# Customer Grievance and Appeals Process & Customer Services

VBCMH Training – FY25

# Customer Grievance and Appeals Process

- Customers have the ability to fully participate in their services, including using the Grievance and Appeals systems, when not satisfied.
- The Medicaid system, which traditionally has had no limits on services, now has limits imposed by utilization management under managed care. Therefore, customers have rights to contest such limits that occur outside of their participation.
- The system is set up to accommodate the customer. Each customer has several mechanisms to use (depending upon whether they are filing a “Grievance”, Appealing an “Adverse Benefit Determination”, or requesting a “Second Opinion”).

# What is a “Grievance”?

**Grievance:**

This is a formal way for our customers to tell us they are unhappy with service issues that are NOT about an “adverse benefit determination.” This would include things such as quality of care or services provided, aspects of interpersonal relationships between the mental health provider (caseworker, therapist, doctor, etc.) and the customers, failure to respect the customer’s rights, as well as several other scenarios where they are dissatisfied with something the agency has done or not done.

# What is a “Grievance”?

It can be considered a Grievance when there is a request for a different caseworker, therapist, nurse, job coach, CLS worker, doctor, etc. if the consumer’s request is reporting a grieving incident as the reason.

Even if you immediately assign a new provider and the customer is completely satisfied, you must let the Customer Services, customerservices@vbcmh.com, know about the request, brief reason for the request, and resolution. **Customer Services must call and speak to the customer or guardian about the issue also. Please let them know this call will happen!**

# What is an “Adverse Benefit Determination” (ABD)?

An **Adverse Benefit Determination (ABD)** (previously known as an Action) is a decision that negatively impacts a customer's claim for services:

An ABD for **Medicaid** Consumers are due when there is a:

- Denial or limited authorization of a requested service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within 14 calendar days from the receipt of a standard request for a service.
- Failure to make an expedited authorization decision within 3 working days from the date of receipt of a request for expedited service authorization.

# What is an “Adverse Benefit Determination” (ABD)?

- Failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning and as authorized.
- Failure to resolve within 30 calendar days from the date of a request for a standard appeal.
- Failure to resolve within 72 hours from the date of a request for an expedited appeal.
- Failure to provide disposition and notice of a local grievance/complaint within 90 calendar days of the date of the request.
- For a resident of a rural area with only one MCO, the denial of a request to exercise their right to obtain services outside of the network.
- Denial of a request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other financial responsibilities.

# Non-Medicaid Adverse Benefit Determination Notices

Beginning in 2017, VBCMH began to provide 30 calendar day Adverse Benefit Determination Notices to **Non-Medicaid** customers whenever services already in their Person-Centered Plans are being reduced, suspended, or terminated – unless this change to currently authorized services is coming from a recommendation by the treating psychiatrist, or a request from the customer/parent/legal guardian in writing.

*If requested by the psychiatrist or customer, change in services can begin as soon as it can be made possible.

# What is an Appeal?

A **Local Appeal** is a complaint filed by a customer, parent or legal representative about services that were denied, reduced, suspended or terminated or not started in a timely manner. Typically, these actions are communicated via a document titled: Adverse Benefit Determination.

- Example: After being assessed for CMH services, a customer is told we are recommending outpatient therapy, and we are denying their request for case management services. The customer must be given their denial in writing at the time of the clinical decision. The customer then has the right to Appeal our denial of case management services (our Adverse Benefit Determination). The Appeal process starts as soon as the request for the Appeal is made verbally or in writing.

# What Can A Customer Do If They Are Unhappy With Services?

- They can let their case manager, therapist, program supervisor or any VBCMH staff person know.
- They can file a Grievance or Appeal the "Adverse Benefit Determination" directly with Customer Services by phone or email.
- They do NOT need to file the grievance or appeal in person or in writing. They are **not required** to talk to Customer Service (CS) in person, but CS will need to call to discuss the issue more.
- Having customers CALL Customer Service by phone (or leaving a voicemail message) is usually the BEST way for them to begin the process.

# Remember!

*It is very important to **immediately** **forward ALL** Grievance, Appeals, Denials, and Second Opinion information right away, even when handled to the customer's satisfaction. This way Customer Service can follow up by calling to discuss, send needed letters, and log in the SWMBH Grievance and Appeals database.*

# This Is Worth Repeating:

*It is **very** important to **immediately** forward **all** Grievance, Appeals, Denials, and Second Opinion information, even when handled to the customer's satisfaction, to Customer Service so follow up calls can be made, letters can be completed, and it can be logged in the SWMBH Grievance and Appeals database.*

Emailing Customer Service (CS) is the most efficient way for STAFF to let CS know if a customer is filing a grievance, appeal, denial, or second opinion. Even if you have already handled the matter, please still let CS know the details and resolution so it can be handled properly.

