description of advocacy and support groups, and other information of interest to recipients and their families. The pamphlet shall include the name, address, and telephone number of the organization designated by the governor under section 931 to provide protection and advocacy for individuals with developmental disability or mental illness.

(2) A community mental health services program shall distribute the pamphlet described in subsection (1) to each recipient receiving services through the community mental health services program and, if applicable, to the recipient's guardian or the parent of a minor recipient.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1707 Rights of minor.

Sec. 707. (1) A minor 14 years of age or older may request and receive mental health services and a mental health professional may provide mental health services, on an outpatient basis, excluding pregnancy termination referral services and the use of psychotropic drugs, without the consent or knowledge of the minor's parent, guardian, or person in loco parentis. Except as otherwise provided in this section, the minor's parent, guardian, or person in loco parentis shall not be informed of the services without the consent of the minor unless the mental health professional treating the minor determines that there is a compelling need for disclosure based on a substantial probability of harm to the minor or to another individual, and if the minor is

notified of the mental health professional's intent to inform the minor's parent, guardian, or person in loco parentis.

(2) Services provided to a minor under this section shall, to the extent possible, promote the minor's relationship to the parent, guardian, or person in loco parentis, and shall not undermine the values that the parent, guardian, or person in loco parentis has sought to instill in the minor.

(3) Services provided to a minor under this section shall be limited to not more than 12 sessions or 4 months per request for services. After the twelfth session or fourth month of services the mental health professional shall terminate the services or, with the consent of the minor, notify the parent, guardian, or person in loco parentis to obtain consent to provide further outpatient services.

(4) The minor's parent, guardian, or person in loco parentis is not liable for the costs of services that are received by a minor under subsection (1).

(5) This section does not relieve a mental health professional from his or her duty to report suspected child abuse or neglect under section 3 of the child protection law, Act No. 238 of the Public Acts of 1975, being section 722.623 of the Michigan Compiled Laws.

History: Add. 1984, Act 186, Imd. Eff. July 3, 1984;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1708 Suitable services; treatment environment; setting; rights.

Sec. 708. (1) A recipient shall receive mental health services suited to his or her condition.

(2) Mental health services shall be provided in a safe, sanitary, and humane treatment environment.

(3) Mental health services shall be offered in the least restrictive setting that is appropriate and available.

(4) A recipient has the right to be treated with dignity and respect.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1710 Physical and mental examination; reexamination.

Sec. 710. Within 24 hours after admission, each resident of a hospital or center shall receive a comprehensive physical and mental examination. Each resident shall be periodically reexamined not less often than annually.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1711 Rights of family members.

Sec. 711. Family members of recipients shall be treated with dignity and respect. They shall be given an opportunity to provide information to the treating professionals. They shall also be provided an opportunity to request and receive educational information about the nature of disorders, medications and their side effects, available support services, advocacy and support groups, financial assistance and coping strategies.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1712 Individualized written plan of services.

Sec. 712. (1) The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.

(2) If a recipient is not satisfied with his or her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.

(3) An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996;—Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997.

330.1713 Choice of physician or mental health professional.

Sec. 713. A recipient shall be given a choice of physician or other mental health professional in accordance with the policies of the community mental health services program, licensed hospital, or service provider under contract with the community mental health services program, or licensed hospital providing services and within the limits of available staff in the community mental health services program, licensed hospital, or service provider under contract with the community mental health services program, or licensed hospital.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1714 Informing resident of clinical status and progress.

Sec. 714. A recipient shall be informed orally and in writing of his or her clinical status and progress at reasonable intervals established in the individual plan of services in a manner appropriate to his or her clinical condition.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1715 Services of mental health professional.

Sec. 715. If a resident is able to secure the services of a mental health professional, he or she shall be allowed to see the professional at any reasonable time.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1716 Surgery; consent.

Sec. 716. (1) Except as provided in subsections (2) and (3), a recipient of mental health services shall not have surgery performed upon him or her unless consent is obtained from 1 of the following:

(a) The recipient if he or she is 18 years of age or over and does not have a guardian for medical purposes.

(b) The guardian of the recipient if the guardian is legally empowered to execute a consent to surgery.

(c) The parent of the recipient who has legal and physical custody of the recipient, if the recipient is less than 18 years of age.

(d) The representative authorized to consent under a durable power of attorney or other advance directive.

(2) If the life of a recipient is threatened and there is not time to obtain consent, surgery may be performed without consent after the medical necessity for the procedure has been documented and the documentation has been entered into the record of the recipient.

(3) If surgery is considered advisable for a recipient, and if no one eligible under subsection (1) to give consent can be found after diligent effort, a probate court may, upon petition and after hearing, consent to performance of the surgery in lieu of the individual eligible to give consent.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1717 Electroconvulsive therapy or other procedure; consent.

Sec. 717. (1) A recipient shall not be the subject of electroconvulsive therapy or a procedure intended to produce convulsions or coma unless consent is obtained from the following:

(a) The recipient, if he or she is 18 years of age or older and does not have a guardian for medical purposes.

(b) The recipient's parent who has legal and physical custody of the recipient, if the recipient is less than 18 years of age.

(c) The recipient's guardian, if the guardian has power to execute a consent to procedures described in this section.

(d) The recipient's designated representative, if a durable power of attorney or other advance directive grants the representative authority to consent to procedures described in this section.

(2) If a guardian consents to a procedure described in this section, the procedure shall not be initiated until 2 psychiatrists have examined the recipient and documented in the recipient's medical record their concurrence with the decision to administer the procedure.

(3) If a parent or guardian of a minor consents to a procedure described in this section, the procedure shall not be initiated until 2 child and adolescent psychiatrists, neither of whom may be the treating psychiatrist, have examined the minor and documented in the minor's medical record their concurrence with the decision to administer the procedure.

(4) A minor or an advocate designated by the minor may object to the administration of a procedure described in this section. The objection shall be made either orally or in writing to the probate court. The procedure shall not be initiated before a court hearing on the minor's or advocate's objection.

(5) At least 72 hours, excluding Sundays or holidays, before the initiation of a procedure described in this section, a minor shall be informed that he or she has a right to object to the procedure.

(6) If a procedure described in this section is considered advisable for a recipient and an individual eligible

to give consent for the procedure is not located after diligent effort, a probate court may, upon petition and after a hearing, consent to administration of the procedure in lieu of the individual eligible to give consent.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1718 Psychotropic drugs.

Sec. 718. Psychotropic drugs shall not be administered to an individual who has been hospitalized by medical certification or by petition under chapter 4 or 5 on the day preceding and on the day of his or her court hearing unless the individual consents or unless the administration of the psychotropic drugs is necessary to prevent physical injury to the individual or others.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1719 Psychotropic drug treatment; duties of prescriber or licensed health professional.

Sec. 719. Before initiating a course of psychotropic drug treatment for a recipient, the prescriber or a licensed health professional acting under the delegated authority of the prescriber shall do both of the following:

(a) Explain the specific risks and the most common adverse effects that have been associated with that drug.

(b) Provide the individual with a written summary of the most common adverse effects associated with that drug.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996;—Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997.

***** *330.1720 THIS SECTION IS AMENDED EFFECTIVE MARCH 24, 2021: See 330.1720.amended* *****

330.1720 Statistical report of deaths.

Sec. 720. The department shall provide an annual statistical report to the members of the house and senate standing committees and appropriations subcommittees with legislative oversight of mental health issues summarizing all deaths and causes of deaths, if known of mental health care recipients that have been reported to the department and all deaths that have occurred in state facilities.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

Compiler's note: Former MCL 330.1720, which pertained to facility standards report, was repealed by Act 302 of 1986, Imd. Eff. Dec. 22, 1986.

***** *330.1720.amended THIS AMENDED SECTION IS EFFECTIVE MARCH 24, 2021* *****

330.1720.amended Statistical report of deaths; investigation.

Sec. 720. (1) The department shall provide an annual statistical report to the members of the house and senate standing committees and appropriations subcommittees with legislative oversight of mental health issues summarizing all deaths and causes of deaths, if known, of mental health care recipients that have been reported to the department, including deaths that occurred within 48 hours after discharge, and all deaths that have occurred in state facilities.

