



HURON BEHAVIORAL HEALTH  
**PROCEDURE**

Procedure #: RR.2.36  
Issue Date: 08/01  
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**Title: Grievance and Appeal Procedure**  
Prepared By: Recipient Rights Officer

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**Purpose:**

To define the proper investigation, documentation, and follow-up activities related to consumer complaints.

**Scope:**

This procedure applies to all providers (including full-time employees, part-time employees, contractual providers, including organizational providers, volunteers, students, and/or interns, of Huron Behavioral Health (HBH) programs, both direct and contracted. It also applies to all consumers served by Huron Behavioral Health.

**Information:**

1. It is the policy of HBH that all consumers will have the right to a fair and efficient process for resolving complaints regarding their services and supports which are managed and/or delivered by HBH. Procedures are in place that ensure a timely, fair, accessible and understandable process for resolving consumer grievances and appeals based on the Michigan Department of Health and Human Services (MDHHS) technical requirement.
2. Consumers and/or their legal representative shall receive written and verbal information about their appeal options at various stages of treatment, including phone screening at a contracted Access/Customer Services provider, intake evaluations, and interim treatment planning at the Community Mental Health Services Program (CMHSP) Affiliates and/or Coordinating Agency (CA) provider network, annual planning meetings, and as requested. It will be provided in a language format needed by the individual to understand the content. (See also "[Appeals Procedure](#)" RR.2.02).
3. Individuals may file a grievance or appeal with HBH's contracted Access Center at any time verbally or in writing without any interference or retaliation. The contracted Access/Customer Services staff will offer assistance in completing required forms when the consumer requests help. HBH staff may also assist in completing required forms when the consumer requests help. All processes will promote the resolution of concerns and improvement of the quality of care. Complaints should be resolved at the level closest to service delivery whenever possible.
4. Organizational providers may file an appeal or grievance with the Clinical Director at Huron Behavioral Health. If they are not satisfied with this outcome, they may then appeal to the HBH Executive Director.
5. Written notice is given whenever a Medicaid State Plan, waiver, or alternative service is denied, reduced, suspended, or terminated. The notice will be given in writing and in the language which is understandable to the consumer. (When an alternative language or communication method is needed, it will be provided at no cost to the consumer. See "[Limited English Proficiency \(LEP\) Accommodation Policy](#)" RR.1.02). If the consumer disagrees with the action, he/she may request an appeal through the contracted Access/Customer Service provider. A MDHHS State Fair Hearing may also be requested if other grievance resolution options have not been satisfactory to the consumer.
6. If any consumer has a complaint that is a Mental Health Code protected right, the consumer will be referred to the HBH Office of Recipient Rights.
7. Denying an applicant, a current consumer, or guardian access to the grievance process is a recipient rights violation. Recipient rights complaints must be filed with the HBH Recipient Rights Officer if this occurs.
8. HBH staff shall not interfere with a consumer's access to grievance, appeal, or fair hearing processes.
9. Medicaid and Healthy Michigan consumers must be notified of the MDHHS State Fair Hearings process as soon as it becomes evident that services will be denied, suspended, reduced, or terminated. Non-Medicaid consumers are required to exhaust the local grievance process before they can access the MDHHS Alternative Dispute Resolution Process.
  - a. Medicaid and Healthy Michigan eligible consumers may at any time request an Administrative Hearing before an Administrative Law Judge.

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- b. Non-Medicaid eligible consumers may utilize the Dispute Resolution process after the local appeal process has been followed.
9. In compliance with the Michigan Department of Health and Human Services contract attachment C6.3.2.4, HBH is required to have dispute resolution procedures in place to enhance collaboration between mental health and substance abuse therapists when treating dually diagnosed consumers.
10. For the purpose of this procedure, the term "Current Medicaid-Covered Services" refers to Medicaid State Plan, Waiver, or Alternative Services.
11. The Access/Customer Service staff will ensure that all appeals, second opinions, and notices (advance & adequate) are entered into the tracking system for on-going monitoring and reporting.
12. Consumers will be advised of external advocacy services which are available to them.
13. New consumers are screened by the contracted Access/Customer Service provider. If services are requested but denied by the contracted Access/Customer Service provider (as a result of not meeting medical necessity, severity of illness, and/or intensity of service criteria), they will provide Adequate Notice through a Denial Notice and HBH receives a copy.
14. Incentives are not present for the denial, limitation, or discontinuation of services to any consumer.