# Who Can File a Grievance or Appeal?

- The Customer
- Legal Guardian
- Parent of a Minor
- Authorized Representative – *an individual who has been given written permission to act for the customer regarding the issue.*
  - *Providers can file FOR a customer IF they have been named as authorized representative. If not the named representative, providers can and should provide support/help/assistance to the customer throughout the process.*

# What type of information needs to be documented for a Grievance?

- Customer Name (and system # if available).
- Who the complainant is (customer, legal guardian, parent of a minor customer or authorized representative).
- Date the Grievance was received.
- Date it was resolved, if it has been resolved already.
- Type of Insurance if known or available.
- Comments/description of what had occurred. It is helpful to be given the reason for the action provided by the customer
- **Please inform the person that Customer Service will be contacting them.**

***IMPORTANT**

IF THE GRIEVANCE WAS NOT RESOLVED IN **90** CALENDAR DAYS, WITH WRITTEN NOTIFICATION TO THE CUSTOMER, THIS IS NOW AN "ADVERSE BENEFIT DETERMINATION" AND THEY HAVE THE RIGHT TO APPEAL.

# What Needs To Be Documented For A Local Appeal?

- Name of Customer (and system # if available)
- Who is appealing the Adverse Benefit Determination (Customer, Legal Guardian, Parent of the Minor Customer, or Authorized Representative)
- Date of the request for a local appeal was received
- Was appeal made by phone, in person, email, letter?
- Type of insurance if available
- Comments/description of what had occurred
- **Inform them that Customer Service will be contacting them.**

# What Are The Options For A Customer Appealing An "Adverse Benefit Determination"?

**Denial of Hospitalization or Initial Access to CMH Service Program**

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Second Opinion

**Denial, Suspension, Termination, Reduction, or Unreasonable Delay of a Medicaid Covered Service**

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Local Level Appeal

State Fair Hearing

# Where do Second Opinions Rights Come From?

Federal

- Code of Federal Regulations
  - 42CFR 438.206 (b) (3)

State

- Michigan Mental Health Code
  - MCL 330.1705
  - MCL 330.1409

Regional

- SWMBH Policy 6.4 Customer Appeal System

Local

- VBCMH Grievance and Appeal Procedure

# Mental Health Code Access Second Opinion

- If denied mental health services
- Second Opinion requests are filed by customer, guardian, or parent of a minor
- Second Opinion is completed by a “physician, licensed psychologist, registered professional nurse, or master’s level social work, or master’s level psychologist”
- If customer is found to have a serious mental illness, serious emotional disturbance, or a developmental disability, or is experiencing an emergency/urgent situation, the CMH agency will direct services to the customer.

# Mental Health Code
# Inpatient Psych Hospital Second Opinion

- If denied IP Psych Hospital Admission
- Must be performed within 3 days of the request for second opinion (excluding Sundays and legal holidays)
- Completed by psychiatrist,  physician, or licensed psychologist.
- If second opinion differs from original denial:
  - Executive Director and Medical Director of the CMH agency will make a decision based on available clinical information.
  - Decision will be confirmed in writing to the customer.
    - Written decision must include signatures of executive director and medical director (or verified that medical director was consulted)
- If second opinion agrees with original denial, CMH agency will provide information to customer regarding alternative services and referrals.

# Code of Federal Regulations

Each PIHP/region must: Provide for a second opinion from a network provider or arrange for the customer to obtain one outside the network, at no cost to the customer.

Regionally, these additional requests for a Second Opinion could include matters such as:

- Diagnoses
- Medications
- Plan of care – such as type of therapy, treatment modalities, etc.

# Timelines and Process For Request and Resolution

## Second Opinions

- Whenever an initial service or a hospitalization is denied, a customer *must* be informed **in writing** of their right to a Second Opinion.
- A Second Opinion Consultation regarding hospitalization must be provided by a physician or fully licensed psychologist within 3 days (excluding Sundays and legal holidays) unless it is an emergency.
- A Second Opinion Consultation regarding initial services may be provided by a master's level or higher clinician within 3 days (excluding Sundays and legal holidays) unless it is an emergency.
- Second Opinions in situations assessed to be of an emergent nature, will be conducted within 24 hours.