(2) In the report described in subsection (1), the department must include information indicating whether or not it has initiated an investigation or is in the process of an investigation as required under section 721 regarding the recipient's death and, if known, the findings of the investigation.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996;—Am. 2020, Act 318, Eff. Mar. 24, 2021.

Compiler's note: Former MCL 330.1720, which pertained to facility standards report, was repealed by Act 302 of 1986, Imd. Eff. Dec. 22, 1986.

330.1721 Investigation of certain deaths reported by psychiatric hospital or psychiatric unit.

Sec. 721. The department must investigate all deaths reported by a psychiatric hospital or psychiatric unit that are the result of a suicide or where the cause of death is reported as unknown.

History: Add. 2020, Act 318, Eff. Mar. 24, 2021.

330.1722 Protection of recipient from abuse or neglect.

Sec. 722. (1) A recipient of mental health services shall not be subjected to abuse or neglect.

(2) The department, each community mental health services program, each licensed hospital, and each service provider under contract with the department, community mental health services program, or licensed hospital shall ensure that appropriate disciplinary action is taken against those who have engaged in abuse or neglect.

(3) A recipient of mental health services who is abused or neglected has a right to pursue injunctive and other appropriate civil relief.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1723 Suspected abuse of recipient or resident; report to law enforcement agency.

Sec. 723. (1) A mental health professional, a person employed by or under contract to the department, a licensed facility, or a community mental health services program, or a person employed by a provider under contract to the department, a licensed facility, or a community mental health services program who has reasonable cause to suspect the criminal abuse of a recipient immediately shall make or cause to be made, by telephone or otherwise, an oral report of the suspected criminal abuse to the law enforcement agency for the county or city in which the criminal abuse is suspected to have occurred or to the state police.

(2) Within 72 hours after making the oral report, the reporting individual shall file a written report with the law enforcement agency to which the oral report was made, and with the chief administrator of the facility or agency responsible for the recipient.

(3) The written report required by subsection (2) shall contain the name of the recipient and a description of the criminal abuse and other information available to the reporting individual that might establish the cause of the criminal abuse and the manner in which it occurred. The report shall become a part of the recipient's clinical record. Before the report becomes part of the recipient's clinical record, the names of the reporting individual and the individual accused of committing the criminal abuse, if contained in the report, shall be deleted.

(4) The identity of an individual who makes a report under this section is confidential and is not subject to disclosure without the consent of that individual or by order or subpoena of a court of record. An individual acting in good faith who makes a report of criminal abuse against a recipient is immune from civil or criminal liability that might otherwise be incurred. The immunity from civil or criminal liability granted by this subsection extends only to acts done under this section and does not extend to a negligent act that causes personal injury or death.

(5) An individual who makes a report under this section in good faith shall not be dismissed or otherwise penalized by an employer or contractor for making the report.

(6) This section does not relieve an individual from the duty to report criminal abuse under other applicable law.

(7) The department, a community mental health services program, a licensed facility, and a service provider under contract with the department, community mental health services program, or licensed facility shall cooperate in the prosecution of appropriate criminal charges against those who have engaged in criminal abuse.

(8) Except as otherwise provided in subsection (5), this section does not preclude nor hinder the department, a licensed facility, a community mental health services program, or a service provider under contract to the department, a licensed facility, or a community mental health services program from investigating reported claims of criminal abuse of a recipient by its employees, and from taking appropriate disciplinary action against its employees based upon that investigation.

(9) This section does not require a person to report suspected criminal abuse if either of the following applies:

(a) The individual has knowledge that the incident of suspected criminal abuse has been reported to the appropriate law enforcement agency as provided in this section.

(b) The suspected criminal abuse occurred more than 1 year before the date on which it first became known to an individual who would otherwise be required to make a report.

(10) This section does not require an individual required to report suspected criminal abuse under subsection (1) to disclose confidential information or a privileged communication except under 1 or both of the following circumstances:

(a) If the suspected criminal abuse is alleged to have been committed or caused by a mental health professional, an individual employed by or under contract to the department, a licensed facility, or a community mental health services program, or an individual employed by a service provider under contract to the department, a licensed facility, or a community mental health services program.

(b) If the suspected criminal abuse is alleged to have been committed in 1 of the following:

(*i*) A state facility or a licensed facility.

(*ii*) A county community mental health services program site.

(*iii*) The work site of an individual employed by or under contract to the department, a licensed facility, or a community mental health services program or a provider under contract to the department, a licensed facility, or a community mental health services program.

(*iv*) A place where a recipient is under the supervision of an individual employed by or under contract to the department, a licensed facility, a community mental health services program, or a provider under contract to the department, a licensed facility, or a community mental health services program.

History: Add. 1986, Act 224, Eff. Mar. 31, 1987;—Am. 1988, Act 32, Imd. Eff. Feb. 25, 1988;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1723a Appointment of guardian ad litem.

Sec. 723a. The court with jurisdiction in each case resulting from a report made under section 723 shall appoint a guardian ad litem for the recipient.

History: Add. 1986, Act 224, Eff. Mar. 31, 1987;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1723b Report by person not employed by or under contract to department, facility, or community mental health services program.

Sec. 723b. Section 723 does not prohibit an individual who is not employed by or under contract to the department, a licensed facility, or a community mental health services program and who has reasonable cause to suspect the criminal abuse of a recipient from making a report to the appropriate law enforcement agency or to the department or community mental health services program.

History: Add. 1986, Act 224, Eff. Mar. 31, 1987;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1723c Violation of MCL 330.1723 or making of false report as misdemeanor; civil liability.

Sec. 723c. (1) An individual who intentionally violates section 723 or who knowingly makes a false report pursuant to section 723 is guilty of a misdemeanor.

(2) An individual who violates section 723 is civilly liable for the damages proximately caused by the violation.

History: Add. 1986, Act 224, Eff. Mar. 31, 1987;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1724 Fingerprints, photographs, audiorecording, or use of 1-way glass.

Sec. 724. (1) A recipient of mental health services shall not be fingerprinted, photographed, audiorecorded, or viewed through a 1-way glass except in the circumstances and under the conditions set forth in this section. As used in this section, photographs include still pictures, motion pictures, and recordings.

(2) Fingerprints, photographs, or audiorecordings may be taken and used and 1-way glass may be used in order to provide services, including research, to a recipient or in order to determine the name of the recipient only when prior written consent is obtained from 1 of the following:

(a) The recipient if 18 years of age or over and competent to consent.

(b) The guardian of the recipient if the guardian is legally empowered to execute such a consent.

(c) The parent with legal and physical custody of the recipient if the recipient is less than 18 years of age.

(3) Fingerprints, photographs, or audiorecordings taken in order to provide services to a recipient, and any copies of them, shall be kept as part of the record of the recipient.

(4) Fingerprints, photographs, or audiorecordings taken in order to determine the name of a recipient shall be kept as part of the record of the recipient, except that when necessary the fingerprints, photographs, or audiorecordings may be delivered to others for assistance in determining the name of the recipient. Fingerprints, photographs, or audiorecordings so delivered shall be returned together with copies that were made. An individual receiving fingerprints, photographs, or audiorecordings shall be informed of the requirement that return be made. Upon return, the fingerprints, photographs, or audiorecordings, together with copies, shall be kept as part of the record of the recipient.

(5) Fingerprints, photographs, or audiorecordings in the record of a recipient, and any copies of them, shall be given to the recipient or destroyed when they are no longer essential in order to achieve 1 of the objectives set forth in subsection (2), or upon discharge of the resident, whichever occurs first.

(6) Photographs of a recipient may be taken for purely personal or social purposes and shall be maintained as the recipient's personal property. A photograph of a recipient shall not be taken or used under this subsection if the recipient has indicated his or her objection.

(7) Photographs or audiorecordings may be taken and 1-way glass may be used for educational or training purposes only when express written consent is obtained from 1 of the following:

(a) The recipient if 18 years of age or over and competent to consent.

(b) The guardian of the recipient if the guardian is legally empowered to execute such a consent.

(c) The parent with legal and physical custody of the recipient if the recipient is less than 18 years of age.

(8) This section does not apply to recipients of mental health services referred under chapter 10.

