Subject: Provider Grievance and Appeal - Non-clinical	**Accountability:** Provider Network	**Effective Date:** 1/1/2014	Pages: 3
REQUIRED BY: **BBA Section** _____ **PIHP Contract Section** P.7.1.1 **NCQA/URAC Standard** CR1, CR7 **Other** _____		Last Reviewed Date: 5/18/17	Past Reviewed Dates: 5/18/15
LINE OF BUSINESS: ☒ Specialty Waiver (B/C) ☒ 1115 Waiver ☒ Healthy Michigan ☒ SUD Medicaid ☒ SUD Block Grant ☒ MI Health Link ☐ OTHER: _____	**APPLICATION:** ☒ SWMBH Staff and Ops ☒ Participant CMHSPs ☒ SUD Providers ☒ MH / DD providers ☐ Other: _____	Last Revised Date: 5/18/17	Past Revised Dates: 5/18/15
Approved : [signature] Date: 5/18/17		Required Reviewer: Director of Provider Network Management and Clinical Improvement	

I. Purpose

To outline the mechanism for provider complaints (grievances) and requests for reconsideration of decisions (appeal) related to provider network management issues. To ensure SWMBH appropriately notifies authorities, including state licensing agencies and/or the National Practitioner Database (NPDB), when actions are taken against practitioners (e.g., suspension and termination from the SWMBH Provider Network). This policy does not apply to medical necessity appeals or claims payment appeals, which are addressed in separate Southwest Michigan Behavioral Health (SWMBH) policies (see SWMBH Policy Manual Sections 6 and 9).

II. Policy

The intent of SWMBH and participant CMHSPs is to foster a positive and mutually supportive relationship with its provider network. When problems and disagreements arise, the following policy should be used for provider grievances and appeals. SWMBH will appropriately notify authorities, including state licensing agencies and/or the National Practitioner Database (NPDB), when actions are taken against practitioners (e.g., suspension and termination from the SWMBH Provider Network).

III. Standards and Guidelines:

A. General Standards and Application

1. The provider grievance and appeals process applies to including, but not limited to:
   a. Suspension or termination of a provider with cause.
   b. Denial, restriction, or reduction of credentialing privileges.
   c. Contract compliance issues resulting in a sanction.
   d. Material breaches highlighted in the contract.
   e. Results reported through provider monitoring reviews.
   f. Other issues related to quality of care or contract compliance.

2. An appeal of contract termination shall have no effect on the immediate termination of the contract and services under contract. The termination will remain in effect until the appeal process is completed, and will be rescinded only if the termination in not upheld on appeal.
3. The right to appeal will be included in each provider agreement and referenced by policy.
4. When SWMBH or its participant CMHs take action against a practitioner for quality reasons (contract termination for quality concerns, or denial, restriction, or reduction of credentialing privileges for quality concerns may include, but are not limited to: evidence of substandard treatment rendered to customers, customer complaints or grievances related to quality concerns, and malpractice judgments/settlements related to quality concerns), SWMBH or the CMH will provide written notification to the provider of the review action, reasons for the action, and a summary of the appeal rights and process.
5. All provider appeals must be received, in writing, within 30 days of notification of the action that is being appealed. Supporting documents, written statements, and other documentation that support the appeal may accompany the appeal request.

B. SWMBH Process for Practitioner Appeals regarding Quality Concerns

1. First Level Appeal. A SWMBH leader who was not involved in the initial action and who is familiar with the subject matter, and an appropriately trained and licensed practitioner in a practice similar to that of the affected practitioner, but not in direct competition with the practitioner, will participate in the review of the appeal. A determination will be made in writing within 30 days of receipt of the appeal, and will explain the facts upon which the determination was made.
2. Second Level Appeal. If the appeal was denied, the appeal may be reviewed at a second level. The provider may request the second level appeal up to 30 days after receipt of the determination of the first level appeal. A SWMBH leader who was not involved in the initial action and who is familiar with the subject matter, and an appropriately trained and licensed practitioner in a practice similar to that of the affected practitioner, but not in direct competition with the practitioner, will participate in the review of the appeal.
3. Practitioners may be represented by an attorney or another person of their choice at the Second Level Appeal. The appeal will be heard and reviewed by the assigned appeal committee. A Second Level Appeal hearing will occur within 60 days of the request date.
4. A written disposition of the Level Two Appeal, containing the specific reason(s) for the decision and will explain the facts upon which the determination was made, will be provided to the provider within 60 days of the Second Level Appeal hearing. After this time the matter will be considered closed.
5. When all appeal processes have been exhausted, the SWMBH Director of Provider Network Development and Clinical Improvement will report any practitioner suspensions lasting greater than 30 days, and any practitioner terminations, to any agencies that delegate credentialing to SWMBH, and to MDHHS and the NPDB, within 15 days of the final determination.

C. SWMBH Process for All other Provider Appeals

1. First Level Appeal. A SWMBH leader who was not involved in the initial action and who is familiar with the subject matter will review the appeal. A determination will be made in writing within 30 days of receipt of the appeal, and will explain the facts upon which the determination was made.
2. Second Level Appeal. If the appeal was denied, the appeal may be reviewed at a second level. The provider may request the second level appeal up to 30 days after receipt of the determination of the first level appeal. A SWMBH leader who was not involved in the initial

action and who is familiar with the subject matter will review the appeal.

3. A written disposition of the Level Two Appeal, containing the specific reason(s) for the decision and will explain the facts upon which the determination was made, will be provided to the provider within 60 days of receipt of the Second Level Appeal. After this time the matter will be considered closed.

D. Role of Participant CMHSP

1. The Participant CMHSP is required to have a local Provider grievance and appeal policy that comports with the Participant Sub-Contract and Medicaid regulations. The right to appeal will be included in each provider agreement, and the CMHSP will make its policy and procedure for provider appeals available to each of its contracted providers through posting on a public website or email/mail distribution (minimally of annually or when changes are made). The procedures will include:
    a. Time frames for submitting grievances and appeals
    b. Documentation requirements
    c. At least two successive levels for review of grievances and appeals by the participant CMHSP
    d. Individuals responsible for review, decisions, and responses to grievances and appeals.
    e. Timeframes for responding to grievance and appeals.

IV. Definitions

A. Appeal

A formal process which is established so that providers may request reconsideration of an action or decision that has been made by the PIHP or contracting CMHSP.

B. Grievance

An expression of dissatisfaction by a provider or customer regarding a perceived inequitable issue, aspects of interpersonal relation or other related issues.

V. References

A. MDHHS/PIHP Medicaid Managed Specialty Supports and Services Contract – Attachment P

B. 7.1.1 Credentialing and Re-Credentialing Processes

C. NCQA CR7 and CR1

VI. Attachments

None