



PENINSULA RSN

COMPLAINT, GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: COMPLAINT, GRIEVANCE, APPEAL AND FAIR HEARING GENERAL REQUIREMENTS **Policy Number:** 6.01

Reference: 42 CFR 438.400; WAC 388-865-0255; Exhibit N

Effective Date: 6/2005

Revision Date(s): 11/2010

Approved by: PRSN Executive Board

CROSS REFERENCES

- Form: Exhibit N Reporting Forms (Medicaid , non-Medicaid, and Appeal)
- Policy: Appeal Process
- Policy: Complaint and Grievance
- Policy: Corrective Action Plan
- Policy: Fair Hearing
- Policy: Notice Of Action Requirements
- Policy: Grievance Oversight and Recordkeeping

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to establish a process for both Medicaid enrollees and state funded individuals to pursue a complaint, grievance, appeal, and access an Administrative Fair Hearing.

This policy is designed to allow individuals and/or advocates/representatives the opportunity to have a complaint/grievances heard in a uniform manner and resolved in a timely fashion.

The PRSN policy will outline the rights, responsibilities and requirements of the PRSN, consumers, providers, and other involved parties at all levels of the complaint, grievance, appeal, and fair hearing system.

This policy applies to Medicaid enrollees and state funded individuals receiving services paid for by the PRSN. The PRSN is the Pre-Paid Inpatient Health Plan (PIHP).

DEFINITIONS

A complaint is an agency-based issue of dissatisfaction with some aspect of mental health services that a client (or their designated advocate) expresses verbally or in writing.

A grievance is an issue of dissatisfaction that a client (or their designated advocate) expresses at the RSN level. All verbal grievances must be followed-up with a written and signed statement within seven (7) days.

- Issues of dissatisfaction related to Medicaid *actions* (authorization decisions) are resolved through the RSN appeal process.

These are concerns expressed by Medicaid and state funded individuals.

Appeal means a request for review and reconsideration of an action outlined in a written notice of action. There is an expedited appeal process that can be activated.

An Action in the context of Medicaid services includes:

- The denial or limited authorization of a requested services
- The reduction, suspension, or termination of a previously authorized service
- The denial in whole or in part, of payment for a service
- The denial of a request for inpatient authorization
- The failure of the PRSN to act within the timeframes provided in section 42 CFR 438(b) or
- For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under section 42 CFR 438.52 (b) (2) (ii), to obtain services outside the network

Administrative Fair Hearing means a hearing conducted through the auspices of the state Office of Administrative Hearings in accordance with Washington Administrative Code (WAC) 388-02. An issue of dissatisfaction must complete the PRSN Grievance/and Grievance Appeal process prior to requesting a DSHS Administrative Fair Hearings.

- The term Fair Hearing is synonymous with Administrative Hearing.

Mental Health Care Provider means an individual with primary responsibility for implementing an individualized service plan for mental health services.

Provider means any PRSN contracted network community mental health agency licensed to provide mental health services covered in the PRNS contracts (PIHP and SMHC). Community Mental Health Agency is synonymous with provider.

PROCEDURE

1. The PRSN values the resolution of complaints, grievances and appeals at the local/ lowest possible level, in a confidential manner and without retaliation.

Retaliation, formal or informal, against an individual or a mental health agency will not occur by developing a multi-level and independent grievance system.

- There will be no retaliation or punitive action of any kind against an individual who initiates a complaint, grievance, appeal or request for fair hearing.
 - There will be no retaliation against a provider, or providers, that initiate a grievance or appeal on behalf of an individual.
2. All offered resolutions to complaints and grievances honor individual voice, choice, and rights of and on behalf of the individual filing the concern. Ensure that at all stages of the process emphasis shall be placed on a consumer-defined solution.
 - Resolutions will consider the most effective clinical practices, Access to Care Standards, medical necessity, laws and federal, state and contractual requirements.
 3. Individuals, and their designated advocates, may initiate and pursue a complaint, grievance, appeal and fair hearing.
 - Complaints, grievances and appeals can be filed either orally or in writing. A written, signed request must be submitted within seven (7) days of an initial oral request. The oral filing may be used to establish the earliest filing date.
 - For Medicaid enrollees, previously authorized services will continue or be reinstated during the complaint and grievance process at the individual's request. During appeals, previously authorized services may continue or be reinstated under certain circumstances.