(9) Video surveillance may be conducted in a psychiatric hospital for purposes of safety, security, and

quality improvement. Video surveillance may only be conducted in common areas such as hallways, nursing station areas, and social activity areas within the psychiatric unit. Video surveillance recordings taken in common areas shall not be used for treatment or therapeutic purposes. Before implementation of video surveillance, the psychiatric hospital shall establish written policies and procedures that address, at a minimum, all of the following:

(a) Identification of locations where video surveillance images will be recorded and saved.

(b) Mechanisms by which recipients and visitors will be advised of the video surveillance.

(c) Security provisions that assure that only authorized staff members have access to view recorded surveillance video. The security provisions shall include all of the following:

(*i*) Who may authorize viewing of recorded surveillance video.

(*ii*) Circumstances under which recorded surveillance video may be viewed.

(*iii*) Who may view recorded surveillance video with proper authorization.

(*iv*) Safeguards to prevent and detect unauthorized viewing of recorded surveillance video.

(*v*) Circumstances under which recorded surveillance video may be duplicated and what steps will be taken to prevent unauthorized distribution of the duplicate.

(d) Documentation required to be maintained for each instance of authorized access, viewing duplication, or distribution of any recorded surveillance videos.

(e) Process to assure retrieval of distributed recorded surveillance video when the purpose for which the video was distributed no longer exists.

(f) Archived footage of video surveillance recordings for up to 30 days unless notice is received that an incident requires investigation by the department's office of recipient rights, the licensing division of the bureau of health systems, law enforcement, licensed psychiatric hospital or unit office of recipient rights, and the United States department of health and human services centers for medicaid and medicare services. In that case, archived footage of video surveillance recordings may be retained for the duration of the investigation.

(g) Recorded video surveillance images shall not be maintained as part of a recipient's clinical record.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1975, Act 208, Imd. Eff. Aug. 21, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996;—Am. 2012, Act 508, Eff. Mar. 28, 2013.

330.1726 Communication by mail and telephone; visits.

Sec. 726. (1) A resident is entitled to unimpeded, private, and uncensored communication with others by mail and telephone and to visit with persons of his or her choice, except in the circumstances and under the conditions set forth in this section.

(2) Each facility shall endeavor to implement the rights guaranteed by subsection (1) by making telephones reasonably accessible, by ensuring that correspondence can be conveniently and confidentially received and mailed, and by making space for visits available. Writing materials, telephone usage funds, and postage shall be provided in reasonable amounts to residents who are unable to procure such items.

(3) Reasonable times and places for the use of telephones and for visits may be established and, if established, shall be in writing and posted in each living unit of a residential program.

(4) The right of a resident to communicate by mail or telephone or receive visitors shall not be further limited except as authorized in the resident's individual plan of services.

(5) A limitation upon the rights guaranteed by subsection (1) shall not apply between a resident and an attorney or a court, or between a resident and other individuals if the communication involves matters that are or may be the subject of legal inquiry.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1728 Personal property.

Sec. 728. (1) A resident is entitled to receive, possess, and use all personal property, including clothing, except in the circumstances and under the conditions set forth in this section.

(2) Each facility shall provide a reasonable amount of storage space to each resident for his or her clothing and other personal property. The resident shall be permitted to inspect personal property at reasonable times.

(3) A facility may exclude particular kinds of personal property from the facility. Any exclusions shall be officially adopted and shall be in writing and posted in each residential unit.

(4) The individual in charge of the plan of services for a resident may limit the rights guaranteed by subsection (1) if each limitation is essential for 1 of the following purposes:

(a) In order to prevent theft, loss, or destruction of the property, unless a waiver is signed by the resident.

(b) In order to prevent the resident from physically harming himself, herself, or others.

(5) A limitation adopted under the authority of subsection (4), the date it expires, and justification for its adoption shall be promptly noted in the record of the resident.

(6) A limitation adopted under the authority of subsection (4) shall be removed when the circumstance that justified its adoption ceases to exist.

(7) A receipt shall be given to a resident and an individual designated by the resident for any of his or her personal property taken into the possession of the facility. Any personal property in the possession of a facility at the time the resident to whom the property belongs is released from the facility shall be returned to the resident.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1730 Money.

Sec. 730. (1) The department shall establish policies and procedures designed to ensure that money in the accounts of residents of a state facility are safeguarded against theft, loss, or misappropriation.

(2) A state facility may require that all money that is on the person of a resident, that comes to a resident, or that the facility receives on behalf of the resident under a benefit arrangement or otherwise, be turned over to the facility for safekeeping. The money shall be accounted for in the name of the resident and recorded periodically in the records of the resident. Upon request, money accounted for in the name of a resident shall be turned over to a legal guardian of the resident if the guardian has such authority.

(3) A resident of a state facility is entitled to easy access to the money in his or her account and to spend or otherwise use the money as he or she chooses, except as provided in policies and procedures of the department established under subsection (1). Policies and procedures shall be established in writing for each state facility giving residents easy access to the money in their accounts and enabling residents to spend or otherwise use their money as they choose.

(4) Money accounted for in the name of a resident of a state facility may be deposited with a financial institution. Any earnings attributable to money in an account of a resident shall be credited to that account.

(5) All money, including any earnings, in an account of a resident of a state facility shall be delivered to the resident upon his or her release from the facility.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1732 Accepting funds for use of resident.

Sec. 732. A state facility may accept funds that a parent, guardian, or other individual wishes to provide for the use or benefit of a resident of the facility. Unless otherwise restricted by law, the possession and use of funds so provided are governed by section 730, the individual plan of services, and any additional directions given by the provider of the funds.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1734 Facility as representative payee or fiduciary.

Sec. 734. In the absence of any other responsible party, a state facility may accept an appointment to serve as a representative payee, fiduciary, or in a similar capacity for payments to a resident under a public or private benefit arrangement unless otherwise restricted by law. Funds received under that arrangement are subject to section 730 except to the extent laws or regulations governing payment of the benefits provide otherwise.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1736 Performance of labor by resident.

Sec. 736. (1) A resident may perform labor that contributes to the operation and maintenance of the facility for which the facility would otherwise employ someone only if the resident voluntarily agrees to perform the labor, engaging in the labor would not be inconsistent with the individual plan of services for the resident, and the amount of time or effort necessary to perform the labor would not be excessive. In no event shall discharge or privileges be conditioned upon the performance of such labor.

(2) A resident who performs labor that contributes to the operation and maintenance of the facility for which the facility would otherwise employ someone shall be compensated appropriately and in accordance with applicable federal and state labor laws, including minimum wage and minimum wage reduction provisions.

(3) A resident who performs labor other than that described in subsection (2) shall be compensated an appropriate amount if an economic benefit to another individual or agency results from his or her labor.

(4) The governing body of the facility may provide for compensation of a resident when he or she performs labor not governed by subsection (2) or (3).

(5) Subsections (1), (2), and (3) do not apply to labor of a personal housekeeping nature or labor performed as a condition of residence in a small group living arrangement.

(6) One-half of any compensation paid to a resident under this section is exempt from collection under this act as payment for services rendered.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1738 Repealed. 1995, Act 290, Eff. Mar. 28, 1996.

Compiler's note: The repealed section pertained to right to education.

330.1740 Physical restraint.

Sec. 740. (1) A resident shall not be placed in physical restraint except in the circumstances and under the conditions set forth in this section or in other law.

(2) A resident may be restrained only as provided in subsection (3), (4), or (5) after less restrictive interventions have been considered, and only if restraint is essential in order to prevent the resident from physically harming himself, herself, or others, or in order to prevent him or her from causing substantial property damage. Consideration of less restrictive measures shall be documented in the medical record. If restraint is essential in order to prevent the resident from physically harming himself, herself, or others, the resident may be physically held with no more force than is necessary to limit the resident's movement, until a restraint may be applied.

(3) A resident may be temporarily restrained for a maximum of 30 minutes without an order or authorization in an emergency. Immediately after imposition of the temporary restraint, a physician shall be contacted. If, after being contacted, the physician does not order or authorize the restraint, the restraint shall be removed.

(4) A resident may be restrained prior to examination pursuant to an authorization by a physician. An authorized restraint may continue only until a physician can personally examine the resident or for 2 hours, whichever is less. If it is not possible for the physician to examine the resident within 2 hours, a physician may reauthorize the restraint for another 2 hours. Authorized restraint may not continue for more than 4 hours.