**Procedure:**

Recipients of, or applicants for, public mental health services may pursue their complaint within multiple options, including:

- Office of Recipient Rights
- CMHSP Second Opinion Process
- Informal Conflict Resolution
- Customer Service provider Appeal Process
- MDHHS State Fair Hearing (if Medicaid or Healthy Michigan recipient)(in relation to adverse actions)
- MDHHS Alternative Dispute Resolution (if not a Medicaid recipient and local processes have been exhausted) (in relation to adverse actions)
- Customer Service provider Grievance Processes (for both Medicaid and Non-Medicaid consumers) (for all other issues that are not in relation to adverse actions or recipient rights)

**A. Informal Dispute Resolution/Local Resolution Process:**

1. Any consumer may request the grievance resolution process regarding a complaint by calling the HBH Office of Recipient Rights.
2. HBH records the grievance, sends acknowledgement letter to consumers, and notifies HBH Clinical Director.
3. The HBH Clinical Director involves the appropriate internal resources to investigate the grievance (i.e. Recipient Rights Officer, Primary Worker, Program Supervisor, etc.) to resolve the issue.
4. Once a resolution is determined HBH sends a disposition letter to the consumer.
5. If a notice of adverse action is sent to the consumer by HBH, and the consumer appeals the action, the appeal will be processed by HBH.
6. If HBH denies an expedited resolution of an appeal, it is transferred to the standard resolution timeframe (14 calendar days) and HBH will make reasonable efforts to give the consumer a prompt oral notice of the denial, and will also follow up within two (2) calendar days with a written notice to the consumer.

**Second Opinion:****A. Hospitalizations & Crisis Residential: Sections 330.1409 & 330.1498(e):**

1. If a consumer is screened for in-patient psychiatric hospitalization or crisis residential services and is denied access to either, they may request a second opinion (see Second Opinion Procedure RR.2.47).
2. The request for the second opinion shall be processed in accordance with of the Mental Health Code. Within three (3) days of the request for a second opinion (excluding Sundays and legal holidays), the Executive Director shall arrange for an additional evaluation by a psychiatrist, other physician or licensed psychologist to be conducted. If the

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conclusion of the second opinion is different from the initial decision, the Executive Director, in conjunction with the Medical Director, shall make a determination based upon the clinical information available within three (3) business days. (See Request for [Second Opinion Form for Hospitalization 90-181](#)).

**B. All Other Services: (330.1705):**

1. The request for the second opinion shall be processed in compliance with 330.1705 of the Michigan Mental Health Code. Upon request for a second opinion regarding services, the HBH Executive Director will obtain a second opinion from a physician, licensed psychologist, master's level psychologist, master's level social worker, or registered professional nurse. If the conclusion of the second opinion determines the individual to have a serious mental illness, serious emotional disturbance, or developmental disability, or if the individual is experiencing an emergent/urgent situation, mental health services will be provided. (See "[Second Opinion Form for Non-Emergent Services](#)" # 90-370).
2. The Executive Director (or designee) will complete their determination within the following timeframes:
  - a. Standard Determinations: HBH staff has fourteen (14) calendar days from the receipt date to make a determination and notify the consumer of the decision.
  - b. Expedited Determinations: HBH staff has three (3) working days from receipt date to make a determination and notify the consumer of the decision.

**Recipient Rights Complaints**

If staff is made aware or if they suspect that a rights violation has occurred, they will:

1. Immediately contact the HBH Recipient Rights Officer
2. Complete (or assist the consumer in completing) a complaint form (DCH#0030)
3. Forward the completed complaint form to the Recipient Rights Officer

