Customer Grievances and Service Decision Appeals

Completing Action Notice documents

Southwest Michigan Behavioral Health Prepaid Inpatient Health Plan Serving:	
★ Barry County	*Barry County Community Mental Health Authority*
★ Berrien County	*Berrien County Community Mental Health Authority*
★ Branch County	*Pines Behavioral Health*
★ Calhoun County	*Summit Pointe*
★ Cass County	*Woodlands Behavioral Healthcare*
★ Kalamazoo County	*Kalamazoo Community Mental Health and Substance Services*
★ St. Joseph County	*Community Mental Health and Substance Abuse Services of St. Joseph County*
★ Van Buren County	*Van Buren Community Mental Health Authority*

version 1/12/16

Grievance System Overview

A Grievance System is: Federal terminology for the overall local system of grievances and appeals required for Medicaid beneficiaries in the managed care context, including access to the fair hearing process.

The Grievance System for customers of the SWMBH Mental Health and Substance Use Disorder services includes three components based on what the customer is experiencing.

- **Grievance**
- **Appeal**
- **Recipient Rights Complaint**
    - RR complaints are covered in depth in other training opportunities

Grievance System Overview

Grievances	Appeals	Recipient Rights
Expression of dissatisfaction about service issues, other than an *Action* or protected *Right*.	Request for a review of an Action.	Oral or Written statement alleging violation of rights.
Examples: quality of care or service provided, or interpersonal issues between the service provider and customer. (ie – request for new service provider)	Action is defined as: suspension, reduction or termination of currently authorized services; denial or limited service authorization of requested service; failure to make authorization decision within 14 days. MDCH/PIHP contract attachment P6.3.2.1	Rights as protected by Chapter 7 of Michigan Mental Health Code or Public Health Code, PA 368 for SUD services
Typically addressed by CMH Customer Services Office.	Typically addressed by CMH Customer Services Office. When Customer accesses Administrative Fair Hearing, SWMBH manages the Hearing process.	Typically addressed by the CMH Recipient Rights Office or the RR Office of the service provider for SUD authorized services.

Customer access to the Grievance System

- How do customers learn about these processes?
  - At initiation/orientation to services
    - In SWMBH Handbook
    - In RR booklets/brochures
  - Annually
    - Handbooks/brochures
    - As documented in Plans of Service
  - When/As information need arises
    - On Action Notice documents
  - When requested by customer/authorized representative
    - At point of contact with Customer Services or RR offices
  - Via posters/flyer in common areas of service sites

Filing a Grievance or Appeal

- Federal Requirements for the Grievance System ensure that any Grievance or Appeal filed are based on the preferences of the customer and not any other individual or agency providing services.
- Who can file a Grievance or Appeal?
  - Customer
  - Legal Guardian
  - Parent of Minor
  - Authorized Representative – an individual given written permission to act for the customer in any grievance or appeal
    - Providers can file FOR a customer if they have been granted status of Authorized Representative by the customer. If not the representative, providers can provide help/assistance to customer but not speak FOR them.

Grievances

- Grievances can be filed at any time – there are no time limits.
- Any person served or their authorized representative may file a grievance. Providers can assist or file on behalf of a person served with written permission from that person.
- A grievance may be filed over the phone, in person, or in writing. All methods are acceptable.
- Customers should be prepared to describe their situation and provide what they feel a fair resolution will be.
- Note, even when "resolved" there may be times in which a PIHP/CMH cannot fully solve the grievance to the 100% satisfaction of the customer.

Grievance Processing

- PIHP/CMH agency responsibilities for Grievances filed:
  - Provide assistance to the customer throughout the process by answering questions and completing any necessary documents.
  - Provide prompt resolution/response.

    (The maximum time allowed is 60 days.)
  - Provide assurance that individuals involved were not part of an initial situation the grievance is regarding.
  - Provide a mechanism for expedited response.
  - Provide written resolution: for each grievance filed a letter stating the resolution is sent to the individual.
  - Keep records of grievance - for improvement purposes and PIHP/State review.

- If the CMHSP/PIHP fails to respond to a grievance within 60 calendar days, it can become an “action” that can be “appealed” by an individual served.