When grievances or appeals are not resolved wholly in favor of the individual, under certain circumstances they may be asked to pay for these services.
 - Filed complaints, grievances, and appeals will be investigated even if the individual is no longer receiving services.
 4. The PRSN will ensure that individual's are made aware that at any point in the process they may utilize an advocate or representative to assist them (with written permission), such as:
 - A community mental health agency, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal, or

- A community mental health agency may file a grievance, appeal or request a state fair hearing on behalf of an enrollee and act as the enrollee's authorized representative.
 - At a minimum, Ombuds services will be offered at all levels of the process.
 - Reasonable assistance shall be provided in completing forms and taking other procedural steps. This may include providing interpreter services and toll-free numbers that have adequate TTY/TTD capability.
5. Individuals may request an appeal of an action by the PRSN or its formal designee. Appeals regarding authorization decisions by PRSN are pursued with CommCare.

Individuals will receive a written notice of action that outlines their rights to appeal actions including service determination or authorization by the PRSN designee, CommCare, and the process to appeal these actions with the PRSN.

- Outpatient and inpatient actions, for Medicaid individuals, can be pursued through the appeal process.
6. A request for a Fair Hearing may be made at anytime a consumer, or their designated advocate, believes there has been a violation of the Washington Administrative Code (WAC). A Fair Hearing may also be requested if they are dissatisfied with the PRSN resolution of a grievance or appeal.
- Ensure that at no time does this procedure cancel the individual's right to request a Fair Hearing.
7. The PRSN informs individuals of their rights to initiate a complaint, grievance (including expedited grievances), appeal, and fair hearing through distributing published DSHS Benefit Booklet, PRSN brochures, Ombuds material, PRSN handbook and PRSN standardized consumer rights forms with readily understandable language.

The DSHS Benefit Booklet is mailed to Medicaid recipients annually from the state.

The PRSN brochures are available in public areas throughout the community. The PRSN handbook is mailed to all individuals authorized and re-authorized for care within the network.

The PRSN standardized outpatient client rights form is provided along with consent for treatment and grievance information. The rights are also listed in the DSHS Benefits booklet, Ombuds brochure and PRSN brochure and handbook.

- This information shall be made available to all current and potential users of publicly funded mental health services, and advocates in language that is clear and easily understood to the individual.

- The individual filing the complaint, grievance, or appeal (or their designated advocate) may examine their case file, including medical records, documents and records considered at any time before and during the grievance appeal process.
8. The PRSN, network providers and subcontractors will cooperate with and promptly abide by all complaint, grievance, appeal, and Fair Hearing decisions. The PRSN will require this in contracts and will monitor compliance with this requirement through the annual administrative review process.
 9. The PRSN and network providers maintain records of complaints, grievances, appeals, and Fair Hearings. All records will be retained for six (6) years following a resolution.
 - All records of complaints, grievances, appeals, and Fair Hearings will be kept confidential and separate from clinical records. These records will not be disclosed without the individual's written authorization, except as necessary, in the following circumstances:
 - i. to resolve the issue(s) of concern
 - ii. to DSHS if a fair hearing is requested
 - iii. or for review as part of the quality improvement or state quality strategy

MONITORING

1. This policy will be monitored through PRSN:
 - Review and approval of network providers complaint policies
 - Annual network provider and subcontractor Administrative Reviews
 - PRSN Trainings
 - Exhibit N: PRSN Grievance tracking. Information about individual complaints, grievances, appeals, or Fair Hearings that have system wide implications may be used for quality improvement.
 - Quality Management Plan activities, such as standard review of Exhibit N form and report, analysis of targeted trends and system recommendations. Information about types of agency complaints, PRSN grievances, PRSN appeals, Fair Hearing requests and denials will be used to analyze patterns or trends and identify areas for quality improvement.
 - The Department conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/youth. The MHSIP measures general consumer satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The PRSN requests over sampling of the region to gather specific catchment area data and analyze for trends

2. If a provider/contractor performs below expected standards during any of the reviews listed above a Corrective Action Plan will be required for PRSN approval.