(5) A resident may be restrained pursuant to an order by a physician made after personal examination of the resident. An ordered restraint shall continue only for that period of time specified in the order or for 8 hours, whichever is less.

(6) A restrained resident shall continue to receive food, shall be kept in sanitary conditions, shall be clothed or otherwise covered, shall be given access to toilet facilities, and shall be given the opportunity to sit or lie down.

(7) Restraints shall be removed every 2 hours for not less than 15 minutes unless medically contraindicated or whenever they are no longer essential in order to achieve the objective which justified their initial application.

(8) Each instance of restraint requires full justification for its application, and the results of each periodic examination shall be placed promptly in the record of the resident.

(9) If a resident is restrained repeatedly, the resident's individual plan of services shall be reviewed and modified to facilitate the reduction of the use of restraints.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1742 Seclusion.

Sec. 742. (1) Seclusion shall be used only in a hospital, a center, or a child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128. A resident placed in a hospital or center shall not be kept in seclusion except in the circumstances and under the conditions set forth in this section.

(2) A minor placed in a child caring institution shall not be placed or kept in seclusion except as provided in 1973 PA 116, MCL 722.111 to 722.128, or rules promulgated under that act.

(3) A resident may be placed in seclusion only as provided under subsection (4), (5), or (6) and only if it is essential in order to prevent the resident from physically harming others, or in order to prevent the resident from causing substantial property damage.

(4) Seclusion may be temporarily employed for a maximum of 30 minutes in an emergency without an authorization or an order. Immediately after the resident is placed in temporary seclusion, a physician shall be contacted. If, after being contacted, the physician does not authorize or order the seclusion, the resident shall be removed from seclusion.

(5) A resident may be placed in seclusion under an authorization by a physician. Authorized seclusion shall continue only until a physician can personally examine the resident or for 1 hour, whichever is less.

(6) A resident may be placed in seclusion under an order of a physician made after personal examination of the resident to determine if the ordered seclusion poses an undue health risk to the resident. Ordered seclusion

shall continue only for that period of time specified in the order or for 8 hours, whichever is less. An order for a minor shall continue for a maximum of 4 hours.

(7) A secluded resident shall continue to receive food, shall remain clothed unless his or her actions make it impractical or inadvisable, shall be kept in sanitary conditions, and shall be provided a bed or similar piece of furniture unless his or her actions make it impractical or inadvisable.

(8) A secluded resident shall be released from seclusion whenever the circumstance that justified its use ceases to exist.

(9) Each instance of seclusion requires full justification for its use, and the results of each periodic examination shall be placed promptly in the record of the resident.

(10) If a resident is secluded repeatedly, the resident's individual plan of services shall be reviewed and modified to facilitate the reduced use of seclusion.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996;—Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997;—Am. 2004, Act 527, Imd. Eff. Jan. 3, 2005.

330.1744 Freedom of movement.

Sec. 744. (1) The freedom of movement of a recipient shall not be restricted more than is necessary to provide mental health services to him or her, to prevent injury to him or her or to others, or to prevent substantial property damage, except that security precautions appropriate to the condition and circumstances of an individual admitted by order of a criminal court or transferred as a sentence-serving convict from a penal institution may be taken.

(2) A restriction adopted under the authority of subsection (1), the date it expires, and justification for its adoption shall be promptly noted in the record of the recipient.

(3) A restriction adopted under the authority of subsection (1) shall be removed when the circumstance that justified its adoption ceases to exist.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1746 Record.

Sec. 746. (1) A complete record shall be kept current for each recipient of mental health services. The record shall at least include information pertinent to the services provided to the recipient, pertinent to the legal status of the recipient, required by this chapter or other provision of law, and required by rules or policies.

(2) The material in the record shall be confidential to the extent it is made confidential by section 748.

History: 1974, Act 258, Eff. Aug. 6, 1975.

330.1748 Confidentiality.

Sec. 748. (1) Information in the record of a recipient, and other information acquired in the course of providing mental health services to a recipient, shall be kept confidential and is not open to public inspection. The information may be disclosed outside the department, community mental health services program, licensed facility, or contract provider, whichever is the holder of the record, only in the circumstances and under the conditions set forth in this section or section 748a.

(2) If information made confidential by this section is disclosed, the identity of the individual to whom it pertains shall be protected and shall not be disclosed unless it is germane to the authorized purpose for which disclosure was sought. When practicable, no other information shall be disclosed unless it is germane to the authorized purpose for which disclosure was sought.

(3) An individual receiving information made confidential by this section shall disclose the information to others only to the extent consistent with the authorized purpose for which the information was obtained.

(4) For case record entries made subsequent to March 28, 1996, information made confidential by this section shall be disclosed to an adult recipient, upon the recipient's request, if the recipient does not have a guardian and has not been adjudicated legally incompetent. The holder of the record shall comply with the adult recipient's request for disclosure as expeditiously as possible but in no event later than the earlier of 30 days after receipt of the request or, if the recipient is receiving treatment from the holder of the record, before the recipient is released from treatment.

(5) Except as otherwise provided in this section or section 748a, when requested, information made confidential by this section shall be disclosed only under 1 or more of the following circumstances:

(a) Under an order or a subpoena of a court of record or a subpoena of the legislature, unless the information is privileged by law.

(b) To a prosecuting attorney as necessary for the prosecuting attorney to participate in a proceeding governed by this act.

(c) To an attorney for the recipient, with the consent of the recipient, the recipient's guardian with authority to consent, or the parent with legal and physical custody of a minor recipient.

(d) If necessary in order to comply with another provision of law.

(e) To the department if the information is necessary in order for the department to discharge a responsibility placed upon it by law.

(f) To the office of the auditor general if the information is necessary for that office to discharge its constitutional responsibility.

(g) To a surviving spouse of the recipient or, if there is no surviving spouse, to the individual or individuals most closely related to the deceased recipient within the third degree of consanguinity as defined in civil law, for the purpose of applying for and receiving benefits.

(6) Except as otherwise provided in subsection (4), if consent is obtained from the recipient, the recipient's guardian with authority to consent, the parent with legal custody of a minor recipient, or the court-appointed personal representative or executor of the estate of a deceased recipient, information made confidential by this section may be disclosed to all of the following:

(a) A provider of mental health services to the recipient.

(b) The recipient or his or her guardian or the parent of a minor recipient or another individual or agency unless in the written judgment of the holder the disclosure would be detrimental to the recipient or others.

(7) Information may be disclosed by the holder of the record under 1 or more of the following circumstances:

(a) As necessary in order for the recipient to apply for or receive benefits.

(b) As necessary for treatment, coordination of care, or payment for the delivery of mental health services, in accordance with the health insurance portability and accountability act of 1996, Public Law 104-191.

(c) As necessary for the purpose of outside research, evaluation, accreditation, or statistical compilation. The individual who is the subject of the information shall not be identified in the disclosed information unless the identification is essential in order to achieve the purpose for which the information is sought or if preventing the identification would clearly be impractical, but not if the subject of the information is likely to be harmed by the identification.

(d) To a provider of mental or other health services or a public agency, if there is a compelling need for disclosure based upon a substantial probability of harm to the recipient or other individuals.

(8) If required by federal law, the department or a community mental health services program or licensed facility shall grant a representative of the protection and advocacy system designated by the governor in compliance with section 931 access to the records of all of the following:

(a) A recipient, if the recipient, the recipient's guardian with authority to consent, or a minor recipient's parent with legal and physical custody of the recipient has consented to the access.

(b) A recipient, including a recipient who has died or whose location is unknown, if all of the following apply:

(*i*) Because of mental or physical condition, the recipient is unable to consent to the access.

(*ii*) The recipient does not have a guardian or other legal representative, or the recipient's guardian is the state.

(*iii*) The protection and advocacy system has received a complaint on behalf of the recipient or has probable cause to believe based on monitoring or other evidence that the recipient has been subject to abuse or neglect.

(c) A recipient who has a guardian or other legal representative if all of the following apply:

(*i*) A complaint has been received by the protection and advocacy system or there is probable cause to believe the health or safety of the recipient is in serious and immediate jeopardy.

(*ii*) Upon receipt of the name and address of the recipient's legal representative, the protection and advocacy system has contacted the representative and offered assistance in resolving the situation.

(*iii*) The representative has failed or refused to act on behalf of the recipient.