**MDHHS State Fair Hearing Process:**

1. All Medicaid beneficiaries will be informed of their right to access the Fair Hearing process. Information on how to access this is provided in the "MDHHS State Fair Hearing Brochure" (from MDHHS) and includes:
  - a. The right to a state fair hearing
    - The method of obtaining a hearing
    - The rules that govern representation at the hearing
  - b. The right to file grievances and appeals
    - The requirements and time frames for filing a grievance or appeal
    - The availability of assistance in the filing process
    - The toll-free number that beneficiaries can use to file a grievance or appeal by phone
  - c. Continued benefits when requested by the beneficiary. Benefits may continue if he/she files an appeal or a request for fair hearing within the time frames specified for filing. The beneficiary may be required to pay the cost of services furnished, if the final decision is adverse to the beneficiary.
2. HBH employees shall not limit or interfere with the applicant's or consumer's right to make a request for a hearing and will assist the consumer in submitting the grievance or appeal when requested.
3. Consumers of service or service providers who assist a consumer in the grievance and dispute resolution process shall be protected from discrimination and/or retaliation.
4. HBH must reinstate and continue services until a hearing decision if any of the following occurs:
  - a. Action was taken without the required Advance Notice
  - b. The consumer requests a hearing within twelve (12) calendar days of the mailing of the action
  - c. HBH determines that the action resulted from factors other than the application of Federal or State law or policy
8. A consumer may request a Fair Hearing by filling out the MDHHS Hearing Request Form DCH-0092 ([www.michigan.gov/documents/Dch-0092\\_9635\\_7.doc](http://www.michigan.gov/documents/Dch-0092_9635_7.doc)) with assistance from HBH staff, if requested.
9. A Fair Hearing Officer has been designated at HBH, whose responsibilities include:
  - Serving as the HBH representative for the alternative dispute resolution process

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- Scheduling a private room and ensuring that all the equipment is available for the Administrative Law Judge to conduct the Fair Hearing
  - Contacting the Administrative Law Judge if it is anticipated that someone critical to the case will be late for the hearing
  - Ensuring all witnesses relevant to the case and all documents supporting HBH's case are available at the hearing
10. An Administrator or Legal Counsel shall be designated by the Executive Director as the individual representing HBH at the Fair Hearing whose responsibilities will include:
- Completing a Hearing Summary Report (DCH-0367 ( [www.michigan.gov/documents/Dch-0367\(E\)\\_9638\\_7.doc](http://www.michigan.gov/documents/Dch-0367(E)_9638_7.doc) ). This Report and all relevant documents to be entered into evidence will be submitted to the Administrative Law Judge ten (10) days prior to the Fair Hearing date. A copy of these materials will be forwarded to the consumer prior to the Fair Hearing.
  - Assisting the consumer (when requested) with contacting the Administrative Tribunal to reschedule the Fair Hearing meeting if the consumer cannot attend the scheduled Fair Hearing
  - Making the opening and closing statements representing HBH's position, calling and questioning the witnesses relevant to the case, and ensuring that all HBH evidence is presented for consideration by the Administrative Law Judge
11. The Primary Worker is responsible for:
- Assisting the consumer with transportation needs if requested so that the consumer can attend the hearing
  - Modifying the PCP after the hearing results are available (when applicable)
12. The Administrative Tribunal will notify HBH and the consumer as to the date of the Fair Hearing.
13. In instances where medical issues are involved, the Administrative Law Judge may determine that a medical assessment other than that completed by the original treating physician is necessary. In these cases, HBH will be responsible for obtaining the additional assessment at no expense to the consumer. The assessment will be maintained by HBH in the consumer's case record.
14. The consumer may withdraw a request for a Fair Hearing in writing by submitting a Hearing Withdrawal Form DCH-0093. HBH employees will ensure the consumer understands that, at no point, are they required to withdraw their request for a Fair Hearing. Only the consumer or their legal representative can withdraw the Fair Hearing request.
15. If HBH's action is supported by the Fair Hearing decision, HBH may seek reimbursement from the consumer for the cost of any services provided to the consumer during this period of time, up to the consumer's ability to pay (see Ability to Pay Procedure ISP.2.04).

**Advance & Adequate Notices:**

1. When it is determined that a covered service is suspended, reduced, or terminated, the consumer shall be given the appropriate Adequate or Advance Notice (in the Electronic Medical Record/EMR system) per the table below:

Action	ADVANCE Notice	ADEQUATE Notice	Time frame for Notice
Denial of Service Request		<b>X</b>	At the time of the decision
PCP developed		<b>X</b>	At the time of the PCP
Reduction, Suspension, or Termination of Service(s) currently being received per the PCP	<b>X</b>		12 calendar days BEFORE the action occurs  (NOTE – EFFECTIVE 12/01/16, For GF Consumers 30 calendar days BEFORE the action occurs)
Standard Authorization Decision that denies/limits service(s) requested		<b>X</b>	Within 14 calendar days of the request
Expedited/Quickened Authorization Decision that denies/limits services requested		<b>X</b>	Within 3 working days of request
Consumer is deceased, cannot be reached, has relocated out of county or to another PIHP, admitted to institution where ineligible for further services, or consumer clearly states (in writing) that they wish services to be terminated/reduced		<b>X</b>	At the time of the decision

2. If the consumer receives notice and disagrees with the action, he/she may request a local appeal. A MDHHS State Fair Hearing may be requested in lieu of or in addition to all of the other grievance and appeal dispute options.

