

CHELAN-DOUGLAS RSN/PHP POLICY AND PROCEDURE MANUAL		Chapter:	9.1.6
Title:	COMPLAINTS, CONFLICTS, AND DISPUTES	Page:	1 of 5
		Date Effective:	July 1, 2004
SUBJECT:	GRIEVANCE SYSTEM; ; CONTINUATION OF BENEFITS	Date Revised:	August 8, 2005
		Authorizing Signature:	

AUTHORITY: Guiding Principle(s): Consumer Focused, Holistic/Humanitarian, Accessible, Normalizing/Non-Stigmatizing, Responsive, Effectively Managed
WAC 388-865-0255, Consumer Grievance Process
Chelan-Douglas Contract, Basic Agreement
DSHS Standard Work Order, RSN/PHP Services, Grievance Procedure
DSHS Title XIX Contract and Federal Waiver
42CFR 438.420(a)(1)(2);(b)(1)-(5);(c)(1)-(4);(d) reference to 431.230(b)
42 CFR 438.424
State MHD Quality Strategy Doc Sec IV, VI
State MHD Grievance Template Doc
SCOPE: This policy applies to Chelan-Douglas Regional Support Network/Prepaid Health Plan (CDRSN/PHP) and its contractors (agencies/providers), and subcontractors (referred to as contractors or agencies or providers throughout this policy).

PURPOSE: This policy establishes that the CDRSN/PIHP and all contracted providers abide by the terms of the BBA protocol on continuation of benefits to enrollees involved in pending CDRSN/PIHP appeals, and ongoing State Fair Hearings.

DEFINITIONS: "Action" means : An "action" means a decision that has been made by the CDRSN/PIHP, as described below in further detail:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension, or termination of a previously authorized service.'
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner, as defined by the State;
5. The failure of the CDRSN/PIHP to act within the timeframes provided in 438.408(b).

“Administrative Hearing” means: A hearing conducted through the auspices of the state Office of Administrative hearings in accordance with Washington Administrative Code (WAC) 388-02. The term "fair hearing" is synonymous with administrative hearing.

“Appeal” means a request for review of an action, as “Action” is defined in this section. Norsen document states on Page 8: “Appeals can only be made at the CDRSN/PIHP level only if the decision constitutes an “action.” (as defined above) If the CDRSN/PIHP contracts with an ASO—Administrative Services Organization—then the appeal process applies to the ASO. The appeal process does not apply to a CMHA.

“Complaint” means: A verbal complaint about services or the lack thereof, which a consumer or potential consumer may file with a provider, the CDRSN/PIHP, or the Ombuds services. The goal is to resolve complaints at the lowest possible level. There is no deadline for resolution of complaints. And, there is not requirement that an enrollee has to file a complaint prior to filing a grievance.

“Denial” means: The decision by a CDRSN/PIHP no to authorize covered Medicaid mental health services that meet the Mental Health Division Access to Care Standards or the Medical Assistance Administration memorandum #01-03MAA, Psychiatric Hospitalization. Or the decision by a CDRSN/PIHP not to authorize covered Medicaid mental health services due to lack of medical necessity. The decision by a Community Mental Health Agency (CMHA) not to provide a covered service is not a denial and cannot be appealed. An enrollee who objects to a CMHA decision not to provide a covered service may request a grievance or a second opinion.

“Grievance” means an expression of dissatisfaction about any matter other than an action, as “action” is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the CDRSN/PIHP level and access to the State Fair Hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights.)

“Reduction” means: The decision by a CDRSN/PIHP to decrease an enrollee’s previously authorized covered Medicaid

mental health services. The decision by a CMHA to decrease a covered service is not a reduction.

“Suspension” means: The decision by a CDRSN/PIHP to decrease an enrollee’s previously authorized covered Medicaid mental health services. The decision by a CMHA to decrease a covered service is not a suspension.

“Termination” means: The decision by a CDRSN/PIHP to stop a previously authorized, covered Medicaid mental health service. The decision by a CMHA to stop a covered service is not a termination.