Authorized PRSN Community Mental Health Providers

Crisis services are available 24 hours a day, 7 days a week.
For non-crisis hours of operation, please contact the individual
Mental Health Provider at its local number.

East Clallam County

Peninsula Community Mental Health Center
118 East 8th Street
Port Angeles, WA 98362
360-457-0431 Services
360-452-4500 Crisis



West Clallam County

*Forks Community Hospital – West End
Outreach Services*
530 Bogachiel Way
Forks, WA 98331
360-374-6177 (Services or **Crisis**)



Jefferson County

Jefferson Mental Health Services
884 W Park
Port Townsend, WA 98368
360-385-0321 or 877-410-4803 (Services or **Crisis**)



Kitsap County

Kitsap Mental Health Services
5455 Almira Drive NE
Bremerton, WA 98311-8330
360-373-5031 TDD 360-478-2715
Emergency Services 360-373-3425
Crisis Clinic 360-479-3033 or 800-843-4793
From North Kitsap 360-535-5400
From Bainbridge Island 206-694-4655



PRSN Administration Offices
614 Division Street, MS-23
Port Orchard, WA 98366-4676
360-337-4604 FAX 360-337-5721
Toll Free 1-800-525-5637

Peninsula Regional Support Network

*Community Mental Health Services in
Clallam, Jefferson & Kitsap Counties*

Complaint, Grievance, & Fair Hearing Brochure

December 2011



Administered by the Kitsap County
Department of Personnel & Human Services

If you have a concern about the quality of your mental health services or access to services, you have the right to file an agency complaint, Peninsula Regional Support Network (PRSN) grievance, or fair hearing.

By sharing your concerns, problems are resolved and we can ensure improvement to the overall system.

Ombuds Services are offered at no cost to assist individuals who have questions or need assistance with filing a complaint, grievance or fair hearing.

PRSN Ombuds Services

BRIDGES Mental Health Ombuds

9004 Washington Ave NW

Silverdale, WA 98383

(360) 692-1582 or

1-888- 377-8174

ombuds@kitsapdrc.org

All calls are kept confidential and support client-directed solutions.

It is a good idea to try to resolve your concerns with the person directly involved or ask the Ombuds to assist you before taking formal action because problems can usually be resolved in a timelier manner.

- Explain your concern. Be clear about what an acceptable solution will be.
- Try to find ways to reach agreement that will satisfy both you and the other person.

What is a Complaint?

A complaint is any issue of dissatisfaction with some aspect of service. Complaints are filed with the network mental health agency.

What is a Grievance?

A grievance is an expression of dissatisfaction about the overall system, usually after unsuccessful resolution of a complaint. Grievances are filed with the PRSN.

What is a Fair Hearing?

A fair hearing is an expression of dissatisfaction, after filing a PRSN grievance. Fair Hearings are filed with the Department of Social & Health Services (DSHS) Office of Administrative Hearings.

How do I file a Complaint or grievance?

A complaint or grievance may be submitted in person, by telephone or in writing.

You may file the concern or an authorized representative may file the concern for you.

Complaints about direct services are filed with your mental health agency. For your convenience, forms are available in the agency main lobby or by calling the Ombuds office.

Grievances regarding the overall system can be directed to the:

Peninsula Regional Support Network

614 Division Street MS-23

Port Orchard, WA 98366-4676

(360) 337-4604 or

1-800-525-5637

What happens after I file a complaint or grievance?

Every agency complaint and PRSN grievance is acknowledged in writing. The letter explains what actions will be taken to resolve your concern.

A written resolution will be provided within 30 days from the filing date. This timeframe can be extended, with permission granted from the Department of Behavioral Rehabilitation Services of DSHS.

Can I continue to receive services while my complaint / grievance is in process?

Yes, your mental health services will continue through your authorization period. Contact the PRSN immediately if you feel your services have been affected as a result of sharing your concern.

What if I am not satisfied with the offered resolution?

If you are not satisfied with the offered resolution to your complaint, you can file a grievance.