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**E. MDHHS Alternative Dispute Resolution Process for Non-Medicaid Consumers and Consumers Receiving Medicaid Alternative Services:**

1. Consumers must begin with the local resolution process first. The consumer is entitled to the MDHHS Dispute Resolution Process only after completion of the local appeal resolution process. (See "A. Local Grievance Process/Informal Conflict Resolution Processes" section of this procedure).
2. The notice of Informal Dispute Resolution/Local Grievance decision or Second Opinion Action Notice ([90-181](#)) to a consumer will include information on the consumer's right to request access to the MDHHS Alternative Dispute Resolution process. This notice will also include information regarding the consumer's right to file a Recipient Rights Complaint with the Recipient Rights Officer, alleging a violation of the recipient's right to treatment suited to his/her condition.
3. Consumers interested in accessing the Alternative Dispute Resolution Process must request a review in writing using the "Request for Review Form" ([90-290](#)) within five (5) business days of the written outcome of the Local Appeal Resolution or Second Opinion. The request will include the following (as applicable):
  - a. Name of consumer
  - b. Name of Guardian legally empowered to make treatment decisions or parent of minor child
  - c. Daytime phone number where the consumer, guardian legally empowered to make treatment decisions, or parent of a minor child may be reached
  - d. Name of the Agency/Program where services have been denied, suspended, reduced or terminated
  - e. Description of the service being denied, suspended, reduced or terminated
  - f. Description of the adverse impact on the consumer caused by the denial, suspension, reduction or termination of service
4. The Fair Hearing Officer will work with the MDHHS representative (from the division of Program Development, Consultation, and Contacts) to complete the MDHHS Alternative Dispute Resolution process.
5. MDHHS representative will refer the dispute to the appropriate MDHHS Bureau of Community Mental Health Services representative for contractual action within one (1) business day if the denial, suspension, termination, or reduction of services and/or supports will pose an immediate and adverse impact upon the individual's health and safety. Contractual action will be taken consistent with the applicable provisions of the MDHHS/CMHSP contract. This referral will be communicated in writing to the consumer, guardian, or parent of a minor child within twenty-four (24) hours.
6. The assigned MDHHS representative will complete his/her review within fifteen (15) business days in cases that do not pose an immediate danger to the individual's health and/or safety. Written notice of the resolution shall be submitted to the consumer, his/her guardian, or parent of a minor.

**Denial or Termination of Family Support Subsidy:**

1. The responsible HBH employee will review all applications for the Family Support Subsidy and promptly approve or deny the application.
2. HBH employees will provide written notice to the applicant of the action and the right of the parent or guardian to administratively appeal the decision if it is adverse.
3. If the application is denied due to insufficient information on the application form or the required attachments, the HBH employees shall identify the insufficiency in the written notification.
4. If an application for a Family Support Subsidy is denied or terminated by HBH, the parent or legal guardian will be informed of their right to request a Informal Dispute Resolution/Local Grievance Process.
5. The request for an Informal Dispute Resolution/Local Grievance Process must be submitted in writing within two (2) months of the notice of termination or denial. HBH employees will provide assistance if requested by the consumer.
6. A Informal Dispute Resolution/Local Grievance Process will 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.

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## Definitions/Acronyms:

### DEFINITIONS:

#### **Action:**

- Denial or limited authorization of a requested Medicaid or non-Medicaid service, including the type or level of service
- Reduction, suspension, or termination of a previously authorized Medicaid or previously provided non-Medicaid covered service
- Denial, in whole or in part of payment for a Medicaid or non-Medicaid covered service
- Failure to make a standard authorization decision and provide notice about the decision within fourteen (14) calendar days
- Failure to make an expedited authorization decision within three (3) working days from the date of receipt of a request for expedited service authorization
- Failure to provide services within fourteen (14) calendar days of the start date agreed upon during the PCP process and as authorized
- Failure to act within forty-five (45) days from the date of a request for a standard appeal
- Failure to act within three (3) working days from the date of a request for an expedited appeal
- Failure to provide disposition and resolution notice of a local grievance/complaint within sixty (60) calendar days

**Adequate Notice:** refers to written notice mailed or delivered at the time of the action or at the time of the signing of the individual plan of services/supports, including a statement of the action, reason for the action, regulations that support the action, and explanation of the consumer's right to request an Administrative Fair Hearing.