(9) The records, data, and knowledge collected for or by individuals or committees assigned a peer review function, including the review function under section 143a(1), are confidential, shall be used only for the purposes of peer review, are not public records, and are not subject to court subpoena. This subsection does not prevent disclosure of individual case records under this section.

(10) The holder of an individual's record, if authorized to release information for clinical purposes by the individual or the individual's guardian or a parent of a minor, shall release a copy of the entire medical and clinical record to the provider of mental health services.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1982, Act 236, Imd. Eff. Sept. 22, 1982;—Am. 1986, Act 50, Imd. Eff. Mar. 17, 1986;—Am. 1987, Act 192, Imd. Eff. Dec. 2, 1987;—Am. 1990, Act 167, Imd. Eff. July 2, 1990;—Am. 1995, Act 290, Eff. Mar. 28,

1996;—Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997;—Am. 1998, Act 497, Eff. Mar. 1, 1999;—Am. 2016, Act 559, Eff. Apr. 10, 2017.

330.1748a Child abuse or neglect investigation; request for mental health records and information; immunity from civil or administrative liability; imposition of duties under another statute.

Sec. 748a. (1) If there is a compelling need for mental health records or information to determine whether child abuse or child neglect has occurred or to take action to protect a minor where there may be a substantial risk of harm, a family independence agency caseworker or administrator directly involved in the child abuse or neglect investigation shall notify a mental health professional that a child abuse or neglect investigation has been initiated involving a person who has received services from the mental health professional and shall request in writing mental health records and information that are pertinent to that investigation. Upon receipt of this notification and request, the mental health professional shall review all mental health records and information in the mental health professional's possession to determine if there are mental health records or information that is pertinent to that investigation. Within 14 days after receipt of a request made under this subsection, the mental health professional shall release those pertinent mental health records and information to the caseworker or administrator directly involved in the child abuse or neglect investigation.

(2) The following privileges do not apply to mental health records or information to which access is given under this section:

(a) The physician-patient privilege created in section 2157 of the revised judicature act of 1961, 1961 PA 236, MCL 600.2157.

(b) The dentist-patient privilege created in section 16648 of the public health code, 1978 PA 368, MCL 333.16648.

(c) The licensed professional counselor-client and limited licensed counselor-client privilege created in section 18117 of the public health code, 1978 PA 368, MCL 333.18117.

(d) The psychologist-patient privilege created in section 18237 of the public health code, 1978 PA 368, MCL 333.18237.

(e) Any other health professional-patient privilege created or recognized by law.

(3) To the extent not protected by the immunity conferred by 1964 PA 170, MCL 691.1401 to 691.1415, an individual who in good faith gives access to mental health records or information under this section is immune from civil or administrative liability arising from that conduct, unless the conduct was gross negligence or willful and wanton misconduct.

(4) A duty under this act relating to child abuse and neglect does not alter a duty imposed under another statute, including the child protection law, 1975 PA 238, MCL 722.621 to 722.638, regarding the reporting or investigation of child abuse or neglect.

History: Add. 1998, Act 497, Eff. Mar. 1, 1999.

330.1749 Statement correcting or amending information.

Sec. 749. A recipient, guardian, or parent of a minor recipient, after having gained access to treatment records, may challenge the accuracy, completeness, timeliness, or relevance of factual information in the recipient's record. The recipient, guardian, or parent of a minor recipient shall be allowed to insert into the record a statement correcting or amending the information at issue. The statement shall become part of the record.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1750 Privileged communications.

Sec. 750. (1) Privileged communications shall not be disclosed in civil, criminal, legislative, or administrative cases or proceedings, or in proceedings preliminary to such cases or proceedings, unless the patient has waived the privilege, except in the circumstances set forth in this section.

(2) Privileged communications shall be disclosed upon request under 1 or more of the following circumstances:

(a) If the privileged communication is relevant to a physical or mental condition of the patient that the patient has introduced as an element of the patient's claim or defense in a civil or administrative case or proceeding or that, after the death of the patient, has been introduced as an element of the patient's claim or defense by a party to a civil or administrative case or proceeding.

(b) If the privileged communication is relevant to a matter under consideration in a proceeding governed by this act, but only if the patient was informed that any communications could be used in the proceeding.

(c) If the privileged communication is relevant to a matter under consideration in a proceeding to determine the legal competence of the patient or the patient's need for a guardian but only if the patient was

informed that any communications made could be used in such a proceeding.

(d) In a civil action by or on behalf of the patient or a criminal action arising from the treatment of the patient against the mental health professional for malpractice.

(e) If the privileged communication was made during an examination ordered by a court, prior to which the patient was informed that a communication made would not be privileged, but only with respect to the particular purpose for which the examination was ordered.

(f) If the privileged communication was made during treatment that the patient was ordered to undergo to render the patient competent to stand trial on a criminal charge, but only with respect to issues to be determined in proceedings concerned with the competence of the patient to stand trial.

(3) In a proceeding in which subsections (1) and (2) prohibit disclosure of a communication made to a psychiatrist or psychologist in connection with the examination, diagnosis, or treatment of a patient, the fact that the patient has been examined or treated or undergone a diagnosis also shall not be disclosed unless that fact is relevant to a determination by a health care insurer, health care corporation, nonprofit dental care corporation, or health maintenance organization of its rights and liabilities under a policy, contract, or certificate of insurance or health care benefits.

(4) Privileged communications may be disclosed under section 946 to comply with the duty set forth in that section.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1984, Act 362, Eff. Mar. 29, 1985;—Am. 1989, Act 123, Eff. Sept. 1, 1989;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1752 Policies and procedures.

Sec. 752. (1) The department, each community mental health services program, each licensed hospital, and each service provider under contract with the department, a community mental health services program, or a licensed hospital shall establish written policies and procedures concerning recipient rights and the operation of an office of recipient rights. The policies and procedures shall provide a mechanism for prompt reporting, review, investigation, and resolution of apparent or suspected violations of the rights guaranteed by this chapter, shall be consistent with this chapter and chapter 7a, and shall be designed to protect recipients from, and prevent repetition of, violations of rights guaranteed by this chapter and chapter 7a. The policies and procedures shall include, at a minimum, all of the following:

(a) Complaint and appeal processes.

(b) Consent to treatment and services.

(c) Sterilization, contraception, and abortion.

(d) Fingerprinting, photographing, audiotaping, and use of 1-way glass.

(e) Abuse and neglect, including detailed categories of type and severity.

(f) Confidentiality and disclosure.

(g) Treatment by spiritual means.

(h) Qualifications and training for recipient rights staff.

(i) Change in type of treatment.

(j) Medication procedures.

(k) Use of psychotropic drugs.

(*l*) Use of restraint.

(m) Right to be treated with dignity and respect.

(n) Least restrictive setting.

(o) Services suited to condition.

(p) Policies and procedures that address all of the following matters with respect to residents:

(*i*) Right to entertainment material, information, and news.

(*ii*) Comprehensive examinations.

(*iii*) Property and funds.

(*iv*) Freedom of movement.

(*v*) Resident labor.

(*vi*) Communication and visits.

(*vii*) Use of seclusion.

(2) All policies and procedures required by this section shall be established within 12 months after the effective date of the amendatory act that added section 753.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1753 Recipient rights system; review by department.

Sec. 753. The department shall review the recipient rights system of each community mental health

services program in accordance with standards established under section 232a, to ensure a uniformly high standard of recipient rights protection throughout the state. For purposes of certification review, the department shall have access to all information pertaining to the rights protections system of the community mental health services program.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1754 State office of recipient rights; establishment by department; selection of director; powers and authority of state office of recipient rights.

Sec. 754. (1) The department shall establish a state office of recipient rights subordinate only to the director.

(2) The department shall ensure all of the following:

(a) The process for funding the state office of recipient rights includes a review of the funding by the state recipient rights advisory committee.

(b) The state office of recipient rights will be protected from pressures that could interfere with the impartial, even-handed, and thorough performance of its duties.

(c) The state office of recipient rights will have unimpeded access to all of the following:

(*i*) All programs and services operated by or under contract with the department except where other recipient rights systems authorized by this act exist.

(*ii*) All staff employed by or under contract with the department.

(*iii*) All evidence necessary to conduct a thorough investigation or to fulfill its monitoring function.