If you are not satisfied with the offered resolution to your grievance, you have the right to file a Fair Hearing request with:

DSHS Office of Administrative Hearings

1-800-583-8271



December 2011





PENINSULA RSN

COMPLAINT, GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: COMPLAINT AND GRIEVANCE

Policy Number: 6.02

Reference: 42 CFR 438.214
WAC 388-865-0255

Effective Date: 8/2004

Revision Date(s): 5/2011

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Appeal Process
- Policy: Complaint, Grievance, Appeal, and Fair Hearing General Requirements
- Policy: Corrective Action Plan
- Policy: Fair Hearing
- Policy: Grievance Oversight and Recordkeeping
- Policy: Notice Of Action Requirements

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to establish a process for both Medicaid enrollees and state funded individuals to pursue a complaint and grievance (expedited grievance) requirements.

This policy is designed to allow individuals and/or advocates/representatives the opportunity to have a complaint/grievances heard in a uniform manner and resolved in a timely fashion.

The PRSN policy will outline the rights, responsibilities and requirements of the PRSN, consumers, providers, and other involved parties at all levels of the complaint, grievance, appeal, and fair hearing system.

This policy applies to Medicaid enrollees and state funded individuals receiving services paid for by the PRSN. The PRSN is the Pre-Paid Inpatient Health Plan (PIHP).

DEFINITIONS

A complaint is an agency-based issue of dissatisfaction with some aspect of mental health services that a client (or their designated advocate) expresses verbally or in writing.

A grievance is an issue of dissatisfaction that a client (or their designated advocate) expresses at the RSN level. All verbal grievances must be followed-up with a written and signed statement within seven (7) days.

- Issues of dissatisfaction related to Medicaid *actions* (authorization decisions) are resolved through the RSN appeal process.

These are concerns expressed by Medicaid and state funded individuals.

PROCEDURE

1. The PRSN will ensure Ombuds services and assistance is available to provide advocacy, assistance, and investigation to individuals with concerns, family members and other interested parties throughout the complaint and grievance process.
 - Ombuds work to assist in resolving the complaint at the lowest level possible.
2. For all complaints and grievances, individuals with concerns may have representation of their choice involved throughout the process(es). This may include, but is not limited to Ombuds, family members, mental health care professional, network provider, and network mental health agency.
3. For Medicaid enrollees, individuals filing an agency complaint or PRSN grievance will be notified that previously authorized services will continue or be reinstated during the process at the individual's (or their advocates) request.
4. Individuals or their advocates may examine case files, including medical records and any other documentation considered during the complaint and grievance process (before and during).
5. Qualified mental health care professionals who have the appropriate clinical expertise will participate in the complaint and grievance resolution process(es).
 - Staff with the authority to resolve the issue(s) of concern or require corrective action will participate in the process and offer a face to face meeting as needed to resolve the issue(s).

Network Agency Complaint Process

1. The PRSN will provide information about the complaint/grievance system to all network providers and subcontractors at the time they enter into a contract with the PRSN.
2. The PRSN will insert into each network provider and service contract the condition to abide by all grievance, appeal and administrative hearing decisions.
3. If the issue of dissatisfaction is defined as an agency complaint, the network provider agency will have a complaint process that includes:
 - a. An agency single point of contact.
 - b. A standard process not to exceed thirty (30) days, inclusive of established filing date (oral or written) and agency offered solution.
 - The oral filing may be used to establish the earliest filing date. A written, signed request must be submitted within seven (7) days of an initial oral request.
 - The network agency will attempt to resolve the complaint quickly and to the individual's satisfaction. The resolution shall be resolved as expeditiously as the individual's mental health condition requires.
 - Assistance will be provided to the individual and Ombuds services will be offered.
 - c. An agency complaint form is easily understood and includes the name (and designated advocate), contact information, date of filing, issue of dissatisfaction, defined requested resolution, signature, and agency action taken, solution(s) offered and date solution(s) were offered.
 - d. The agency offered resolution shall be provided in writing. The written response will include the reason for the decision, the right to pursue a PRSN grievance, the right for previously authorized services to continue or be reinstated during the grievance process at the individual's request, and the process and available supports if the individual (or their advocate) has any additional concerns about retaliation.
 - If the individuals is not satisfied with the agency offered solution(s), a process to forward and begin the PRSN grievance process within one (1) working day.
4. The PRSN will send a Notice of Action to the individual about their rights to request a Fair Hearing if the PRSN fails to meet the thirty (30) day timeline to the disposition of the grievance.