**Administrative Law Judge:** refers to a qualified individual designated by MDHHS to conduct a hearing in accordance with rules of evidence, Department rules, and state and federal regulations and statutes.

**Administrative Tribunal:** refers to a division of MDHHS responsible for oversight, operations, and decisions of the Administrative Law Judges carrying out their responsibility conducting Fair Hearings as required by the Michigan Mental Health Code, Public Health Code, Social Welfare Act, Administrative Code, Administrative Procedures Act, and/or federal law/ regulation.

**Administrative Tribunal Hearing:** An evidentiary hearing for a Medicaid consumer conducted by an Administrative Tribunal regarding a decision by HBH to deny, terminate, reduce or suspend services.

**Advance Notice:** refers to a written notice mailed twelve (12) calendar days in advance of the action, when previously authorized or provided services are reduced, suspended or terminated, that includes a statement of the action HBH intends to take, reason for the intended action, regulations supporting the intended action, an explanation of the individual's right to request an evidentiary hearing, and an explanation of the circumstances under which services are continued if a hearing is requested. (Note – per section 942 of PA 268 of 2016 for GF consumers the written notice must occur 30 days in advance of the action.)

**Adverse Action:** A determination impacting a consumer/customer's services, such as denial, reduction, suspension, or termination of service.

**Alternative Services:** refers to a set of MDHHS-approved, flexible services that are offered to beneficiaries in lieu of Medicaid state plan services, and for which Medicaid-capitated funds may be used to pay under the authority of the Section (A) (1) (a) of the Social Security Act and approved for use via Michigan's 1915 (b) waiver by the federal Centers for Medicare and Medicaid.

**Appeal:** refers to a request for a review of an adverse action (as defined above) relative to a Medicaid-covered service or non-Medicaid covered service with which the consumer does not agree.

**Authorized Hearing Representative:** refers to an individual who stands in for (or represents) the consumer in the hearing process. The legal right to do so comes from one of the following sources (an individual who assists, but does not stand in for the beneficiary in the hearing process does not need to meet the criteria):

- Written authorization, signed by the beneficiary, giving the individual authority to act for the beneficiary in the hearing process;
- Court appointed guardian or conservator;
- Legal parent of a minor child;
- The beneficiary's spouse, or a deceased beneficiary's widow or widower, only when no one else has the authority to represent the beneficiary.

**Consumer:** A person that is either a current recipient of, or desiring eligibility determination for, mental health and/or substance abuse services funded by the CMHSP Affiliate and or/Substance Abuse Coordinating Agency (CA). It could also apply to the person's authorized representative, his/her family, his/her representative of a deceased enrollee's estate, and other referral sources. Unless otherwise noted, this requirement applies to all funding sources. Also referred to as "Recipient" or "Customer".

**Expedited Appeal :** A speedy review of an action requested by the beneficiary or the beneficiary's provider when the time for normal appeal process could jeopardize the beneficiary's life, health, or ability to maintain, attain, or regain maximum function. If

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requested by the beneficiary, HBH determines if an expedited appeal is warranted. If the beneficiary's provider makes or supports the request, HBH must grant the request.

**Fair Hearing:** refers to an impartial review conducted by an impartial Administrative Law Judge of MDHHS regarding a consumer's dissatisfaction with an HBH decision related to actions taken (see above).

**Grievance:** refers to an expression of dissatisfaction about any matter relative to a Medicaid or non-Medicaid covered service, other than an action as defined above, which does not involve a rights complaint as defined below (e.g. quality of care, services provided, aspects of interpersonal relationships between a service provider and the consumer, etc).

**Informal Dispute Resolution:** This is a process by which the customer may resolve grievances or appeals directly with the treating staff, supervisor, or administrator prior to accessing the formal Local Appeal and Grievance Process and/or MDHHS Medicaid Fair Hearing/Dispute Resolution Processes. Also referred to as "Local Resolution Process".