(d) Staff of the state office of recipient rights receive training each year in recipient rights protection.

(e) Each contract between the department and a provider requires both of the following:

(*i*) That the provider and his or her employees receive annual training in recipient rights protection.

(*ii*) That recipients will be protected from rights violations while they are receiving services under the contract.

(f) Technical assistance and training in recipient rights protection are available to all community mental health services programs and other mental health service providers subject to this act.

(3) The department shall endeavor to ensure all of the following:

(a) The state office of recipient rights has sufficient staff and other resources necessary to perform the duties described in this section.

(b) Complainants, staff of the state office of recipient rights, and any staff acting on behalf of a recipient will be protected from harassment or retaliation resulting from recipient rights activities.

(c) Appropriate remedial action is taken to resolve violations of rights and notify the complainants of substantiated violations in a manner that does not violate employee rights.

(4) After consulting with the state recipient rights advisory committee, the department director shall select a director of the state office of recipient rights who has the education, training, and experience to fulfill the responsibilities of the office. The department director shall not replace or dismiss the director of the state office of recipient rights without first consulting the state recipient rights advisory committee. The director of the state office of recipient rights shall have no direct service responsibility. The director of the state office of recipient rights shall report directly and solely to the department director. The department director shall not delegate his or her responsibility under this subsection.

(5) The state office of recipient rights may do all of the following:

(a) Investigate apparent or suspected violations of the rights guaranteed by this chapter.

(b) Resolve disputes relating to violations.

(c) Act on behalf of recipients to obtain appropriate remedies for any apparent violations.

(d) Apply for and receive grants, gifts, and bequests to effectuate any purpose of this chapter.

(6) The state office of recipient rights shall do all of the following:

(a) Ensure that recipients, parents of minor recipients, and guardians or other legal representatives have access to summaries of the rights guaranteed by this chapter and chapter 7a and are notified of those rights in an understandable manner, both at the time services are requested and periodically during the time services are provided to the recipient.

(b) Ensure that the telephone number and address of the office of recipient rights and the names of rights officers are conspicuously posted in all service sites.

(c) Maintain a record system for all reports of apparent or suspected rights violations received, including a mechanism for logging in all complaints and a mechanism for secure storage of all investigative documents and evidence.

(d) Initiate actions that are appropriate and necessary to safeguard and protect rights guaranteed by this chapter to recipients of services provided directly by the department or by its contract providers other than

community mental health services programs.

(e) Receive reports of apparent or suspected violations of rights guaranteed by this chapter. The state office of recipient rights shall refer reports of apparent or suspected rights violations to the recipient rights office of the appropriate provider to be addressed by the provider's internal rights protection mechanisms. The state office shall intervene as necessary to act on behalf of recipients in situations in which the director of the department considers the rights protection system of the provider to be out of compliance with this act and rules promulgated under this act.

(f) Upon request, advise recipients of the process by which a rights complaint or appeal may be made and assist recipients in preparing written rights complaints and appeals.

(g) Advise recipients that there are advocacy organizations available to assist recipients in preparing written rights complaints and appeals and offer to refer recipients to those organizations.

(h) Upon receipt of a complaint, advise the complainant of the complaint process, appeal process, and mediation option.

(i) Ensure that each service site operated by the department or by a provider under contract with the department, other than a community mental health services program, is visited by recipient rights staff with the frequency necessary for protection of rights but in no case less than annually.

(j) Ensure that all individuals employed by the department receive department-approved training related to recipient rights protection before or within 30 days after being employed.

(k) Ensure that all reports of apparent or suspected violations of rights within state facilities or programs operated by providers under contract with the department other than community mental health services programs are investigated in accordance with section 778 and that those reports that do not warrant investigation are recorded in accordance with subdivision (c).

(*l*) Review semiannual statistical rights data submitted by community mental health services programs and licensed hospitals to determine trends and patterns in the protection of recipient rights in the public mental health system and provide a summary of the data to community mental health services programs and to the director of the department.

(m) Serve as consultant to the director in matters related to recipient rights.

(n) At least quarterly, provide summary complaint data consistent with the annual report required in subdivision (o), together with a summary of remedial action taken on substantiated complaints, to the department and the state recipient rights advisory committee.

(o) Submit to the department director and to the committees and subcommittees of the legislature with legislative oversight of mental health matters, for availability to the public, an annual report on the current status of recipient rights for the state. The report shall be submitted not later than March 31 of each year for the preceding fiscal year. The annual report shall include, at a minimum, all of the following:

(*i*) Summary data by type or category regarding the rights of recipients receiving services from the department including the number of complaints received by each state facility and other state-operated placement agency, the number of reports filed, and the number of reports investigated.

(*ii*) The number of substantiated rights violations by category and by state facility.

(*iii*) The remedial actions taken on substantiated rights violations by category and by state facility.

(*iv*) Training received by staff of the state office of recipient rights.

(*v*) Training provided by the state office of recipient rights to staff of contract providers.

(*vi*) Outcomes of assessments of the recipient rights system of each community mental health services program.

(*vii*) Identification of patterns and trends in rights protection in the public mental health system in this state.

(*viii*) Review of budgetary issues including staffing and financial resources.

(*ix*) Summary of the results of any consumer satisfaction surveys conducted.

(*x*) Recommendations to the department.

(p) Provide education and training to its recipient rights advisory committee and its recipient rights appeals committee.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996;—Am. 2006, Act 604, Imd. Eff. Jan. 3, 2007.

Administrative rules: R 330.1001 et seq. of the Michigan Administrative Code.

330.1755 Office of recipient rights; establishment by community mental health services program and hospital.

Sec. 755. (1) Each community mental health services program and each licensed hospital shall establish an office of recipient rights subordinate only to the executive director or hospital director.

(2) Each community mental health services program and each licensed hospital shall ensure all of the

following:

(a) Education and training in recipient rights policies and procedures are provided to its recipient rights advisory committee and its recipient rights appeals committee.

(b) The process for funding the office of recipient rights includes a review of the funding by the recipient rights advisory committee.

(c) The office of recipient rights will be protected from pressures that could interfere with the impartial, even-handed, and thorough performance of its duties.

(d) The office of recipient rights will have unimpeded access to all of the following:

(*i*) All programs and services operated by or under contract with the community mental health services program or licensed hospital.

(*ii*) All staff employed by or under contract with the community mental health services program or licensed hospital.

(*iii*) All evidence necessary to conduct a thorough investigation or to fulfill its monitoring function.

(e) Staff of the office of recipient rights receive training each year in recipient rights protection.

(f) Each contract between the community mental health services program or licensed hospital and a provider requires both of the following:

(*i*) That the provider and his or her employees receive recipient rights training.

(*ii*) That recipients will be protected from rights violations while they are receiving services under the contract.

(3) Each community mental health services program and each licensed hospital shall endeavor to ensure all of the following:

(a) Complainants, staff of the office of recipient rights, and any staff acting on behalf of a recipient will be protected from harassment or retaliation resulting from recipient rights activities and that appropriate disciplinary action will be taken if there is evidence of harassment or retaliation.

(b) Appropriate remedial action is taken to resolve violations of rights and notify the complainants of substantiated violations in a manner that does not violate employee rights.

(4) The executive director or hospital director shall select a director of the office of recipient rights who has the education, training, and experience to fulfill the responsibilities of the office. The executive director shall not select, replace, or dismiss the director of the office of recipient rights without first consulting the recipient rights advisory committee. The director of the office of recipient rights shall have no direct clinical service responsibility.

(5) Each office of recipient rights established under this section shall do all of the following:

(a) Provide or coordinate the protection of recipient rights for all directly operated or contracted services.

(b) Ensure that recipients, parents of minor recipients, and guardians or other legal representatives have access to summaries of the rights guaranteed by this chapter and chapter 7a and are notified of those rights in an understandable manner, both at the time services are initiated and periodically during the time services are provided to the recipient.

(c) Ensure that the telephone number and address of the office of recipient rights and the names of rights officers are conspicuously posted in all service sites.

(d) Maintain a record system for all reports of apparent or suspected rights violations received within the community mental health services program system or the licensed hospital system, including a mechanism for logging in all complaints and a mechanism for secure storage of all investigative documents and evidence.

(e) Ensure that each service site is visited with the frequency necessary for protection of rights but in no case less than annually.