“Timely filing” means: Filing on or before the later of the following: within 10 days of the NAME OF PIHP mailing of notice of action; and, the intended effective date of the NAME OF PIHP’s proposed action.

POLICY: The CDRSN/PIHP abides by the terms of the BBA protocol on continuation of benefits to enrollees involved in pending CDRSN/PIHP appeals, and ongoing State Fair Hearings. The CDRSN/PIHP contracts with a Psychiatrist to review clinical records and respond within the time frames required by the state. The CDRSN/PIHP, Mental Health Division Representatives, and involved Network Provider representatives may take part in the CDRSN/ PIHP appeals process or the Fair hearing Process. The provider network will respond immediately to the findings and directives of the CDRSN/PIHP appeals process or that of the Fair Hearing Process. Specifically, as a matter of policy, the CDRSN/PIHP continues enrollee services/benefits under the following circumstances:

- The enrollee or the Community Mental Health Agency files the appeal timely;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized Community Mental Health Agency;
- The original period covered by the original authorization has not expired; and
- The enrollee requests extension of benefits.

The CDRSN/PIHP continues the services/benefits if the enrollee requests the CDRSN/PIHP to continue or reinstate the benefits while the appeal is pending and are continued until one of the following occurs:

- The enrollee withdraws the appeal.
- Ten days pass after the CDRSN/PIHP mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
- A State fair hearing Office issues a hearing decision adverse to the enrollee.
- The time period or service limits of a previously authorized service has been met.

The CDRSN/PIHP honors the definition of “timely filing” as it relates to this policy. See DEFINITIONS.

The CDRSN/PIHP abides by the BBA protocol as it addresses the assignment of responsibility for payment of services/benefits during various process points in the resolution of grievances and appeals, as follows:

- If the final resolution of the appeal is adverse to the enrollee, that is, upholds the CDRSN/PIHP’s action, the CDRSN/PIHP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in next bullet point.
- If the agency’s action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section.
- If the CDRSN/PIHP, or the State Administrative hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CDRSN/PIHP authorizes or provides the disputed services promptly, and as expeditiously as the enrollee’s mental health condition requires.
- If the CDRSN/PIHP, or the State Administrative hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the CDRSN/PIHP pays for those services.

PROCEDURE: [Note to reviewers: Note that this provision only applies when a PIHP provider previously authorized the service and the Medicaid enrollee received the service and the enrollee

requests that the services be continued. It does not apply to pre-service authorization requests that are denied. This means that the mere action of filing an appeal or for a State fair hearing in a timely manner is not sufficient for benefits to be initiated.]

The documentation required to process grievances and appeals is as follows:

- Documentation is provided that oral inquiries seeking to appeal an action are treated as appeals and therefore establish the earliest possible filing date for the appeal. Oral inquiries must be confirmed in writing.
- Documentation is provided that the enrollee was provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
- Documentation is provided that the enrollee was provided opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.
- Documentation is included from parties to the appeal if the enrollee chooses, his or her representative or advocate; and, legal representative if the appeal involves a deceased enrollee's estate.
- Documentation is provided that the enrollee was provided the choice of an expedited appeal process when it is determined that the standard time for resolution would jeopardize the enrollee's ability to maintain or regain maximum functioning.
- Punitive action cannot be taken against a provider who requests and expedited resolution or supports an enrollee's appeal.

Assure complaint and grievance logs and tracking systems reflect the requirements in practice. Describe who handled the appeal, what their qualifications are, how they do the work consistent with regulations, etc.

The utilization/resource management staff of the CDRSN/PIHP are involved in appeal resolutions through the CDRSN/PIHP Quality Management Oversight Committee, CDRSN/PIHP Advisory Board, and Ombuds. The documentation is reviewed and any recommendations are forwarded to the CDRSN/PIHP staff and CDRSN/PIHP Governing Board for review and monitoring.

SEE ALSO: [Glossary of Terms and Acronyms](#)