**Legal Representative:** refers to an individual who has been appointed by the court to act on a consumers behalf who is a minor, legally incapacitated, or developmentally disabled. (At HBH, the term "Guardian" is used interchangeably. See [ORI.1.15 - Personal Representative/Guardian Policy](#)).

**MDHHS Alternative Dispute Resolution Process:** refers to the MDHHS dispute resolution process established to provide an Administrative forum for grievances and disputes by consumers of Community Mental Health services and public substance abuse services who are not covered by the federal standards related to State Fair Hearing. If a non-Medicaid consumer is dissatisfied with a decision of the contracted Access/Customer Service provider related to a local appeal regarding a suspension, reduction or termination of services he/she may request this review within five (5) business days of the decision.

**MDHHS Fair Hearing: An impartial review by a MDHHS Administrative Law Judge of a decision regarding public mental health and/or substance use disorder services specific to a consumer. A Consumer completes the necessary process to access this service, with PIHP, CMHSP, or CA assistance as needed.**

**Person Centered Plan (PCP):** refers to a plan for treatment that includes clearly stated goals, measurable objectives and methodology that specifies the amount, scope, duration, and intensity of services to be provided. The plan is derived from the assessment of the individual's condition, the persons' wishes and desires and considering health and safety factors. This plan is developed in the context of Person and/or Family Centered Planning.

**Pre-paid Inpatient Health Plan (PIHP) Provider Network: The regional provider network for both public mental health and public substance abuse services. For public mental health, this includes the PIHP named Mid-State Health Network (MSHN), the CMHSP Affiliates within the MSHN, and the CMHSP Affiliates' contracted provider networks.**

**Primary Worker:** refers to the staff with primary responsibility for the coordination of the consumer's services. This may be a Case Manager, Supports Coordinator, Clinical Specialist, Family Support/Respite Services Worker, ACT or Home Based Services staff.

**Recipient:** refers to a person receiving services, or the individual's authorized representative (if applicable) or the individual's parent (if they are a minor child), and/or guardian (if applicable). Also referred to as "Consumer".

**Residential Facility:** refers to a specialized residential, 24-hour supervised, program where treatment is provided and is operated under contract with HBH.

**Recipient Rights Complaint** – Statements or allegations, verbal or written, by the consumer or anyone acting on his/her behalf that alleged a violation of a Mental Health Code protected right cited in Chapter 7 will be resolved through processes established in Chapter 7A of the Michigan Mental Health Code. The recipient rights for persons with substance use disorders is protected by the MDHHS substance abuse program licensing rules R 325.14301-325.14306.

**Treatment Plan** (specifically for substance use disorder services: Plan for treatment that includes clearly stated goals, measurable objectives, and methodology that specifies the amount, scope, duration, and intensity of services to be provided. The plan is derived from an assessment of the individual's condition and includes the customer in its development.

**Unreasonable Delay** – Postpone of services beginning by 14 or more calendar days beyond the start date agreed upon during the Person Centered Planning and as authorized.

### ACRONYMS:

ADA – Americans with Disabilities

CA - Coordinating Agency

CMHSP – Community Mental Health Service Programs

EMR – Electronic Medical Record

HBH – Huron Behavioral Health

MDHHS – Michigan Department of Health and Human Services

MSHN – Mid-State Health Network

PCP - Person Centered Plan

PIHP – Pre-paid Inpatient Health Plan

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## Forms:

[90-181 Second Opinion Form \(for hospitalizations and crisis residential\)](#)

[90-290 Dispute Resolution Request Form](#)

[90-370 Second Opinion Form \(For non-emergent services\)](#)

[90-406 Death – Adequate Notice Cover Letter Form](#)

Adequate Notice Form (in EMR)

Advance Notice Form (in EMR)

DCH-0030 Recipient Rights Complaint Form

DCH-0092 Request for Administrative Hearing Instructions Form ( [www.michigan.gov/documents/Dch-0092\\_9635\\_7.doc](http://www.michigan.gov/documents/Dch-0092_9635_7.doc) )

DCH-0093 Hearing Request Withdrawal Form ( [www.michigan.gov/documents/Dch-0093\\_9637\\_7.doc](http://www.michigan.gov/documents/Dch-0093_9637_7.doc) )

DCH-0367 Hearing Summary Form ( [www.michigan.gov/documents/Dch-0367\(E\)\\_9638\\_7.doc](http://www.michigan.gov/documents/Dch-0367(E)_9638_7.doc) )

DCH Medicaid Fair Hearings Brochure ( [www.michigan.gov/documents/ADMINISTRATIVEHEARINGS\\_81632\\_7.brochure.pdf](http://www.michigan.gov/documents/ADMINISTRATIVEHEARINGS_81632_7.brochure.pdf) )

## Records:

Records of all grievances and appeals are retained by the HBH Grievance and Appeals Coordinator. Records of all grievances, appeals, and complaints are tracked by the contracted Access/Customer Services provider.