(f) Ensure that all individuals employed by the community mental health services program, contract agency, or licensed hospital receive training related to recipient rights protection before or within 30 days after being employed.

(g) Review the recipient rights policies and the rights system of each provider of mental health services under contract with the community mental health services program or licensed hospital to ensure that the rights protection system of each provider is in compliance with this act and is of a uniformly high standard.

(h) Serve as consultant to the executive director or hospital director and to staff of the community mental health services program or licensed hospital in matters related to recipient rights.

(i) Ensure that all reports of apparent or suspected violations of rights within the community mental health services program system or licensed hospital system are investigated in accordance with section 778 and that those reports that do not warrant investigation are recorded in accordance with subdivision (d).

(j) Semiannually provide summary complaint data consistent with the annual report required in subsection (6), together with a summary of remedial action taken on substantiated complaints by category, to the department and to the recipient rights advisory committee of the community mental health services program

or licensed hospital.

(6) The executive director or hospital director shall submit to the board of the community mental health services program or the governing board of the licensed hospital and the department an annual report prepared by the office of recipient rights on the current status of recipient rights in the community mental health services program system or licensed hospital system and a review of the operations of the office of recipient rights. The report shall be submitted not later than December 30 of each year for the preceding fiscal year or period specified in contract. The annual report shall include, at a minimum, all of the following:

(a) Summary data by category regarding the rights of recipients receiving services from the community mental health services program or licensed hospital including complaints received, the number of reports filed, and the number of reports investigated by provider.

(b) The number of substantiated rights violations by category and provider.

(c) The remedial actions taken on substantiated rights violations by category and provider.

(d) Training received by staff of the office of recipient rights.

(e) Training provided by the office of recipient rights to contract providers.

(f) Desired outcomes established for the office of recipient rights and progress toward these outcomes.

(g) Recommendations to the community mental health services program board or licensed hospital governing board.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1756 State recipient rights advisory committee; appointment by director.

Sec. 756. (1) The director shall appoint a 12-member state recipient rights advisory committee. The membership of the committee shall be broadly based so as to best represent the varied perspectives of department staff, government officials, attorneys, community mental health services program staff, private providers, recipients, and recipient interest groups. At least 1/3 of the membership of the state recipient rights advisory committee shall be primary consumers or family members, and of that 1/3, at least 2 shall be primary consumers. In appointing members to the advisory committee, the director shall consider the recommendations of the director of the state office of recipient rights and individuals who are members of the recipient rights advisory committee.

(2) The state recipient rights advisory committee shall do all of the following:

(a) Meet at least quarterly, or more frequently as necessary, to carry out its responsibilities.

(b) Maintain a current list of members' names to be made available to individuals upon request.

(c) Maintain a current list of categories represented, to be made available to individuals upon request.

(d) Protect the state office of recipient rights from pressures that could interfere with the impartial, even-handed, and thorough performance of its functions.

(e) Recommend to the director of the department candidates for the position of director of the state office of recipient rights and consult with the director regarding any proposed dismissal of the director of the state office of recipient rights.

(f) Serve in an advisory capacity to the director of the department and the director of the state office of recipient rights.

(g) Review and provide comments on the report submitted by the state office of recipient rights to the department under section 754.

(3) Meetings of the state recipient rights advisory committee are subject to the open meetings act, Act No. 267 of the Public Acts of 1976, being sections 15.261 to 15.275 of the Michigan Compiled Laws. Minutes shall be maintained and made available to individuals upon request.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1757 Recipient rights advisory committee; appointment by community mental health services program board.

Sec. 757. (1) The board of each community mental health services program shall appoint a recipient rights advisory committee consisting of at least 6 members. The membership of the committee shall be broadly based so as to best represent the varied perspectives of the community mental health services program's geographic area. At least 1/3 of the membership shall be primary consumers or family members, and of that 1/3, at least 1/2 shall be primary consumers.

(2) The recipient rights advisory committee shall do all of the following:

(a) Meet at least semiannually or as necessary to carry out its responsibilities.

(b) Maintain a current list of members' names to be made available to individuals upon request.

(c) Maintain a current list of categories represented to be made available to individuals upon request.

(d) Protect the office of recipient rights from pressures that could interfere with the impartial, even-handed,

and thorough performance of its functions.

(e) Recommend candidates for director of the office of recipient rights to the executive director, and consult with the executive director regarding any proposed dismissal of the director of the office of recipient rights.

(f) Serve in an advisory capacity to the executive director and the director of the office of recipient rights.

(g) Review and provide comments on the report submitted by the executive director to the community mental health services program board under section 755.

(h) If designated by the board of the community mental health services program, serve as the appeals committee for a recipient's appeal under section 784.

(i) Meetings of the recipient rights advisory committee are subject to the open meetings act, Act No. 267 of the Public Acts of 1976, being sections 15.261 to 15.275 of the Michigan Compiled Laws. Minutes shall be maintained and made available to individuals upon request.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1758 Recipient rights advisory committee; appointment by licensed hospital.

Sec. 758. Unless otherwise provided by contract with the local community mental health services program, each licensed hospital shall appoint a recipient rights advisory committee. At least 1/3 of the membership shall be primary consumers or family members and, of that 1/3, at least 1/2 shall be primary consumers. The recipient rights advisory committee shall do all of the following:

(a) Meet at least semiannually or as necessary to carry out its responsibilities.

(b) Maintain a current list of members' names and a separate list of categories represented, to be made available to individuals upon request.

(c) Protect the office of recipient rights from pressures that could interfere with the impartial, even-handed, and thorough performance of its functions.

(d) Review and provide comments on the report submitted by the hospital director to the governing board of the licensed hospital under section 755.

(e) Serve in an advisory capacity to the hospital director and the director of the office of recipient rights.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

MENTAL HEALTH CODE (EXCERPT)
Act 258 of 1974

CHAPTER 7A
DISPUTE RESOLUTION

330.1772 Definitions.

Sec. 772. As used in this chapter:

(a) "Allegation" means an assertion of fact made by an individual that has not yet been proved or supported with evidence.

(b) "Appeals committee" means a committee appointed by the director or by the board of a community mental health services program or licensed hospital under section 774.

(c) "Appellant" means the recipient, complainant, parent, or guardian who appeals a recipient rights finding or a respondent's action to an appeals committee.

(d) "Complainant" means an individual who files a rights complaint.

(e) "Investigation" means a detailed inquiry into and systematic examination of an allegation raised in a rights complaint.

(f) "Office" means all of the following:

(*i*) With respect to a rights complaint involving services provided directly by or under contract with the department, unless the provider is a community mental health services program, the state office of recipient rights created under section 754.

(*ii*) With respect to a rights complaint involving services provided directly by or under contract with a community mental health services program, the office of recipient rights created by a community mental health services program under section 755.

(*iii*) With respect to a rights complaint involving services provided by a licensed hospital, the office of recipient rights created by a licensed hospital under section 755.

(g) "Rights complaint" means a written or oral statement that meets the requirements of section 776.

(h) "Respondent" means the service provider that had responsibility at the time of an alleged rights violation for the services with respect to which a rights complaint has been filed.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996;—Am. 2020, Act 55, Imd. Eff. Mar. 3, 2020.

330.1774 Appeals committee.

Sec. 774. (1) The director shall appoint an appeals committee consisting of 7 individuals, none of whom shall be employed by the department or a community mental health services program, to hear appeals of recipient rights matters. The committee shall include at least 3 members of the state recipient rights advisory committee and 2 primary consumers.

(2) The board of a community mental health services program shall do 1 of the following:

(a) Appoint an appeals committee consisting of 7 individuals, none of whom shall be employed by the department or a community mental health services program, to hear appeals of recipients' rights matters. The appeals committee shall include at least 3 members of the recipient rights advisory committee, 2 board members, and 2 primary consumers. A member of the appeals committee may represent more than 1 of these categories.

(b) Designate the recipient rights advisory committee as the appeals committee.

(3) The governing body of a licensed hospital shall designate the appeals committee of the local community mental health services program to hear an appeal of a decision on a recipient rights matter brought by or on behalf of a recipient of that community mental health services program.