Appealable "Actions" defined

- Denial of requested service(s)
- Limited authorization of requested service(s)
  - Less (in amount/scope/duration) than requested
- Reduction in current service(s)
- Suspension of current service(s)
- Termination of current service(s)
- Delay in providing authorized/approved services
  - If over 14 calendar days from agreed upon start date
- Grievance of over 60 calendar days to complete
- Previous appeal over 45 (30) calendar days to complete
- To deny payment for a service NOT previously authorized

Specific local action/appeal Second Opinion

As directed by the Michigan Mental Health Code, any customer who is denied:

- access to community mental health services upon initial screening/assessment
- Access to psychiatric inpatient hospitalization

has the right to request a second opinion regarding that decision. Second Opinions are managed by the local community mental health organizations.

This process will include review of the service denial and must be done by appropriately credentialed clinician NOT already involved in the denial. The local CMH process should include:

- Discussion with customer about any changes to their circumstances or information that they feel was not presented initially
- Document review and/or further assessment
- Communication with customer regarding determination within 5 working days for access denial and within 3 working days for hospital denial.

Notice of Action

There are THREE instances of Action communication to customers:

- Person-Centered or Treatment Plan Development
  - The Notice provided in this instance is “Adequate”.
- Person-Centered Plan Addendum or Treatment Plan Revision
  - If the Addendum/Revision is making changes (ie: reduction or termination) of services identified on the Plan and currently being provided then “Advance” Notice is required.
  - If Addendum/Revision is adding services or replacing previous services, “Adequate” Notice is required.
- Actions taken outside of the Planning Process
  - If ever a Utilization Management decision is made outside of the Planning process, and the decision will effect the current Plan services, “Advance” Notice is necessary.

Providing Notice

- All Notices should be addressed/written to:
  - The Customer
  - Customer's legal guardian if applicable
  - Customer's parent if a minor child
    - Unless another *authorized representative* has been appointed to speak for the customer, the customer/guardian/parent will be the individual filing appeal about the Action taken.
  - Whenever mailed, Notice should be sent to the last known address on file/record for the customer or guardian or parent.

Giving Notice with: *Person Centered* or *Treatment* Plan

- Because Plans have **specific start and end dates** of goals/objectives and the services provided to meet them, "Advance" Notice is not necessary when full Person Centered or Treatment Plan is completed. Even if services that were previously in place are targeted for reduction, suspension or termination. In writing the Plan, the team is agreeing on the new start date for services. And, the old services have expired according to "plan".

- Adequate Notice of the right to appeal the services contained in the plan is required. Typically in SWMBH service network, Notice is part of the Plan document from the EMR or can added as a "static" last page to any Plan if not already included. (This is also true for any Plan Addendum or Revision documents.)

- Customers can file an appeal regarding the services contained in the Plan if not satisfied with how Plan is devised.

Giving Notice with:
Plan *Addendum* or *Revision*

- The Addendum or Revision is a formal change to what was agreed upon in the Plan – could effect amount, scope or duration of currently authorized services. In essence, what was promised in the Plan is changing.

- For the protection of due process rights of the customer and protection of the agency writing the addendum, "Advance" notice is recommended whenever an addendum/revision is reducing, suspending or terminating the already agreed upon amount/scope/duration of services. The addendum/revision could be signed today (ex. May 30) and in the addendum/revision the start date for any modified goals/objectives and the services intended to meet them could be identified to start 12 days into the future (ex. June 11).

Giving Notice with:
Plan *Addendum* or *Revision*

- Note, if an addendum/revision is reducing, suspending or terminating currently authorized services AND is also adding new services to replace the current services, (or even simply adding new services) then "Adequate" Notice is sufficient. The team will be agreeing on the start date of the new service. Adequate Notice is necessary.

- If an appeal regarding services changes in an addendum/revision is requested by customer/guardian within the 12-day "Advance Notice" time period, AND the customer/guardian requests services to continue as in Plan, the service changes as outlined in the addendum are <u>not</u> to take effect pending the outcome of any appeal.