5. Agency complaints will be documented and tracked for continuous quality improvement regardless of the resolution.
 - Complaints filed by allied systems, advocates, family members or other parties as a designated advocate and on behalf of the individual (and the individual chose to not pursue the complaint) will be documented.

PRSN Grievance Process

1. If the issue of dissatisfaction meets the definition for PRSN grievance or the individual is not satisfied with the network provider or subcontractor offered resolution, the PRSN grievance process applies.
 - If the issue is related to a Medicaid authorization determination decision, the PRSN appeal process applies.
 - If the issue is related to extending an authorization decision beyond the standard fourteen (14) days from request, the PRSN ASO will provide the individual a written notice of the reason for the extension and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

For extended authorizations, the determination will be provided as expeditiously as the individual's health condition requires and no later than the date the extension expires.

2. The PRSN grievance process includes a standard thirty (30) day process and expedited three (3) day review process.
 - The PRSN will attempt to resolve the grievance quickly and to the individual's satisfaction. The resolution shall be resolved as expeditiously as the individual's mental health condition requires.
 - The standard thirty (30) day process may be extended an additional fourteen (14) days if:
 - i. the enrollee, provider or representative acting on behalf of the individual requests the extension and there is written agreement requests the extensions, and
 - ii. the PRSN shows (to the satisfaction of the State, upon its request) that there is a need for additional information and how the delay is in the enrollee's interest, and
 - iii. the reason for the delay is provided in writing.
3. The PRSN will acknowledge receipt of a formal grievance in writing within one (1) working day.
 - For Medicaid enrollees, the written acknowledgement will include notice to the designated advocate that previously authorized services will continue

or be reinstated during the grievance process at the individual's (or their advocates) request and circumstances in the individual may be asked to pay for the cost of those benefits if the grievance upholds the original decision.

- A copy of the written acknowledgement will be provided to the involved network provider agency.
- a. Oral filings are permitted to allow for earliest possible filings.
- Oral requests must be followed up with a written and signed request, by the individual with the concerns or their designated advocate (with written permission) within seven (7) days of the oral filing.
Email requests will be treated like a verbal request, and a written signed statement must be received within seven (7) days of the email request.
Written statements can be received electronically, faxing, or via mail.
 - Written requests should include the name, how the PRSN can best contact the person (and their advocate), the nature of the grievance, the requested resolution, and any additional information the individual would like to submit for consideration.
The PRSN Grievance form was created as an optional form for this purpose.
3. If the individual is dissatisfied with the results of the grievance process, they may under circumstances request additional consideration of the formal grievance from the state.
- The individual must request consideration within five (5) days of receipt to the PRSN offered resolution.
4. The individual may also request a Fair Hearing, with the Office of Administrative Hearings. Requests for Fair Hearings must be made within twenty (20) days of notice of offered resolution of a grievance.
- Requests for a Fair Hearing can occur at any time if they believe there has been a violation of the Washington Administrative Code (WAC).

Standard Grievance Process (not expedited)

1. The individual, and their designated advocate, will be provided assistance with the grievance process. If the individual or their advocate is not receiving assistance from the Ombuds services, Ombuds services will be offered.
2. The PRSN Administrator, or a designated PRSN staff committee with appropriate clinical expertise, will review the grievance and make the decision/ offered resolution.

- Designated PRSN committee cannot have any previous involvement, review, or decision-making in the issue(s) or case.
3. PRSN staff with the authority to resolve the grievance or require corrective action will participate in the process and offer face to face meeting with the individual to discuss the grievance. The individual may invite representatives of their choice to the meeting and have representatives of their choice involved throughout the grievance process.
 - All documentation being considered in the grievance review will be made available to the individuals and their advocate five (5) days prior to the review and grievance meeting.
 4. Upon conclusion of the grievance review, the PRSN will make a final determination regarding the grievance.
 5. The PRSN will provide a written resolution to the individuals and their advocate as expeditiously as the mental health condition requires and not to exceed thirty (30) days of receipt of the grievance (oral or written, whichever is first).
 - The written resolution will include the reason for the decision, the results of the resolution process, the date it was completed, the process and available supports if the individual was concerned about retaliation. The notice will also include information about the process to request additional consideration via the Fair Hearing process.