*If the request for a second opinion is denied - this is a violation of their Mental Health Code protected rights - and they should be assisted in filing a Recipient Rights Complaint.*

# Timelines and Process (continued)

Local Level Appeal

- Must be requested within 60 days from the date of the "Notice of Adverse Benefit Determination."
- Written Resolution of Appeal must be given within 30 calendar days from the date the request for the appeal was received.

# Fair Hearing Process

State Appeal Processes

If the customer is not satisfied with the disposition of local appeal:

- Customers with Medicaid are entitled to a "State Fair Hearing" by an Administrative Law Judge **ONLY** after a local appeal resolution is reached. The request must be made within 120 calendar days from the local appeal resolution notice.

- Customers without Medicaid can request an "Alternative Dispute Resolution Process" **ONLY** after a local appeal resolution is reached. The request must be made within 10 calendar days from the local appeal resolution notice.

# Mediation Services

Customers have the right to get Mediation Services from a neutral 3rd party. They can ask for Mediation at any time for dispute about service planning or provided services or supports by VBCMH or contracted providers.

Customers are informed about Mediation Services at the time services are started and annually thereafter. Information is also on VBCMH website.

Customers can ask for Mediation at the same time as a Grievance, Appeal, or State Fair Hearing.

Mediation does not apply to disputes about Medical Necessity decisions or Recipient Rights

# What Situations Require A Notice or Other Grievance Process?

- When a customer is expressing dissatisfaction with the CMH they should be informed that they can file a grievance with the agency.
- If the grievance was not resolved within 90 days, the customer must be informed that they now have the right to a local level appeal.
- When denied an initial service and/or hospitalization, all customers are provided a **written** right to a Second Opinion Notice.
- Whenever a new treatment plan is done, all customers receive an "Treatment Plan Notice of Service Authorization Determination." **This does replace the need for an ABD for denial, termination, reduction or suspension.**
- Notices are given to indicate a change (suspension, reduction or termination) of services in which the customer *was not a part of (as documented by the customer's signature)* must be mailed *10 days* before the ABD is to take effect.
- Notices for Delay of Authorization, Denial or Limited Authorization, including determinations based on type or level of service, requirements for medical necessity, appropriateness, etc. must be sent **in writing immediately** after a decision is made.

# How Does the Customer Learn of These Processes?

- They are given this information at the time of the intake/assessment and offered annually.
- They are given this information at each person-centered plan or addendum to the plan.
- They are given this information with their resolution letters to any grievances (written response to their dissatisfaction with the agency in some way).
- They are given this information upon request.
- They are given this information each time a “Notice of an Adverse Benefit Determination” occurs.

*This Information is located in the SWMBH Customer Handbook given to each customer with Medicaid and also found under publications on our website.*

# Notification Outside of PC Planning
# Customer Choice – Special Circumstance - ATO

While most customers can choose to end their involvement with CMH or even request changes in their services, individuals who are currently under a Deferral, Alternative Treatment Order (ATO) or Assisted Outpatient Treatment (AOT) Order through Probate Court are not able to make such requests in the same manner.

- If a customer on a Deferral, ATO or AOT is requesting to leave services, or "step down" from a high level of care, the primary clinician should consult with the supervisory clinical team to determine if another level of care or agency could provide services in a manner to support the Deferral, ATO or AOT.

# How Are Most Grievances and Appeals Avoided?

- By involving the customer in decisions about their treatment.
- By negotiating alternatives resolutions when services requested do not match the customer's needs.
- By asking the customer frequently (at least at the time of their periodic review) whether they are satisfied with services.
- By reviewing the person-centered plan to ensure that the customer believes that it continues to be appropriate and is still meeting their expectations.
- By promoting a welcoming environment at all times!

# Customer Services and Recipient Rights

## Customer Services

- Assists with problem solving and working toward acceptable resolutions
- Handles Grievances, Appeals, Denials, and Second Opinions
- Combats customer stigma and discrimination
- Ensures and promotes that customers are our central focus throughout all organizational decisions and service provisions
- Advocates on behalf of customers and their families
- Provides a listening ear so that customers and their families feel heard

## Recipient Rights

- Provides education and training for CMH staff regarding customer rights
- Reminds staff that it is their responsibility to report abuse, neglect or rights violations
- Talks directly with customers who feel their rights have been violated
- Investigates and responds to all recipient rights complaints that are filed
- Makes recommendations to the CEO when rights violations have occurred

# Your Customer Services Representative:

**SANDY THOMPSON or CS representative**

**Phone: 269-655-3333**

**Email: customerservice@vbcmh.com**

*Who else is Customer Service?*

**WE ALL ARE!**

*It takes each of us working together to fulfill the role of Customer Service.*