Giving Notice outside of Service Planning Process

- Action Notice is necessary any time a Utilization Management or Service Authorization decision is made to:
  - Deny services requested in addition to the Plan
    - "Adequate" Notice (meaning asap after decision made) is required
  - Reduce, Suspend, Terminate currently authorized services
    - "Advance" Notice (of 12 calendar days prior to Action) is required

- Notice must include (and documents provide prompts for):
  - Name/ID # of customer
  - Date of Action and for "Advance" Notice – effective date of change
  - Name of Service(s) affected
  - Reason for Action (why we are giving this "no" message)
  - Due Process rights for available appeal processes

Adequate Notice of Action

Timing- At the time of a decision/action:

* To deny payment for a service NOT previously authorized
* To deny initial authorization for mental health or substance services
* To deny a requested service
    - Typically, the Effective Date to indicate on the documentation is the same date as the date the Notice is completed – but not to exceed 14 calendar days from request

- Adequate Notice – as previously noted, is part of the process for development and alteration of a *Person-Centered* or T*reatment* Plan.

Advance Notice of Action

Required Timeframe - Must be given <u>at least 12 calendar days prior</u> to the action date for

- Actions taken against currently authorized services:
  - Termination
  - Reduction
  - Suspension
- So, the Effective Date of the Action indicated on the Notice document will be at least 12 calendar days into the future of the date the Notice form is completed.

- The purpose of the Advance timeframe is to allow customers to receive the information and determination if they would like to appeal PRIOR to the action occurring.
  - The MH/SUD service system has responsibility to continue services during appeal period … see “Appeals/Service Continuation”

LIMITED Exceptions to Advance Notice

- Unless noted, Adequate Notice form is still necessary when . . .
  - the provider/CMHSP/PIHP has factual information confirming customer death (no notice necessary)
  - a customer provides a clear, written and signed statement that s/he no longer wishes services. This can be a signature on the Notice form itself.
  - a customer has been admitted to an institution where s/he is ineligible for further authorization of current services (for example, jail, nursing home)
  - a customer's whereabouts are unknown and the post office returns mail with no indication of forwarding address. Attempt to mail Notice must be made. Please keep returned mail in records.
  - a customer has been accepted for services by another CMHSP/Provider/PIHP
  - if a reduction/suspension/termination/increase is according to the customer's Person-Centered Plan, no notice necessary - the consumer was given notice with their Plan. Plan had end date(s)
  - the change in services is a decision made by the customer's physician/psychiatrist providing treatment.

Exceptions to Advance Notice

Cont'd:

- in case of an imminent health or safety concern, services can be suspended **immediately** with adequate Notice given to the individual that includes documentation of the seriousness of the issue added.

  If the intention of such Notice is to terminate the services, the termination can be indicated on the same Notice form. This Notice must be clear on the intent of suspension leading to termination. The effective date of the termination would be 12 calendar days from the date suspension began. To keep the service, the individual must appeal during the 12-day suspension period.

Completing Action Notice Document

Outside of Service Plan/Addendum/Revision

For Notices, the Action Taken MUST be indicated. Below are the typical Actions communicated throughout SWMBH that require Adequate Notice – as the services referenced are not currently authorized.

The Action we have taken is:
□ Service(s) Authorized If your PC Plan document has Notice included at the end, please do not use this Notice form at PC Planning.
□ Limited Service Authorization (less than requested) *May not be on all versions of the form.* Use when a service is NOT being authorized as requested – typically if lesser than requested is authorized.
□ Undue Service Delay (over 14 days from agreed start date) *Form may say: Delayed 14 Days on Notice.* If service not starting "on time" per what was agreed to in the plan of services/addendum
□ Failure to provide timely authorization decision / Notice *May not be on all versions of the form.* If a decision has not been made w/in 14 days about a service that was requested.
□ Service(s) Denied: System denies the service as requested. □ At time of application/intake □ Requested Inpatient service □ Services in addition to Plan *Not all versions of the form may have the 3 denial junctures specifically stated on the form.*
□ Authorized per your Person-Centered Plan revision *If your PC Plan document has Notice included at the end, please do not use this Notice form at PC Planning.*
□ Other: Please list any other reason *Please contact Customer Services if ever you have a situation that you believe may require notice but are unsure of how to complete the Action Taken section.*

Completing Action Notice

Outside of Service Plan/Addendum or Revision

For Notices, the Action Taken MUST be indicated. Below are the typical Actions communicated throughout SWMBH that require Advance (12 calendar day) Notice before the Action can be taken – because they are regarding services that are already authorized:

The Action we have taken is:
□ Reduction in Current Services. Less of a current Service will be provided as of the Effective Date on the Notice. (fewer hours/week or sessions/month for example)
□ Suspension of Current Services Use when a service is being put "on hold" for a while. The start of the suspension requires Notice.
□ Termination of Current Services. Current service(s) are ending as of the Effective Date on the Notice.

Completing Action Notice

Outside of PC Plan/Addendum

For Notices, the Reasons for Action MUST be indicated. Below are the typical Reasons communicated throughout SWMBH. Note, not all notice versions may have exact wording or order of reasons.

The Reason for this Action is:
□ Clinical Eligibility not met. Indicating to customer that their situation does not qualify them for CMH/SUD service funding. They are "above" the presentation typical for individuals receiving services.
□ Medical necessity not met. Indicating that the service they are requesting is not identified as appropriate treatment at this time.
□ Other resources are available Indicating that another funder (insurance source) can provide funding for the same services as are being requested. The CMH system is known as the "funder of last resort"
□ Residency To indicate that the CMH is not responsible for service funding/authorization because the individual lives in another county or is in an institution (jail, nursing home) that has responsibility for providing services.
□ Plan of Service goals have been met. Your Individual Plan of Service goals and objectives have been met. If this is the case, the individual has no medical necessity for services. This type of notice is not necessary if the goals/objectives are met according to the date(s) on the Plan of Service, but necessary if accomplished outside of those dates.
□ Lack of Capacity to Benefit. For times in which an individual has been receiving the same level of services for a long time (2+ yrs) and no observable progress is being made. There is a long period of stability with symptom management.

Completing Action Notice

Outside of PC Plan/Addendum

For Notices, the Reasons for Action MUST be indicated. Below are the typical Reasons communicated throughout SWMBH. Note, not all notice versions may have exact wording or order of reasons.

The Reason for this Action is:
□ Lack of Participation Typically if an individual is not participating, the case should be closed at 3 months no contact at **the latest.** And, if no services in 3 months, a new eligibility screen is necessary. Sending this type of notice if no contact in 1 month will allow the individual to choose to engage or not before a new screening is necessary.
□ You have asked for this action to occur. For times in which an individual asks to change already authorized services. For termination of services, **if** the individual signs the notice below, the termination of service(s) can occur with adequate "now" notice and happen on the date the notice is signed. 12-day Advance notice is not necessary in this instance – however 12-day Advance notice is necessary if the request to end services was made and no signature from the individual is available. (example if a person asks for services to end while on the phone and cannot sign a document to attest to their request).
□ Service requested is not provided by (AGENCY NAME). Indicating that the service they are requesting is not a service provided by the agency sending Notice. Again, not all SWMBH versions of the Action Notice may have this reason for Action included.
□ Other: Please list any other reason *Please contact Customer Services if ever you have a situation that you believe may require notice but are unsure of how to complete the Reasons section.*

Medicaid Status

For purposes of Actions/Notice forms and Appeals, a **Medicaid Beneficiary** includes an individual who has any of the following:

- "Straight" Medicaid
- Healthy Michigan
- All Medicaid Health Plans
- Medicaid Deductible/Spend Down

- Notice forms are designed to be specific for Medicaid status. Customers who are not Medicaid beneficiaries (GF or BG) have a separate form and different appeal rights.

  Note: The GF/BG Notice was designed to be completed in the same manner as the Medicaid Notice.

Appeals/Service Continuation

Medicaid services that were previously authorized, must continue when a local level appeal and/or the State Fair Hearing are pending if:

- The member specifically requests to have the services continued; **and**
- The request is made within 12 calendar days; **and**
- The appeal involves the termination, suspension, or reduction, of the previously authorized course of treatment; **and**
- The services were ordered by an authorized provider; **and**
- The original period covered by the original authorization has not expired
- The member withdraws the appeal; **or**
- 12 days after mailing the notice of disposition following a Local Level Appeal (unless within that time they request a State Fair Hearing); **or**
- The State Fair Hearing office issues a hearing decision adverse to the member; **or**
- The time period or service limits of the previously authorized service has been met

Processing Local Appeals

- Filed by the customer against the PIHP/CMH agency that took an action to deny, reduce, suspend, or terminate a service as requested or authorized. The local appeal process:
  - Provides assistance to the customer throughout the process by answering questions and completing any necessary documents.
  - Assures that the clinical reviewer for the appeal was not involved in initial decision(s) to authorize services to the individual, or to take the Action in question. The clinician must have appropriate experience and credentials to make a determination about the services in question.
  - Provides a written acknowledgement of the appeal.
  - Provides written resolution to the appeal within 45(30) calendar days of the date the local appeal was filed/requested. For each appeal filed, a formal letter is sent.
    - The letter includes the disposition, reasons for disposition, and the next steps the individual can take if the disposition is not wholly in their favor.

State Appeal Processes

- Administrative Fair Hearing
  - Impartial state level review of a **Medicaid Beneficiary's** appeal of an action presided over by an Administrative Law Judge. Medicaid beneficiaries can request a hearing simultaneously with Local Appeal, after a local decision is reached, or instead of a local appeal. The Michigan Administrative Hearing System (MAHS) is the oversight body.

- MDCH Alternative Dispute Resolution Process
  - Impartial state level review of an appeal presided over by MCHHS staff. This process is for **customers without Medicaid**. It can be accessed only after a local appeal is exhausted and the customer is not satisfied with the result.

Administrative Hearing

- Customer must request Hearing within 90 days of the written Notice of Action given to customer about the action in question.
- All parties have opportunity to present evidence via testimony and documentation to the administrative law judge (ALJ)
- Customers can have a representative speak for them after giving written permission to the rep.
- The ALJ reviews all evidence and issues a *Decision and Order* of the case within 90 days of hearing
- Decision and Order will be based on federal and state Medicaid program guidelines

Alternative Dispute Resolution

- Must be requested of MDHHS within 10 days after local CMH appeal decision is received
- All parties have opportunity to submit written information to MDHHS for review
- Decision of MDHHS will be made with consideration for current MDHHS policies and procedures regarding the provision of service to individuals who are not Medicaid beneficiaries

Expedited Appeal Requests

- Customers of the SWMBH network can request that their request for appeal be handled in an expedited manner.
  - This is true for both local appeals and Administrative Hearings.
- The Action Notice document provides information to customer about this option by offering that the request for expedited appeal be based on their belief that a traditional appeal time frame of 45(30) calendar days would jeopardize their life, health or ability to attain/maintain/retain maximum function.
  - The Agency processing the appeal will be responsible to evaluate such a request and communicate back to the customer if the appeal will be addressed as expedited or not.

Involving Customers in Service Decisions – avoiding grievances/appeals

- How can SWMBH network staff work to demonstrate active involvement in customer care and maybe avoid or limit the numbers of Grievances/Appeals (and even RR complaints) filed by customers …?
  - By involving the customer in decisions about their treatment – starting with the assessment process
  - By discussing service discharge criteria from services as a measure of recovery/growth at the onset of services
  - By negotiating for other medically necessary service alternatives when services requested by a customer do not match the customer's needs
  - By asking the consumer frequently (at least at periodic review) whether they are satisfied with services and working with customer to address areas of improvement are identified
  - By reviewing the Plan of Service with the consumer so that the goals and objectives continue to be appropriate and are still meeting customer expectations

Customer Service Contacts

If you have any questions, please contact Customer Services.

County	CS Representative	Phone
Barry	Deb Brice	(269) 948-8041
Berrien	Melissa Ludwig	(269) 934-3478
Branch	Shirley Nystrom	(866) 877-4636
Calhoun	Michele Pascoe	(877) 275-5887
Cass	Mary Munson	(800) 323-0335
Kalamazoo	Teresa Lewis	(877) 553-7160
St. Joseph	Michelle Heffner	(855) 203-1730
Van Buren	Lisa King	(269) 655-3365
SWMBH network	Ashley Esterline/Courtney Dunsmore	(800) 890-3712

Southwest Michigan BEHAVIORAL HEALTH