The right to request a state Fair Hearing, the process for requesting a Fair Hearing, the right to request to continue to receive benefits while the hearing is pending, how to make the request, and notice for any circumstances in which the individual may be asked to pay for the cost of those benefits if the hearing decision upholds the original decision.

A copy of the offered resolution will be mailed to the involved network provider agency.
 6. The PRSN will send a notice of action (NOA) to the individual about their rights to request a Fair Hearing if the PRSN fails to meet the thirty (30) day timeline (unless an extension is granted) to the disposition of the grievance.

Expedited Grievance Process

The PRSN will expedite the grievance process when an individual's condition requires a more immediate response to a grievance. When the individual or their advocate requests an expedited resolution of a grievance, the PRSN must respond within three (3) working days or sooner based on medical necessity of the individual.

1. Requests for expedited resolution may be initiated orally and are not required to be followed by a written signed request by the individual or their designated advocate.

2. The PRSN will make a grievance review and determination, with offered resolution, as expeditiously as the individual's mental health condition requires.
 - Within three (3) working days or sooner based upon the medical necessity of the individual.
 - The PRSN will also make reasonable efforts to provide oral notice.
3. The PRSN will provide the individual or their designated advocate an opportunity to present evidence, and allegations of fact, in person as well as in writing and inform the individual of the limited time available for expedited resolution.
4. The PRSN will ensure that retaliation or punitive action is not taken against an individual who requests an expedited resolution.
5. The PRSN will provide a written resolution to the individuals and their advocate as expeditiously as the mental health condition requires and not to exceed three (3) days of receipt of the grievance.
 - The written resolution will include the reason for the decision, the results of the resolution process, the date it was completed, the process and available supports if the individual was concerned about retaliation. The notice will also include information about the process to request additional consideration via the Fair Hearing process.

The right to request a state Fair Hearing, the process for requesting a Fair Hearing, the right to request to continue to receive benefits while the hearing is pending, how to make the request, and notice for any circumstances in which the individual may be asked to pay for the cost of those benefits is the hearing decision upholds the original decision.
 - A copy of the offered resolution will be mailed to the involved network provider agency.
6. The request for an expedited review shall not cancel an individual's right to request a standard thirty (30) day grievance review.

MONITORING

1. This policy will be monitored through PRSN:
 - Annual network provider and subcontractor Administrative Reviews
 - PRSN Trainings
 - Exhibit N: PRSN Grievance tracking. Information about unresolved individual complaints, grievances, appeals, or fair hearings that have system wide implications may be used for quality improvement.

- Quality Management Plan activities, such as standard review of Exhibit N form and report, analysis of targeted trends and system recommendations. Information about types of complaints, grievances, appeals, fair hearing requests and denials will be used to analyze patterns or trends and identify areas for quality improvement.
 - The Department conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/youth. The MHSIP measures general consumer satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The PRSN requests over sampling of the region to gather specific catchment area data and analyze for trends.
2. If a provider/contractor performs below expected standards during any of the reviews listed above a Corrective Action Plan will be required for PRSN approval.

PRSN GRIEVANCE FORM

This form is to be completed when filing a Grievance request with the Peninsula Regional Support Network (PRSN). This form will help the PRSN understand the resolution you desire.

Name of individual filing Grievance: _____

Address: _____

Phone Number: _____

Name of enrollee advocate/representative: _____

Address: _____

Phone Number: _____

I had/ have Medicaid coverage during the time the Grievance action(s) occurred? Yes No

PRSN Agency/Subcontractor that Grievance involves: _____

Key individuals involved in the Grievance: _____

Grievance facts and circumstances summary: _____

Has the Complaint been filed with the mental health agency/entity? Yes No

What was the agency Complaint response: _____

Page 2

Description or portions of Federal regulations, contract, or Washington Administrative Code which consumer or consumer advocate/representative believes were violated: _____

Enrollee defined solution: _____

Additional comments: _____

Medicaid recipients, only: Your mental health Medicaid benefits shall continue while the Grievance Resolution is pending. If the final resolution is adverse to you by upholding the original decision, you may be financially responsible for the cost of the services furnished while the Grievance is/ was pending. Please contact the number below, if you believe your benefits have discontinued.

I hereby affirm that the information contained in this Grievance document is true to the best of my information and belief.