(4) The governing body of a licensed hospital shall do 1 of the following with respect to an appeal of a decision on a recipient rights matter brought by or on behalf of an individual who is not a recipient of a community mental health services program:

(a) Appoint an appeals committee consisting of 7 members, none of whom shall be employed by the department or a community mental health services program, 2 of whom shall be primary consumers and 2 of whom shall be community members.

(b) By agreement with the department, designate the appeals committee appointed by the department to hear appeals of rights complaints brought against the licensed hospital.

(5) An appeals committee appointed under this section may request consultation and technical assistance from the department.

(6) A member of an appeals committee who has a personal or professional relationship with an individual involved in an appeal shall abstain from participating in that appeal as a member of the committee.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1776 Rights complaint; filing; contents; recording; acknowledgment; notice; assistance; conduct of investigation.

Sec. 776. (1) A recipient, or another individual on behalf of a recipient, may file a rights complaint with the office alleging a violation of this act or rules promulgated under this act.

(2) A rights complaint shall contain all of the following information:

(a) A statement of the allegations that give rise to the dispute.

(b) A statement of the right or rights that may have been violated.

(c) The outcome that the complainant is seeking as a resolution to the complaint.

(3) Each rights complaint shall be recorded upon receipt by the office, and acknowledgment of the recording shall be sent along with a copy of the complaint to the complainant within 5 business days.

(4) Within 5 business days after the office receives a complaint, it shall notify the complainant if it determines that no investigation of the rights complaint is warranted.

(5) The office shall assist the recipient or other individual with the complaint process. The office shall advise the recipient or other individual that there are advocacy organizations available to assist in preparation of a written rights complaint and shall offer to refer the recipient or other individual to those organizations. In the absence of assistance from an advocacy organization, the office shall assist in preparing a written rights complaint. The office shall inform the recipient or other individual of the option of mediation under section 786.

(6) If a rights complaint has been filed regarding the conduct of the executive director, the rights investigation shall be conducted by the office of another community mental health services program or by the state office of recipient rights as decided by the board.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1778 Investigation; initiation; recording; standard of proof; written status report; written investigative report; new evidence.

Sec. 778. (1) The office shall initiate investigation of apparent or suspected rights violations in a timely and efficient manner. Subject to delays involving pending action by external agencies as described in subsection (5), the office shall complete the investigation not later than 90 days after it receives the rights complaint. Investigation shall be initiated immediately in cases involving alleged abuse, neglect, serious injury, or death of a recipient involving an apparent or suspected rights violation.

(2) Investigation activities for each rights complaint shall be accurately recorded by the office.

(3) The office shall determine whether a right was violated by using the preponderance of the evidence as its standard of proof.

(4) The office shall issue a written status report every 30 calendar days during the course of the investigation. The report shall be submitted to the complainant, the respondent, and the responsible mental health agency. A status report shall include all of the following:

(a) Statement of the allegations.

(b) Statement of the issues involved.

(c) Citations to relevant provisions of this act, rules, policies, and guidelines.

(d) Investigative progress to date.

(e) Expected date for completion of the investigation.

(5) Upon completion of the investigation, the office shall submit a written investigative report to the respondent and to the responsible mental health agency. Issuance of the written investigative report may be delayed pending completion of investigations that involve external agencies, including law enforcement agencies and the department of social services. The report shall include all of the following:

(a) Statement of the allegations.

(b) Statement of the issues involved.

(c) Citations to relevant provisions of this act, rules, policies, and guidelines.

(d) Investigative findings.

(e) Conclusions.

(f) Recommendations, if any.

(6) A rights investigation may be reopened or reinvestigated by the office if there is new evidence that was not presented at the time of the investigation.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1780 Remedial action.

Sec. 780. (1) If it has been determined through investigation that a right has been violated, the respondent shall take appropriate remedial action that meets all of the following requirements:

(a) Corrects or provides a remedy for the rights violations.

(b) Is implemented in a timely manner.

(c) Attempts to prevent a recurrence of the rights violation.

(2) The action shall be documented and made part of the record maintained by the office.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1782 Summary report.

Sec. 782. (1) The executive director, hospital director, or director of a state facility shall submit a written summary report to the complainant and recipient, if different than the complainant, within 10 business days after the executive director, hospital director, or director of the state facility receives a copy of the investigative report under section 778(5). The summary report shall include all of the following:

(a) Statement of the allegations.

(b) Statement of issues involved.

(c) Citations to relevant provisions of this act, rules, policies, and guidelines.

(d) Summary of investigative findings.

(e) Conclusions.

(f) Recommendations made by the office.

(g) Action taken, or plan of action proposed, by the respondent.

(h) A statement describing the complainant's right to appeal and the grounds for an appeal.

(2) Information in the summary report shall be provided within the constraints of sections 748 and 750 and shall not violate the rights of any employee.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1784 Summary report; appeal.

Sec. 784. (1) Not later than 45 days after receipt of the summary report under section 782, the complainant may file a written appeal with the appeals committee with jurisdiction over the office of recipient rights that issued the summary report.

(2) An appeal under subsection (1) shall be based on 1 of the following grounds:

(a) The investigative findings of the office are not consistent with the facts or with law, rules, policies, or guidelines.

(b) The action taken or plan of action proposed by the respondent does not provide an adequate remedy.

(c) An investigation was not initiated or completed on a timely basis.

(3) The office shall advise the complainant that there are advocacy organizations available to assist the complainant in preparing the written appeal and shall offer to refer the complainant to those organizations. In the absence of assistance from an advocacy organization, the office shall assist the complainant in meeting the procedural requirements of a written appeal. The office shall also inform the complainant of the option of mediation under section 786.

(4) Within 5 business days after receipt of the written appeal, members of the appeals committee shall review the appeal to determine whether it meets the criteria set forth in subsection (2). If the appeal is denied because the criteria in subsection (2) were not met, the complainant shall be notified in writing. If the appeal is accepted, written notice shall be provided to the complainant and a copy of the appeal shall be provided to the respondent and the responsible mental health agency.

(5) Within 30 days after receipt of a written appeal, the appeals committee shall meet and review the facts as stated in all complaint investigation documents and shall do 1 of the following:

(a) Uphold the investigative findings of the office and the action taken or plan of action proposed by the respondent.

(b) Return the investigation to the office and request that it be reopened or reinvestigated.

(c) Uphold the investigative findings of the office but recommend that the respondent take additional or different action to remedy the violation.

(d) If the responsible mental health agency is a community mental health services program or a licensed hospital, recommend that the board of the community mental health services program or the governing board of the licensed hospital request an external investigation by the state office of recipient rights.

(6) The appeals committee shall document its decision in writing. Within 10 working days after reaching its decision, it shall provide copies of the decision to the respondent, appellant, recipient if different than the appellant, the recipient's guardian if a guardian has been appointed, the responsible mental health agency, and the office.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1786 Notice of decision; appeal.

Sec. 786. (1) Within 45 days after receiving written notice of the decision of an appeals committee under section 784(5), the appellant may file a written appeal with the department. The appeal shall be based on the record established in the previous appeal, and on the allegation that the investigative findings of the local office of recipient rights are not consistent with the facts or with law, rules, policies, or guidelines.

(2) Upon receipt of an appeal under subsection (1), the department shall give written notice of receipt of the appeal to the appellant, respondent, local office of recipient rights holding the record of the complaint, and the responsible mental health agency. The respondent, local office of recipient rights holding the record of the complaint, and the responsible mental health agency shall ensure that the department has access to all necessary documentation and other evidence cited in the complaint.

(3) The department shall review the record based on the allegation described in subsection (1). The department shall not consider additional evidence or information that was not available during the appeal under section 784, although the department may return the matter to the board or the governing body of the licensed hospital requesting an additional investigation.

(4) Within 30 days after receiving the appeal, the department shall review the appeal and do 1 of the following:

(a) Affirm the decision of the appeals committee.

(b) Return the matter to the board or the governing body of the licensed hospital with instruction for additional investigation and consideration.

(5) The department shall provide copies of its action to the respondent, appellant, recipient if different than the appellant, the recipient's guardian if a guardian has been appointed, the board of the community mental health services program or the governing body of the licensed hospital, and the local office of recipient rights holding the record.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

330.1788 Repealed. 2020, Act 55, Imd. Eff. Mar. 3, 2020.

Compiler's note: The repealed section pertained to mediation after an investigative report.