

**NORTH COUNTRY COMMUNITY MENTAL HEALTH
NORTHERN AFFILIATION
ADMINISTRATIVE MANUAL**

CHAPTER: Affiliation Chapter 3
PROCEDURE NAME: Grievance and Appeal Process
PROCEDURE NUMBER: 3003

POLICY:

It is the policy of North Country Community Mental Health, Northern Affiliation, that all beneficiaries and potential beneficiaries have the right to a fair and efficient process for resolving disagreements regarding their services and supports that are managed by the Northern Affiliation.

PURPOSE:

To establish a process and procedure for grievances and disputes over decisions regarding services and supports managed by the Northern Affiliation.

APPLICATION:

All persons, and/or their legal representatives, that currently receive or request publicly funded mental health services managed by North Country Community Mental Health, Northern Affiliation.

Definitions:

A. Action:

1. The denial or limited authorization of a requested Medicaid service including the type and level of service
2. The reduction, suspension, termination of a previously authorized Medicaid service
3. The denial, in whole or in part, of payment for a Medicaid covered service
4. The failure to provide Medicaid covered services in a timely manner. (14 days)
5. The failure to act within the appeal and grievance time frames as established in this policy

B. Additional Mental Health Services: Supports and services available to Medicaid beneficiaries who meet the criteria for Specialty Services and Supports, under the authority of Section 1915 (b)(3) of the Social Security Act. Also referred to as "B3" or HAB Waiver Services.

C. Adequate Notice of Action: Written statement advising the beneficiary of a decision to deny, limit or authorization of Medicaid services that have been requested. Notice is provided on the same day the action takes effect, or at the time of the signing of the Individual plan of service.

D. Advance Notice of Action: Written statement advising the beneficiary of a decision to suspend, reduce or terminate a Medicaid covered service that they are currently receiving. Notice must be mailed at least 12 calendar days in advance of the date of action.

E. Appeal: Request for a review of an action

F. Beneficiary: An individual who is eligible for and enrolled in the Medicaid program in Michigan.

G. Consumer: A person receiving mental health services delivered and/or managed by the PIHP including persons with Medicaid and all others.

H. Expedited Appeal: A request by the beneficiary or the beneficiary's provider when the time for the normal appeal process (45 days) would jeopardize the beneficiary's life, health or ability to maintain, attain or regain normal function.

I. Fair Hearing: Impartial state level review of a Medicaid beneficiary's appeal of an action presided over by an Administrative Law Judge. Also referred to as an Administrative Fair Hearing.

- J. Grievance: An expression of dissatisfaction about any PIHP/CMHSP service issue other than an action or a protected recipient right. This term may also refer to the general system of appeals and grievances.
- K. Local Appeal Progress: Impartial local level and/or PIHP level review of a Medicaid beneficiary's appeal of an action presided over by individuals not involved with decision-making or previous level of review.
- L. Medicaid Services: Services provided to a beneficiary under the Medicaid state plan, Habilitation Supports Waiver.
- M. Recipient Rights Complaint: A written or verbal statement by a consumer, or anyone acting on the consumer's behalf claiming a violation of a protected right by the Michigan Mental Health Code. Recipient Rights Complaints are resolved through the Office of Recipient rights.

PROCEDURES:

- I. While the Northern Affiliation is required to have a local process it is the desire that disputes be resolved at the level closed to service delivery. The PIHP level process shall not supplant the local CMHSP's process nor replace the Medicaid beneficiary's right to file a fair hearing request with MDCH/MSA.
- II. Characteristic of the complaint resolution systems.
 - A. All processes will promote the resolution of concerns and improvement of the quality of care.
 - B. Beneficiaries/consumers/providers may access more than one process simultaneously or sequentially.
 - C. An appeal or grievance may be filed orally or in writing.
 - D. Written notification of complaint resolution will be provided to the individual with information about additional appeals/grievance processes.
 - E. All beneficiaries have the right to an expedited local appeal if waiting for the standard time for a local appeal (45 days) would seriously jeopardize their health or would jeopardize their ability to attain, maintain or regain maximum function.
 - F. A Medicaid Beneficiary has the right to have services continue while the local or state level appeal is pending. The request to continue services must be made prior to the reduction, suspension or termination of services is to occur. If the appeal is upheld, the consumer can be charged for the cost of services.
 - G. A provider may also file an appeal on the behalf of the beneficiary.
- III. The Northern Affiliation staff will be knowledgeable of the Comprehensive providers' process and refer to them as appropriate.
 - A. It is the expectation of the Northern Affiliation that these policies & processes meet the specifications of MDCH as outlined in the Grievance and Appeals Attachment of the MDCH/CMHSP Managed Specialty Supports and Service Contract.
 - B. Each comprehensive provider (CMHSP) will provide the Northern Affiliation with a copy of their Grievance, and Appeals resolution policies, including attachments and copies of forms and brochures.
 - C. Each comprehensive provider (CMHSP) will identify a specific employee to coordinate disputes at the local level.
 - 1. The name and phone number of the local coordinator will be displayed on brochures and posters, explaining the appeal and grievance process.
 - D. Each comprehensive provider (CMHSP) will keep data, about the number, scope and resolution of appeals and grievances.
 - 1. Data logs will be submitted to and tabulated by the Northern Affiliation quarterly.
 - 2. Quarterly data will be shared with:
 - a. The Director of Affiliation Services,
 - b. Operations Committee,
 - c. Provider Quality Oversight Committee,
 - d. Partners in Care Committee, and
 - e. PIHP Quality Improvement Committee.