SIGNED: _____

DATED: _____

CONTACT: Stacey A.S. Smith, Resource Manager
Peninsula Regional Support Network
614 Division Street, MS-23
Port Orchard, WA 98366-4676

Phone: (360) 337-4648 or (800) 525-5637
FAX: (360) 337-5721

(Rev. 5/2007)



PRSN

PENINSULA REGIONAL SUPPORT NETWORK
Providing Public Mental Health Services in
Clallam, Jefferson, and Kitsap Counties

(Date)

EXECUTIVE BOARD

Clallam County

Mike Chapman
Mike Doherty
Steve Tharinger

Jefferson County

John Austin
Phil Johnson
David Sullivan

Kitsap County

Josh Brown
Charlotte Garrido
Rob Gelder

ADVISORY BOARD

Clallam County

Randy Bailey
Arlene Engel
Sandra Garrison
Alice McElroy
Mary Robuck

Jefferson County

Marti Anthony
Daniel Deane
Cheron Dudley, MS
Nancy O'Neill, Ph.D
Suzanne Schmidt

Kitsap County

John Freeburg
Lois Hoell, RN, MS
Ethan Green
Bill Mosiman
Sally O'Callaghan

ADMINISTRATOR

Anders Edgerton

Dear _____,

The purpose of this letter is to acknowledge receipt of the grievance you filed with the PRSN on [date]. Under Washington Administrative Code 388-865-0255, you have the following rights under the grievance process:

1. Acknowledgement that the complaint or grievance has been received within one working day of receipt. Acknowledgement may be by telephone with written acknowledgement mailed within five (5) working days.
2. Investigation and resolution of grievances and a written response within thirty (30) days. This timeframe can be extended by mutual written agreement, not to exceed ninety (90) days.
3. Resolution of grievances at the lowest level possible.
4. Access to a formal process for dispute resolution.
5. Information about how to access the Mental Health Ombuds service for assistance during the grievance process. The Mental Health Ombudsman can be reached at (360) 692-1582 or toll free at 1-8888-377-8474.
6. Participation of other people in the process, at your choice.
7. Access to needed mental health services during the grievance process.
8. Follow-up by the Regional Support Network to assure that there is no retaliation against you for filing a grievance.
9. To be informed of your right to file an administrative hearing with the Department of Social and Health Services (DSHS) instead of using the Regional Support Network complaint and grievance process. You have the right to a hearing when:

- a) You believe there has been a violation of DSHS rule;
- b) The Regional Support Network did not provide a written response within thirty (30) days from the date a written request was received;
- c) The Regional Support Network (mental health pre-paid in-patient health plan), the Department of Social and Health Services, or a provider denies services.

To request a hearing, you may request a Hearing Request form from me at (360) 337-4648, or you may contact our Ombuds at the number listed above. You may also contact the DSHS at 1-800-713-6010 to make a request for administrative hearing.

Please contact me if you have further questions about our grievance policy and procedure.

Sincerely,

Stacey A.S. Smith,
PRSN Resource Manager



PRSN

PENINSULA REGIONAL SUPPORT NETWORK
Providing Public Mental Health Services in
Clallam, Jefferson, and Kitsap Counties

EXECUTIVE BOARD

Clallam County

Mike Chapman
Mike Doherty
Steve Tharinger

Jefferson County

John Austin
Phil Johnson
David Sullivan

Kitsap County

Josh Brown
Charlotte Garrido
Rob Gelder

ADVISORY BOARD

Clallam County

Randy Bailey
Arlene Engel
Sandra Garrison
Alice McElroy
Mary Robuck

Jefferson County

Marti Anthony
Daniel Deane
Cheron Dudley, MS
Nancy O'Neill, Ph.D
Suzanne Schmidt

Kitsap County

John Freeburg
Lois Hoell, RN, MS
Ethan Green
Bill Mosiman
Sally O'Callaghan

ADMINISTRATOR

Anders Edgerton

(Date)

RE: PRSN Grievance Resolution (Template)

Dear _____,

On (date), you filed a Grievance with the Peninsula Regional Support Network (PRSN) regarding: (briefly state issue)

This letter is to inform you that the PRSN has investigated your grievance and would like to offer the following resolutions:

- (one)
- (two)
- (three)

If you do not agree with the resolutions offered above (all or partial), you may contact the mental health Ombuds services to further address your concern and for assistance in pursuing a satisfactory response through the Fair Hearing process. You can reach the Ombuds at (360) 692-1582 or toll free at 1-888-377-8174.