## Reference(s) and/or Legal Authority

PA 516 of 1996

PA 258 of 1974, as amended

PA 306 of 1969, being sections 24.271 to 24.287 of the Michigan Compiled Laws.

S.353-Health Insurance Bill of Rights of 1997

42 CFR sections 438.10 (Information Requirements), 431.200 (Fair Hearings), 438.400 (Appeals and Grievances) @

<http://www.gpo.gov/fdsys/granule/CFR-2010-title42-vol4/CFR-2010-title42-vol4-sec438-404/content-detail.html>

MDHHS Appeal & Grievance Resolution Processes Technical Requirement (Medicaid version)

Michigan Mental Health Code MCL 330.1772 (Recipient Rights Complaints) & MCL 330.1705 (Second Opinions)

Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112)

[RR.2.47 Second Opinion Procedure](#)

[ISP.2.04 Ability to Pay Procedure](#)

[RR.1.01 Limited English Proficiency Policy](#)

[RR.1.02 Limited English Proficiency Accommodation Policy](#)

[RR.1.03 Cultural Competence Policy](#)

[RR.2.02 Appeals Procedure](#)

[RR.2.21 Recipient Rights – Services Suited to Condition Procedure](#)

## Change History:

Change Letter	Date of Change(s)	Changes
A	05/27/03	Brought into new procedure template and controlled documentation system with minimal changes to content.
B	08/31/04	Re-ordered Information section and added items: a, b, d, f, g, j, k, l, m, n, o, p, & q in "Procedure" section, added Grievance types, items 1, 2, 3, 4, 5, 6, & 7; Changed Level One from "5" to "3" days, changed Level Two from "20" to "2" days, changed Level Three from "10" to "2" days, , changed Level Four from "21" to "3" days. Added "Notice Requirements" section, added "Definitions" section, added "acronyms" section: AAM, ADA, CMHSP, PCP; added "Reference" section "Section 504....". Added clarification to comply with the balanced budget act (42 CFR parts 438). Reformatted entire procedure and added numerous sections to more clearly define process and comply with recent Office of Recipient Rights Technical Guidelines and the Balanced Budget Act.
C	2/27/05	Changed #2 in information section to include filing verbally or in writing. Deleted #3 in same section due to incorporating in #2. Local Appeals, #4 changed that services may continue rather than will be and added if the consumer request.... added to #8 bullet 4 that the primary worker will not be involved in this process, #9 added the ED will determine and direct all corrective action. Moved adequate and Advance process before the Fair Hearing process, added reference to deceased consumer's estate under the local appeals section, changed the wording that benefits may (will) continue, moved what must be sent to the consumer prior to the action taken to f. under the local appeal section, added the consumer may request a fair hearing into the Advance Notice section, added definition of when a local appeal and/or State Fair Hearing may be requested in the information section #29, added when adequate notice will be sent under the adequate notice section first bullet, added statement regarding Medicaid consumers right to request hearing..... in Local Appeals section #13, b to comply with BBA & EQR requirements
D	05/23/06	In "Information" section – reworded #8, made #9 & 10 bullets under #8, removed #11, 12, 15, 16, 17, 18, 22, 23, 25, 26, and moved #13 to PCP Procedure (QI.2.18) and added a new #12, added "Second Opinion" section and reworded to include "All other services" and referenced a new form (90-366), changed the form numbers to reflect the AAM regional forms issued 02/06, under "Denial of Services" section removed all steps defined for AAM activity, removed "Reduction, Suspension, Termination" section, removed #7 from "Alternative Dispute Resolution..." section, removed references to HBH forms and added in AAM regional forms, added definitions for "Rights Complaint" and "Unusual Delay", added "All Other Services" under "Second Opinion" section. (For full detail of changes and previous revisions see the QI Coordinator), added form 90-370 for non-emergent services, changed title from "Appeal & Grievance" to "Grievance & Appeal". Numerous additional changes made to consolidate and condense sections; see QI Coordinator for additional details/copies.
E	08/25/06	Added second sentence in the first paragraph in the "Procedure" section to comply with 42 CFR 438.406(a) and the MDCH Grievance system.
F	06/28/07	Revised to comply with the Delegated Managed Care audit requirements. Added # 6, 7, & 8 under "A. Local Resolution Process". Refined the definition of "Appeals" by adding the word "adverse", and also "with which the consumer....".
G	12/03/08	Reviewed and revised to comply with COA 8 <sup>th</sup> Edition Standards and present practices – added "without any interference or



**Title: Grievance and Appeal Procedure**

Prepared By: Recipient Rights Officer

Procedure #: RR.2.36

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		retaliation to the first sentence in #2 (Information section), added the second sentence in A.3.
H	12/08/09	Changes made to correct for regional responsibilities/CMHSP responsibilities as part of the follow-up to AAM's 2009 Delegated Managed Care Audit, removed references to HBH conducting on-site grievance – this is now a regional function, made numerous other changes to support this responsibility change (see QI Coordinator for details and old versions)
I	04/23/12	Changes made to comply with AAM Technical Requirements. Throughout document- changed Medicaid Fair Hearing to MDCH State Fair Hearing, changed Medicaid consumers to Medicaid and ABW consumers, changed Local Resolution Process to Local Grievance Process/Informal Conflict Resolution Processes, added "MDCH" to Alternative Dispute Resolution. Information section- Added #2, #4 first sentence changed HBH to AAM, removed "will offer", added "may", changed "assistance" to "assist". #5- fourth sentence added "through AAM". #11 changed "HBH" to "AAM". Removed sentence starting with "Aggregate report". Procedure section- removed first paragraph and added new first paragraph. A #1 changed "AAM Customer Service" to "the HBH Office of Recipient Rights", #2 changed "AAM" to "HBH" changed "Program Director" to "Clinical Director", #3 changed "program" to "clinical", "complaint" to "grievance", and removed the last sentence. #4 added "via Secure Desktop", changed "AAM" to "HBH", and removed "(See AAM protocols)". Removed original number #5 and #7. Second opinion section A #1 changed "Instruction ER.3.03" to "Procedure RR.2.47". Advanced & Adequate Notices section- added last sentence to #1. Definition section- "consumer" added entirely new definition and added "customer" to the last statement. "grievance" added "quality of care, services" and removed "activities". Added "informal dispute resolution". Removed "Local Resolution Process". "Legal Representative" added "act on a consumers behalf" and removed "exercise specific powers...". "MDCH Alternative Dispute..." added "public substance abuse services". Added "MDCH Fair Hearing". "Person centered Plan" added statement after "methodology" to "is derived". Added "Pre-paid Inpatient Health Plan (PIHP) Provider Network". Added "recipient" to "Rights Complaint" and added last sentence. Added "treatment Plan". "Unreasonable Delay" removed definition and added new one. Acronyms- Added CA-Coordinating Agency. References- removed ER3.03 and added RR.2.47 4/23/12 approved by the HBH Rights Advisory Committee.
J	06/04/14	Changed "AAM" and "BABH" to "contracted Access/Customer Service" provider or staff (9 places). In "Definition" section under "PIHP" changed "AAM" to "MSHN" (2 places)in "Records" section removed "AAM Reference Tracking Log database and replaced with "tracked by contracted Access/Customer Service provider", removed "AAM" from "Acronym" section..
K	04/08/15	In "Scope" section changed "employees" to "providers" (2 places) and added "including organizational providers", changed "ABW" to "Healthy Michigan" throughout document (3 places), added #5 in "Information" section, in "Acronym" section removed "OBRA" & "RRO" and added "EMR", in "Forms" section removed references to form numbers and regional forms and replaced with references to EMR forms, under "Advance & Adequate Notices" #1 (page 4) removed references to form numbers and regional forms and replaced with references to EMR forms, added #14 in "Information" section.
L	05/25/16	Changed "MDCH" to "MDHHS" throughout document (32 places), made several minor grammatical/wording changes/corrections throughout document without changing sentence content.
M	12/02/16	In table under "Advance & Adequate Notices" added "(NOTE"- Effective December 01, 2016, 30 calendar days BEFORE the action occurs for GF consumers)" to comply with HB 5294, sect. 942, in "Definitions" section "Advance Notice" added "NOTE-..."