SWMBH MI Health Link Operating Procedure 6.7.1

Subject: Medicare Member Grievance Procedure	**Accountability:** Member Services	**Effective Date:** 6/3/17	Pages: 4
Overarching Policy: 6.7 Medicare Member Grievance Policy		Last Reviewed Date: 10/23/17	Past Reviewed Dates: 6/3/17
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:	Past Revised Dates:
Approved :_____ Date: 11/10/17		Required Reviewer: Chief Clinical Officer 11/17/17 Director of UM & ME Manager of UM & Call Center	

I. Purpose

This procedure outlines the requirements of Southwest Michigan Behavioral Health (SWMBH) staff to ensure professional, complete, accurate and timely communication, documentation and tracking of Grievances, as defined in section IV of this procedure. Appropriate communication and documentation promotes a high standard of clinical care, improved communication, and dissemination of information between and across providers, as well as an accurate account of grievances filed in order to identify trends and improve care.

II. Scope

Provides staff with guidelines for documenting grievances as well as ongoing interactions with members, providers, and stakeholders in SWMBH's Managed Care Information System (MCIS), as it relates to member complaints and grievances.

III. Procedural Steps

A. Member or Member's authorized representative may contact Southwest Michigan Behavioral Health orally or through writing to express their grievances

B. Grievances will be addressed by the Member Services Department.

C. Initial investigation will determine if the grievance should be investigated and tracked as a grievance or adverse benefit determination appeal.

1. If the nature of the grievances, in whole or part, pertains to an adverse benefit determination the grievance will be treated as an adverse benefit determination appeal solely or concurrently.

D. Member Services will provide empathic listening and problem solving techniques when member and/or his/her authorized representative contacts SWMBH with a grievance. Additionally, Member Services will inquire the desired resolution/outcome that the Member expects from the grievance investigation.

E. Member services will offer and/or facilitate assistance needed, for members requesting bilingual staff or interpreter services, auxiliary aides, and/ or additional support to understand and complete the grievance process.

F. Member services will inform the member or member's authorized representative of their right to present information or evidence concerning the grievance orally or in writing and argue their case, and will inform them of the timeframe in which they have to do so.

G. Member Services will determine if the request will be subject to the standard process, or if the request is clinically urgent and will be processed through the timeframes for an expedited grievance resolution, as defined in Policy 6.7: Medicare Member Grievance Policy.

H. Grievances filed that are believed to be a quality of care complaint, will be brought to SWMBH's Chief Clinical Officer (COO) and/or Director Utilization Management and Member Engagement (UM & ME) for further review. If determined to be a quality of care issue, the COO, Director of UM & ME, and/or other clinical senior leader will be involved in the investigation and outcome determination.

I. If the grievance is regarding a quality care issue, member services will respond to the grievance in writing and include a description of the member's rights to file a grievance with the Quality Improvement Organization (QIO), and how to do so.

J. Member Services will document the nature of the grievance and enter the information into the SWMBH MCIS Grievance & Appeals banner as well as enter a "Contact Note" into the Member's Master Record

1. The initial "Contact Note" will outline the nature of the Member's grievance and the proposed next steps Member Services will conduct in order to investigate the grievance.
2. If the grievance was received in a written format, the document will be uploaded to the member's record under "Grievance Request".
3. Member Services will enter information into the following fields under the "Grievance" tab:
    i. Relation to Client
    ii. Date Received
    iii. Received Via
    iv. Complaint Category
    v. About
    vi. Indicate "Grievance" or "Inquiry"
    vii. Member's demographic information
    viii. Complainant's Name and Address if *not* Member
    ix. Staff Involved in Initial Decision
    x. Explain Issue

K. If Member Services determines that the Grievance investigation will exceed ten business days, Member Services will supply the Member and/or his/her authorized representative with a Grievance Acknowledgment Letter.

1. Grievance Acknowledgment Letter will outline the following:
    i. Date and time Grievance was received by SWMBH
    ii. A broad summation of the grievance
    iii. Steps Member Services will take to investigate the grievance
    iv. Deadline that the grievance must be resolved

v. Member's right to a local level appeal if the Grievance investigation exceeds allotted timeframe

L. Member Services will begin investigating the grievance, including any aspects of clinical care involved, by contacting appropriate individuals related to the grievance. This includes, but is not limited to: Facility involved in grievance, Member's clinical team (if appropriate), Supervisory staff at specified facilities, SWMBH Provider Network Department, SWMBH UM Department, SWMBH Compliance Department, etc.

M. Member Services will enter additional information (including date/time of all contacts) in the "Additional Information" field under the Grievance Tab in SWMBH MCIS

N. If Member Services determines that the Grievance should result in consultation or corrective action, Member Services will work with the appropriate Senior Leaders to impart change/corrective action were determined appropriate

O. In the event the member or authorized representative requests an extension, or SWMBH staff involved in the grievance resolution process can justify the need for additional information or documents and how a delay will be in the member's best interest, Member Services will immediately notify the member/representative of the delay in writing including the anticipated date of resolution within the timeframes allowed.

P. Upon resolution of the grievance investigation, Member Services will complete the following procedural steps:

1. Contact the Member to verbally detail the investigation/resolution
2. Complete a "Contact Note" in the Member's master record indicating that the grievance has been resolved, including date/time of resolution
3. Complete the remaining fields in the Grievance Tab in SWMBH MCIS under RESOLUTION:
    i. Additional Information
    ii. Steps Taken; Steps Taken-Comments
    iii. Outcomes; Outcome- Comments
    iv. Date Resolved
    v. If the Member was informed of his/her right to a local appeal or State Fair Hearing (these rights are outlined in the Grievance acknowledgment and resolution deposition letters)
4. Complete and send a Resolution Disposition Letter to all concerned parties, that includes the following information:
    i. Date and time Grievance was received by SWMBH
    ii. Date and time Grievance was resolved by SWMBH
    iii. A broad summation of the grievance
    iv. A broad summation of the resolution
    v. A statement indicating that the Grievance investigation is closed
    vi. Member's right to a local level appeal if the Grievance investigation exceeds allotted timeframe
5. Member Services will upload both the acknowledgment and resolution disposition letters to the Grievance Tab under "LETTER LIST"

IV. Definitions

A. Adverse Benefit Determination: A determination by or on behalf of a member that the treatment does not meet SWMBH's or Medicare's requirements for medical necessity appropriateness, heath care setting, level of care or coverage denial determination based on an exclusion.

B. Grievance: Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare Health Plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. A member or their representative may file the grievance, either orally or in writing, to a Medicare Health Plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame. A grievance includes complaints regarding concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to members, the claims regarding the right of the member to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the member believes he or she is entitled. Additionally, any appeal of a decision that is not about coverage of a benefit and does not meet the definition of an adverse benefit determination, is categorized under this definition of grievance.

C. Quality of Care: The extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centered. A quality of care complaint may be filed through the Medicare health plan's complaint process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

V. References

A. None

VI. Attachments

A. None