- E. The Northern Affiliation, through the Access Center Care Managers, will begin to verbally orient customers to the grievance and appeal protections available to current and potential service recipients. Each comprehensive provider, contract provider, and/or sub-contract provider will provide verbal and written information to further orient the customer.
 - 1. Orientation will occur at the time of the initial assessment.
 - 2. Comprehensive providers will also post notices of client protection systems in areas frequented by consumers.
 - 3. Comprehensive providers will also have written material available to provide to the customer that describes the client protection systems that are required by contract and federal law.
- III. The types of dispute resolution processes include:
- A. Second Opinion for denial of access to supports and services or to inpatient hospitalization
 - B. Recipient Rights Complaint for rights violations, or denial of a request for a second opinion.
 - C. Local Appeals and Grievance processes.
 - D. MDCH Administrative Fair Hearing for Medicaid Recipients
 - E. MDCH Alternative Dispute Resolution Process for Non-Medicaid Recipients.
- IV. A denial of service may occur as a result of:
- A. Following the assessment for services, provided by the comprehensive provider, when the presenting symptoms or issues do not meet medical/clinical necessity and intensity criteria.
 - B. Request by a consumer or a provider for a service different than the services agreed upon in the Person-Centered Treatment Plan.
 - C. Following an assessment for a request to inpatient hospitalization.
 - D. After admission to an inpatient unit, and upon the request for continued stay in an inpatient setting, if the presenting symptoms do not support continued hospital care.
 - 1. The agency that denies the service request is required to provide the consumer and if appropriate the provider, with the notice and appeal rights.
 - 2. Applicants will never be denied authorization for the emergency assessment.
 - 3. When access to services or continued stay in an inpatient setting are denied:
 - a. Adequate Notice will be provided to the person requesting services and, if involved, the provider, noting that the notice to the provider does not have to be in writing.
 - b. Notice will be provided the day of the denial or be mailed no later than the day of the denial and must contain:
 - What services were requested
 - Reason for the denial
 - Information about client protection systems (grievance and appeals)
 - Right to request a second opinion and the process to request a second opinion
 - Right to an administrative fair hearing
 - Time frames in which to file an appeal
- VII. Grievance and Appeal Process at the PIHP level.
- A. A beneficiary/consumer/provider may request a local appeal of an “Action” within 45 calendar days from the date of the notice of action.
 - B. The request may be oral or in writing. If oral must be confirmed in writing unless expedited resolution was requested.
 - C. The recipient/consumer/provider has a right to an expedited local appeal if waiting for the standard time for a local appeal (45 days) would seriously jeopardize the health or would jeopardize the consumer’s ability to attain, maintain or regain maximum function. An expedited appeal must be resolved and Notice of Disposition provided within 3 working days. If the PIHP denies the request for an expedited appeal, it must follow the timeframe for a standard appeal. The beneficiary/consumer must receive prompt oral notice of the denial and follow up with written notice within 2 days.
 - D. If the beneficiary/consumer/provider requests the local appeal within 12 calendar days of the notice, the service must be continued until a determination is reached. If the appeal is upheld, the consumer may be billed for the cost of service.
 - E. The appeal must be resolved within 45 calendar days from the date the appeal was received.
 - F. A grievance is a statement of dissatisfaction with any aspect of a Medicaid covered services that is not an Action or a protected Recipient Right. A grievance must be resolved within 60 calendar days of receipt of the grievance

- G. The PIHP must give reasonable assistance to the beneficiary/consumer to complete forms and other procedural steps including but not limited to interpreter services.
- H. The PIHP must ensure that persons hearing the local appeal do not have previous involvement in review or decision making and are clinician(s) with an appropriate background. For grievance regarding denial of expedited resolution of an appeal and for a grievance that involves clinical issues, the grievance is reviewed by health care professionals who have the appropriate clinical expertise in treating the enrollee's condition.
- I. The beneficiary/consumer/provider must be provided the opportunity to present information in person and or in writing concerning the complaint. The beneficiary/consumer/provider may also include his or her representative in the grievance/appeal process.
- J. Once Customer Services receives the grievance or appeal
 - 1. Log the complaint.
 - 2. Contact the beneficiary/consumer/provider (document)
 - 3. Process the dispute:
 - 4. Contact the applicant, with the outcome (document), and further means of appeal if the applicant is not satisfied.
 - 5. If services are authorized, process to appropriate source to secure the approved services.
 - 6. Member service staff will assist the applicant (if requested) in filing an appeal at the local, affiliation and state levels.

VIII. On Customer Satisfaction survey tools, inquiry will be made about a customer's level of orientation at the access and provider levels to the grievance systems. Customer will be asked if they ever accessed the process and if they were satisfied with the resolution and the process.

REFERENCES and Legal Authority:

Chapter 7, 7a, 4 and 4 a of the Michigan Mental Health Code, 1996
 Federal Law for Medicaid recipients
 North Country CMH Policy and Procedures to Address Grievance and Disputes regarding service decisions A-007
 Person Centered Planning Practice Guideline
 MDCH/CMHSP contract, attachment 4.7.4 – Consumer Grievances

DISTRIBUTION:

All comprehensive providers
 Affiliation Administrative Manual
 PICC group

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APPROVED: Operations Committee Approval 2/7/07

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Forms/Attachments: