

Centra Wellness Network (CWN) Grievance and Appeals Training

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is used by Centra Wellness Network
with her express written permission.

Grievance and Appeal Training

Purpose - To provide workforce members with the knowledge and understanding of a client's right to make grievances and to request appeals.

Objective – Workforce members are knowledgeable on providing clients with:

- 1) The correct notices when actions are taken that affect a:
 - a. New applicant's request for services
 - b. Client's current service(s) or request for additional service(s)
- 2) Information on when and how clients file
 - a. Grievances
 - b. Appeals



Grievance and Appeal rights are based on the law and policies

All CWN clients and applicants for services have the right to make a grievance and/or to request an appeal. The processes for Medicaid enrollees are slightly different from those clients without Medicaid. The following mandates provide the legal basis for the processes and procedures that CWN follows.

MEDICAID STANDARDS

- 42 CFR (Code of Federal Regulations)
- Medicaid Managed Specialty Supports & Services Concurrent 1915(b)/(c), Waiver Program Contract, Attachment P6.3.1.1 Grievance and Appeal Technical Requirement
Attachment P4.4.1.1 Person Centered Planning Policy
- PIHP Grievance and Appeal Policy
- CWN Grievance and Appeals Policy 03.22

NON-MEDICAID STANDARDS

- Michigan Mental Health Code, Chapter 7, Recipient Rights
- MDHHS/CMHSP Managed Mental Health Supports and Services Contract
Attachment C6.3.2.1 - CMHSP Local Dispute Resolution Process
Attachment C6.3.2.2 – CMHSP Family Support Subsidy Process
- CWN Grievance and Appeal Policy 03.22



Definitions

- **Action:** Sometimes referred to as an adverse benefit determination. A CWN decision that impacts a client's claim for services (new or existing): i.e. denial, reduction, suspension or termination of services, etc.
- **Adverse Benefit Determination:** A decision that adversely impacts a Medicaid Enrollee's claim for services. See page 11 for various decision types.
- **Appeal:** a request by a client or their representative (with the client's written permission) to review an action or adverse benefit determination by a CWN provider. A review at the local level by a PIHP/CMHSP of an adverse benefit determination.
- **Client:** Broad, inclusive reference to an individual requesting or receiving mental health services. May include parent(s) of minor child, guardian, or a new applicant to services.
- **Grievance:** Client's expression of dissatisfaction about any matter other than an action/adverse benefit determination or a recipient rights complaint. Examples could include, but are not limited to quality of care or services provided, or interpersonal relationships between a provider and clients.

Definitions (cont'd)

- **Individual Plan of Service (IPOS)** – “A written IPOS directed by the individual as required by the Mental Health Code. This may be referred to as a treatment plan or a support plan”*. Created by the client and provider using a person-centered planning process.
[*Person-Centered Planning Guideline Attachment P4.4.1.1]
- **Provider:** An individual (e.g. case manager, outpatient therapist) directly employed by CWN who provides services to a client; **or** an individual or organization (e.g. psychiatrist, crisis residential services) contracted by CWN to provide services to a CWN client. CWN workforce members are referred to as providers in this training.
- **Service Authorization** – CWN process of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, scope, or duration or less than requested, all as required under applicable law.

Is the Client a Medicaid Enrollee?

For purposes of Actions / Notices / Appeals / Grievances, a client who has any of the following, will answer this question with a “Yes”.

1. Medicaid (sometimes referred to as “fee-for-service” or “traditional” Medicaid)
2. All Medicaid Health Plans (MHP - i.e. Meridian, Molina, etc.)
3. Healthy Michigan Plan (Expanded Medicaid)
4. Medicaid Deductible/Spend-down (see **NOTE** below)
5. Michigan Medicaid Waiver Programs including:
 - a. Habilitations Supports Waiver (HSW)
 - b. Children’s Waivers [does not include MI-Child]

NOTE: The Medicaid deductible (spend-down) must be met monthly in order for a client to qualify for Medicaid. If the client has **not** met their deductible/spend-down at the time you are providing a Notice, provide a **NON**-Medicaid Notice.

Grievances provide a way for clients to express concerns

Grievances are expressions of dissatisfaction about any matter other than an action or a recipient rights complaint. Examples could include, but are not limited to quality of care or services provided, or interpersonal relationships between a provider and client.

- If a provider of services is unable to provide a resolution to an issue or concern with a client, the provider should notify the client of their right to contact the provider's supervisor and/or Customer Services staff to consult with them and/or to file a grievance.
- Clients (including parents of minors and guardians) may file a grievance at any time either orally or in writing with the Customer Services staff
(CWN Customer Service Representative is Jan Chandler).
- The provider is expected to provide assistance to the client in contacting Customer Services as necessary.
- Providers can also help clients write a letter or use a Grievance form to express their grievance. Grievance forms are available at each CWN site and from Customer Services staff.



Grievances continued...

- Any client may file a grievance at any time – there are no time limits
- Providers can only file a grievance on a client's behalf with the client's written permission.
- The Grievance and Appeal (G&A) Coordinator will submit the grievance to appropriate staff including the supervisor of the affected service, the Clinical Director and/or the Director of Customer and Provider Services, all who can request corrective action.
- The G&A Coordinator must provide a written acknowledgement to the client within 5 business days notifying them that their grievance was received. After a resolution or other outcome has been reached, a disposition letter is sent to the client; within 90 calendar days for Medicaid beneficiaries and within 60 calendar days for Non-Medicaid clients.
- Supervisors should refer client to the G&A Coordinator when they are unable to reach a mutually agreeable resolution to a client's concern or when in their judgment it is preferable to have the G&A Coordinator involved.
- Customer Services staff will forward grievances that are allegations of Recipient Rights violations to the Office of Recipient Rights.

Actions and Service Decisions

Actions or Adverse Benefit Determinations (Medicaid term) are about **SERVICE** decisions.

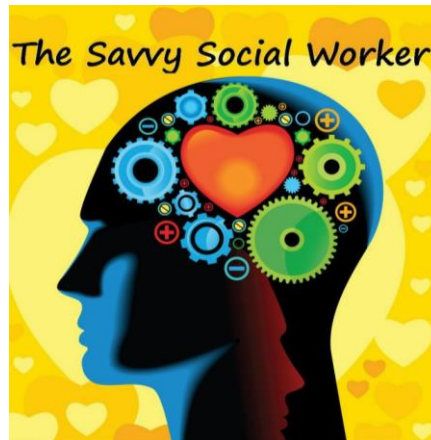
- Service decisions are based on clients meeting medical necessity criteria for community mental health service programs. See page 11 for the various types of service decisions that are made.
- A **Notice** about an action or service decision is required any time a new service decision is made. Decisions can include:
 - denying a request for a new service (including inpatient hospitalization)
 - denying or authorizing a change in service (i.e. amount, scope or duration).
 - authorizing or re-authorizing services on an IPOS or IPOS addendum.
 - reducing, suspending or terminating existing services.



Actions and Service Decisions

WHO makes decisions and provides notices to clients?

- Clinical staff providing intake assessment services staff provide notice when a decision is made to deny their request for initial services with CWN.
- Various work force members (i.e. Day and Night Crisis Staff, primary case holders) provide notices to clients/community members requesting inpatient hospitalization.
- The client's primary worker/provider (i.e. case manager, therapist, RN, etc.) or the CAPS Director worker provides notices to existing clients when a decision is made, or an action is taken, that affects the client's existing services or request for additional services.



Actions and Service Decisions

The notice serves to notify clients of:

- A decision or action that was taken or about to be taken that will affect their current services or their request for new or additional services.
- Their right to file an appeal and how to do it, if they do not agree with the decision.



Time Frames for Providing Notices

Adequate Notice

is handed or mailed to the client or applicant **at the time** an action decision is made or at the time that the IPOS has been finalized and authorized.

- Notice Date – the date the Notice is mailed or handed to the client.
- Effective Date – the same date as the Notice Date.

There are no differences in Adequate Notice date requirements for clients with Medicaid and Non-Medicaid



Time Frames for Providing Notices

Advance Notice

is handed or mailed to the client **before** the action is due to take effect that will affect a client's existing services.

Notice Date – the date the Notice is mailed or handed to the client.

Effective Date –

1. For **Medicaid** enrollees the Effective date is **10** calendar days after the Notice date

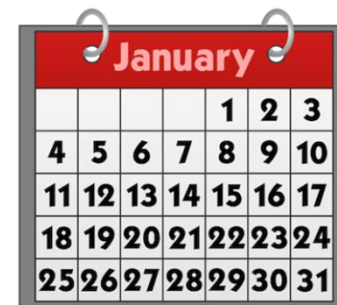
Example: If the Notice date is January 1, then the Effective date is January 11.

2. For **NON-Medicaid** clients the Effective date is **30** calendar days after the Notice date.

Example: If the Notice date is January 1, then the Effective date is January 31.

The elapsed time between Notice date and Effective date allows the client time to request an appeal:

1. before services are affected, and
2. to request that services continue during the appeal process, if they are a Medicaid enrollee.



CWN Adequate & Advance Notice of Adverse Benefit Determination Requirements

| Service Event | Action | Time frame for Notice | How Given |
|--|--|---|-------------------------------------|
| Denial or limited authorization of a requested service, including initial services and hospitalization. Includes determinations based on the type of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. | ADEQUATE NOTICE Denial or limited authorization of requested service | Within 14 days following receipt of the request for service | In person or mailed, as appropriate |
| IPOS developed or modified and authorized - Agreement to add, remove or change services, or to existing services changed in amount, scope, duration | ADEQUATE NOTICE Services Authorized - | At the time of action | In person or mailed, as appropriate |
| Previously authorized services: <ul style="list-style-type: none"> • reduced in amount/scope/duration • suspended • terminated | ADVANCE NOTICE Reduction, suspension or termination of a previously authorized service | 10 calendar days before action* 30 days for Non-Medicaid See "Exceptions to Advance Notice Rule – Medicaid Enrollees" on next page. | In person or mailed, as appropriate |
| Denial, in whole or in part, of a payment for a service. | ADEQUATE NOTICE Denial | At the time of action. | In person or mailed, as appropriate |
| 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 | ADEQUATE NOTICE Failure to make a standard decision with 14 days of request. | At the time that it is known that the 14 days timeframe will not be met. | In person or mailed, as appropriate |
| Failure to make an expedited Service Authorization decision within 72 hours after receipt of a request for expedited service authorization. | ADEQUATE NOTICE Failure to make an expedited decision within 72 hours. | At the time that it is known that the 72 hour timeframe will not be met. | In person or mailed, as appropriate |
| Failure to provide services within 14 calendar days of the start date agreed upon during the person centered planning and as authorized the by the PIHP/CMHSP | ADEQUATE NOTICE Failure to provide services in 14 days | At the time that it is known that the services will be delayed more than 14 days from the agreed upon start date | In person or mailed, as appropriate |
| Failure of the PIHP/CMHSP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. | ADEQUATE NOTICE Failure to resolve an appeal request within 30 days. | At the time that it is known that the appeal will be delayed more than 30 calendar days from its receipt | In person or mailed, as appropriate |
| Failure of the PIHP/CMHSP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal. | ADEQUATE NOTICE Failure to resolve an expedited appeal request within 72 hours | At the time that it is known that the expedited appeal will be delayed more than 72 hours from its receipt | In person or mailed, as appropriate |
| Failure of the PIHP/CMHSP to resolve grievances and provide notice within 90 calendar days of the date of the request. | ADEQUATE NOTICE Failure to resolve a Grievance within 90 days | At the time that it is known that the grievance will be delayed more than 90 calendar days from its receipt | In person or mailed, as appropriate |
| For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right to obtain services outside the network. | ADEQUATE NOTICE Denial to obtain services outside the network | At the time of the action | In person or mailed, as appropriate |
| Denial of a Medicaid Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles coinsurance and other Enrollee financial responsibility. | ADEQUATE NOTICE Denial of payment | At the time of action | In person or mailed, as appropriate |

G&A notice requirements authority: 42CFR Part438 and MDHHS/CMHSP Managed Mental Health Supports and Service Contract P6.3.1.1 FY'18) 1/2018rr

Time Frames for Requests and Resolutions of Grievances and Appeals

| TYPE of REQUEST | TIMEFRAME for Consumers' Requests | TIMEFRAME for CMH / MAHS/ MDHHS to provide a resolution |
|---|--|--|
| MEDICAID | | |
| Grievance P6.3.1.1 (p. 14) | Any time | Within 90 calendar days from receipt of the grievance (orally or in writing) - CMH |
| Local Appeal P6.3.1.1 (p. 10) | "60 calendar days from the date of the Notice" | Within 30 calendar days from receipt of appeal request (orally or in writing) - CMH |
| Fair Hearing with the Administrative Tribunal - MAHS P6.3.1.1 (p.15, 26) | "120 calendar days from the date of the applicable [CMH written] notice of [Local Appeal] resolution." | Within 90 calendar days from receipt of hearing request - MAHS |
| To request that existing services continue during the Local Appeal/Fair Hearing Process P6.3.1.1 (p. 9) | Local Appeal - on or before the latter of: 1)10 calendar days from the date of the Advance notice , or 2) the intended effective date of the Notice. Fair Hearing - Within 10 calendar days after CMH sends Notice of Local Appeal Resolution | |
| NON-MEDICAID | | |
| Grievance C6.3.2.1 (p.2) | Any time | Within 60 calendar days from receipt of the grievance (orally or in writing) - CMH |
| Local Appeal / Dispute Resolution C6.3.2.1 (p.2) | "30 days from the time Notice is received." | Within 45 calendar days from receipt of appeal request (orally or in writing) - CMH |
| Alternative Dispute Resolution with MDHHS C6.3.2.1 (p.5) | "10 days from the [CMH] written notice of the Local Dispute Resolution Process outcome." | "Within 15 business days" from receipt of consumer's written Alternative Dispute Resolution request for review - MDHHS |

P6.3.1.1 – FY'18 DHHS Grievance and Appeal Technical Requirement (Medicaid)

C6.3.2.1 – FY'18 DHHS CMSHP Local Dispute Resolution Process (General Fund/Non-Medicaid)

1/17/18 NLCMH rr

Person Centered Planning and Adequate Notice

- When an Individual Plan of Services (IPOS) is due to expire, the client is required to have a Person Centered Planning (PCP) meeting prior to the Plan's expiration date.
- At the PCP meeting the client and provider discuss whether the client has satisfactorily met their goals. If additional services and goals are assessed as being needed and agreed to by both the client and provider, a new IPOS is developed.
- An Adequate notice must be attached to the authorized IPOS. The Notice notifies the client of their appeal rights if they are not satisfied with the IPOS as completed or revised.
- If a service(s) is not approved or is approved in an amount, scope or duration (level) that is different than what the client is requesting, an Adequate Notice must be provided. The Notice identifies the new service(s) or the new level of an existing service that was requested, but is being denied. The IPOS must be clear as to which service(s) was requested but denied; or was authorized at a lesser (or greater) amount, scope or duration than what was requested.



Person Centered Planning and Advance Notice

- If the client and provider meet and agree that the client's goals have been satisfactorily met, the provider ensures coordination to the next least restrictive level of care or prepares a discharge document, ensuring coordination of any necessary outside services takes place.
- If the client has not participated in a completing their discharge summary, an Advance notice must be mailed to the client notifying them that their services have been terminated regardless if the IPOS has expired or not and regardless if they made a request to be closed by phone.
- If the client does not agree to having a service(s) reduced, suspended or terminated, during a PCP/IPOS Meeting, an Advance Notice must be created to provide the client their Appeal rights. The Notice identifies which existing service(s) the client does not agree to have reduced, suspended or terminated and the effective date.
- The Effective date must be 10 days (30 days for Non-Medicaid) after the Notice date of the service action. Do not extend the Effective date beyond 10 days after the Notice date. Medicaid beneficiaries can only ask for continuation of their services during an appeal if they request them within 10 days of the Notice date.
- Medicaid enrollees have 60 days from the date of the Notice to request an appeal. For clients without Medicaid it is 30 days.
- Notices must be mailed or handed to the client on the Notice Date.

Before Providing Advance Notice

Before the provider sends out an Advance Notice notifying a client that their current service(s) will be terminated, they need to ensure that the CWN medical records clearly document and identify why services are being terminated. Some examples may include:

- Lack of medical necessity for the service as determined by an assessment of the client's needs by a qualified professional.
- Current institutional residence that prohibits CWN authorization for services.
- The client is not participating in services as authorized in their IPOS.
- The client has not responded to outreach contacts.
- Attempts were made to assist with and encourage the client to follow the goals and receive the services which they requested and were authorized.
- The provider's supervisor has reviewed and approves the service termination.

NOTE: When a client is provided notice that their services are being terminated, their case cannot be closed prior to the effective date on the Advance Notice.

Notices: Required Information, Signatures and Dates

There is various information, signatures, and dates required on the Notices and is included in our CASPER generated notice documents:

- **Client Name and Client ID #** are required.
- **Notice has been Provided to** information is the name of the person who the notice is given to: client, guardian, or parent.
- **Notice Date** is the date the Notice is provided (handed to or mailed out) to the client. This date cannot be pre- or post-dated.
- **Via mail or in person** documents how the provider provided notice to the client.
- **Action/decision** (i.e. denied, IPOS completed, terminated) – choose the correct action/decision that has or will occur.
- **Name of Services Affected** – Identify the service(s) for which notice is being given.

Notices: Information, Signatures and Dates (cont'd)

- **Effective Date** is the date the action takes place.
 - 1) On an Adequate Notice the Notice date and Effective date is the same date.
 - 2) On an Advance Notice the Effective date is 10 calendar days after the Notice date for Medicaid enrollees; thirty (30) calendar days for Non-Medicaid.
- **Reason** is the reason for the action. Use language that is clear and understandable to the client. Do not use acronyms (i.e. SMI, IPOS, SED, LOCUS)
- **Workforce member Signature and Date** is the date the CWN provider signs the Notice with their credentials. This date should be the same date as the Notice date. But is always the actual date that it is signed.

Note: The Notice must have all fields filled in.

Notices: Required Information (cont'd)

The **notice of Adverse Benefit Determination (Medicaid)** must meet the following requirements:

1. 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," 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 service decision made];
4. The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;
5. Notification of 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 (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);
6. Notification of the Enrollee's right to request an Appeal, including information on exhausting the PIHP's single local appeal process, and the right to request a State Fair Hearing thereafter;
7. Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal;
8. Notification of the Enrollee's right to have benefits continued 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");
9. Description of the procedures that the Enrollee is required to follow in order to exercise any of these rights; and
10. An explanation that the enrollee may represent himself or use legal counsel, a relative, a friend or other spokesperson.

Appeal Process

Notices are mandated documents, notifying clients of their right to “appeal” an CWN “action” or decision that will affect their current services or request for new or additional services.

Due Process: refers to **legal** protection or rights given to individuals under the law. Due process for clients includes providing:



- 1) prior written **notice** of the Action
- 2) **different levels of appeal** before an impartial decision maker
- 3) **continued benefits (Medicaid)** pending a final decision
- 4) a **timely** decision

Local Appeals Process – Medicaid

- The first level of appeal for clients is at the local CMHSP level. Clients must use the local level process before asking for a state Fair Hearing.
- Clients have **60** calendar days from the “Notice Date” to request a Medicaid local appeal.
- Oral requests for appeals will be accepted and will act as the date the appeal request is officially received. However, the oral request must be followed up in writing with a Request for Local Appeal.
- Appeals are coordinated by the Grievance and Appeal Coordinator in the Customer Services Office.
- Staff can provide clients with a “Request for Local Appeal” or the Grievance and Appeal (G&A) Coordinator will mail one to them after verbal contact with the client.

Local Appeals Process – Medicaid (cont'd)

- The G&A Coordinator will notify the appropriate staff (Supervisor, Director of the services involved, CAPS Director) who will assign a qualified staff person to provide the local appeal review, who
 1. has the appropriate clinical expertise, and
 2. was not part of the original decision process.
- CWN has **30** calendar days from the date the local appeal request was received to provide the client with a written Notice of Local Appeal Resolution.
- Requests for expedited appeals will be honored if waiting for a standard time would seriously jeopardize the client's life or ability to attain, maintain or regain maximum function. Expedited appeals, if approved, must be resolved within 72 business hours.
- Clients can also file a rights complaint in response to actions taken by CWN.
- Applicants to new CWN services do not have rights as recipients to use the Rights process, but they can request a local appeal or second opinion (discussed later).

Fair Hearings - Medicaid

- Clients with Medicaid have the right to request a Fair Hearing only after utilizing the Local Appeal process first.
- Clients can ask for a fair hearing within **120** calendar days from the date of the CWN Notice of Local Appeal Resolution.
- The CWN Fair Hearing Officer will create a Hearing Summary to submit to the Administrative Tribunal/Administrative Law Judge and to the client prior to the Hearing.
- The Hearing Summary is based primarily on documentation in the client's CWN medical record.
- Providers may be asked to attend hearings to provide oral testimony.
- Fair Hearings are also referred to as Administrative Hearings and are handled by the Michigan Administrative Hearing System (MAHS).



Continuation of Services when Advance Notice is given - Medicaid

- If a client with Medicaid requests a local appeal on or before the latter of: 1) 10 calendar days from the date of the Advance notice, or 2) the intended effective date of the Notice, they may request to continue their services until a decision is provided.
- The client must be advised at the time the request is made that if the appeal decision is not in their favor, they may be required to pay for those services received during the appeal process.
- If the service(s) is due to expire during the time of the appeal/hearing process, they are not entitled to receive those services beyond the expiration date. This is one reason, an existing IPOS must be reviewed and re-authorization planned (through Person Centered Planning) well in advance of the current IPOS expiring.
- If the services continued during the local appeal process and the client requests a fair hearing, they may ask for the services to continue during the fair hearing process as well, if they make the request within 10 days of the date on the Notice of Local Appeal Resolution.

Local Appeal/Dispute and Alternative Dispute Resolutions

Non-Medicaid

LOCAL APPEAL/DISPUTE RESOLUTION – CWN

- This resolution process is provided for clients without Medicaid
- The client must ask for a Local Appeal Resolution before they can request a state-level Alternative Dispute Resolution with MDDHS
- A client must request a Local Appeal Resolution within **30** days of the Notice date on the Adequate or Advance notice.
- The client can make an oral request for a Local Appeal Resolution but they must confirm it in writing unless an expedited review is requested and approved.

Local Appeal and Alternative Dispute Resolutions

Non-Medicaid (cont'd)

LOCAL APPEAL RESOLUTION (continued)

- As with Medicaid appeals, the appropriate management staff will assign a qualified staff person to provide the Non-Medicaid local appeal review, who
 1. has the appropriate clinical expertise, and
 2. was not part of the original decision process
- CWN has **45 days** to provide a written response/resolution to the client based on the findings of the staff doing the Local Appeal review.
- If CWN does not recommend hospitalization and/or an alternative services requested by the client/guardian, the CMHSP must notify the client or guardian of the Local Dispute Resolution Process. The Decision from that process must be reached within **3 business days. (C6.3.2.1)**
- Current clients with or without Medicaid can always file a rights complaint in response to actions taken by CWN. Applicants to new services cannot file a rights complaint.

Local Appeal and Alternative Dispute Resolutions

Non-Medicaid (cont'd)

ALTERNATIVE DISPUTE RESOLUTION –

Michigan Department of Health & Human Services / State-level

- If the client is not satisfied with the resolution or response to the local appeal, they may ask for a state-level Alternative Dispute Resolution. A local appeal resolution must be requested before requesting the MDHHS Alternative Dispute Resolution.
- The client has 10 days from receiving CWN's written notice of the Local Dispute Resolution process outcome to request access to the MDHHS Alternative Dispute Resolution process.
- Clients must make a written request to MDHHS. Instructions on how to access this level of appeal is included on the Non-Medicaid Notices.



Local Appeal and Family Support Subsidy

Recipients (Medicaid or Non-Medicaid) of the **Family Support Subsidy (FSS)** can use the CWN Local Appeal process to appeal FSS decisions (i.e. denial, payback requests, and termination of FSS)

1. Requests must be received within two months (60 calendar days) of the date on the CWN notification letter.
2. The CWN Family Support Subsidy Coordinator notifies the Grievance and Appeal Coordinator (CWN Customer Service Rep) when a family requests a local appeal.
3. The CWN Fair Hearing Officer (CWN Director of Systems Development) oversees the Local Appeal/Hearing process. The hearing shall be conducted in the same manner as provided for contested case hearings under Chapter 4 of the Administrative Procedures Act of 1969, Act No. 306 of the Public Acts of 1969, being Sections 24.271 to 24.287 of the Michigan Compiled Laws."
4. This is the highest level of Appeal resolution offered to Recipients of FSS. FSS Recipients can go to the Circuit Court in their county of residence if they are not satisfied with the local appeal resolution decision.

Please refer the client's family or guardian to the CWN FSS Coordinator for any questions or changes in family's status.

CWN Notice Forms

Medicaid Notices

2 types - Adequate and Advance Notice of Adverse Benefit Determination

Non-Medicaid Notices

2 types - Adequate and Advance Notice

- Providers will create Notices in CASPER and print out a copy for the client.
- Paper copies of the Notices are available for limited use (i.e. Emergency Service contacts, home-based services).
- **Request for Local Appeal, Request for Hearing, and Grievance** forms are available in the supply room in all offices and from Customer Services staff.

2nd Opinion Rights

The Grievance and Appeals process is required by law for Medicaid enrollees and by contract with DHHS for clients without Medicaid. In addition, the Michigan Mental Health Code provides clients who are denied services in two specific situations the option of requesting a second opinion, which must be:

- Offered orally and in writing at the time of denial of:
 - 1) An applicant's initial request for CMH services
 - 2) Request for in-patient hospitalization
- Provided within **5** business days of the client's request; within **3** business days for inpatient hospitalization.
- Completed by a qualified person other than the person who originally denied services. Depending on the service request denied, the person providing the second opinion will be a physician, licensed psychologist, registered professional nurse, master's level social worker or master's level psychologist.



Second Opinions (cont'd)

- The decision must be provided both orally and in writing to the client and must be documented and placed in the client's medical record.
- Requests for expedited reviews (3 business days for services, 24 hours for inpatient hospitalization) will be approved and completed **IF** it is determined that the standard time for resolution could seriously jeopardize the individual's life health or safety, or ability to attain, maintain or regain maximum function.
- A second opinion does not replace the right to file a Local Appeal or an Administrative Hearing.

NOTE: If a client/applicant is denied their right to a 2nd opinion, they may file a recipient rights complaint.

Second Opinion rights are based on the following legal requirements:

- Michigan Mental Health Code Act 258 of the Public Acts of 1974 MCL330.1409(4), 1498e(4), 1705
- MDHHS/CMHSP Managed Health Supports and Services Contract, C6.3.2.1
- Northern Lakes CMH Policies 106.106, 106.1001,106.1017, 106.201

Record Keeping

- Fill Notices out completely.
- Make a copy of the Adequate or Advance notice for the medical record if you are providing a Notice that is not created in CASPER.
- The medical record must contain copies of all Notices.
- Record, document, write down and keep accurate and clear records. The records you keep may be used as evidence in an appeal or hearing.
- Error on the side of caution - when in doubt, send it out.



Where to go for assistance

- Coordinating Grievances and Appeals is a Customer Services function.
- Your Grievance and Appeals Coordinator, Jan Chandler, is available to help you and to answer your questions.
 - Located at Admin
 - Phone: (231)882-2139) or toll free 1-877-398-2013