In addition, if you feel that because you have filed a grievance your care is being compromised or you believe you have experience retaliation in some way, please contact me or the Ombuds services immediately. You can reach me directly at (phone number) or toll free at 1-800-525-5637.

Sincerely,

Name
Title



PENINSULA RSN

COMPLAINT, GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: APPEAL PROCESS

Policy Number: 6.03

Reference: 42 CFR 438.214

Effective Date: 8/2004

Revision Date(s): 5/2011

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Complaint, Grievance, Appeal, and Fair Hearing General Requirements
- Policy: Complaint and Grievance
- Policy: Corrective Action Plan
- Policy: Fair Hearing
- Policy: Grievance Oversight and Recordkeeping
- Policy: Notice Of Action Requirements

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to establish a standardized appeal process regarding actions for Medicaid authorization decisions. This policy is designed to outline a uniform and timely procedure for PRSN appeal process and expedited appeal requirements. The PRSN is the Pre Paid Inpatient Health Plan (PIHP).

The PRSN subcontracted Administrative Service Organization (ASO) is responsible for handling the PRSN the appeals process - standard and expedited. The PRSN is responsible for overseeing, is accountable for, and monitors the functions and determinations resulting from the ASO appeal process.

The ASO may adopt more expansive definitions and procedures to ensure Medicaid enrollees receive more information and notification than required in this policy. The ASO procedure shall adhere to URAC/NCQA standards.

PROCEDURE

Medicaid enrollees or providers or representatives on behalf of the enrollee and with the enrollee's written permission may request an appeal of action to the PRSN. They may also ask for an expedited appeal. For appeals of the denial of inpatient authorization or extension request, the inpatient provider may also request an appeal or expedited appeal with written permission of the individual seeking services.

Enrollee's, providers, or other representatives may contact Ombuds services for assistance or may initiate an appeal or expedited appeal verbally or in writing with PRSN ASO.

Ombuds services are available to provide advocacy, assistance, and investigation throughout the appeals process. Ombuds services work to assist individuals or representatives with the standard and expedited appeals process listed below.

1. A Medicaid enrollee will receive a written notice of action (NOA) prepared by the PRSN subcontracted Administrative Service Office (ASO) that explains the authorization action the PRSN intends to take or has taken, the reason for the action, and the right to request an appeal or expedited appeal of these actions.
 - The notice will outline the process to appeal an action.
 - PRSN network providers requesting services on behalf of the enrollee will also receive notice through the regional Profiler and/or Provider 1 information system.
 - For denials of inpatient authorization or extensions the inpatient provider will receive a written notice of action.
 - The PRSN office receives a copy of all notices the ASO provides for 100% review.
2. Appeals are requests by a Medicaid enrollee, provider or representative on behalf of the enrollee and with the enrollee's written permission to the PRSN for review and reconsideration of an action as outlines in the notice of an action.
 - For appeals that involve inpatient services, network community mental health agencies, agency provider staff, and inpatient providers may also request an appeal on behalf of the enrollee, with the enrollee's written permission.
3. Expedited appeals are requests by a Medicaid enrollee, provider or representative on behalf of the enrollee and with the enrollee's written permission to the PRSN for expedited review and reconsideration of an action as outlines in the notice of an action.
 - For appeals that involve inpatient services, inpatient providers may also request an expedited appeal on behalf of the enrollee, with the enrollee's written permission.

4. Enrollees or representatives on behalf of the enrollee with the enrollee's written permission may initiate an appeal or expedited appeal verbally or in writing.
 - Oral requests for appeal must be followed up with a signed written request by the enrollee or representative within seven (7) days.
 - Requests for expedited appeals are not expected to be followed with a written request.
5. Expedited appeals may be requested when the enrollee, provider or other representative believe that taking the time for a standard resolution could seriously jeopardize the enrollee's life, mental health or ability to attain, maintain, or regain maximum functioning.

The PRSN will follow the expedited appeal process outlined below when:

- a. An expedited appeal is requested by an enrollee or representative and the PRSN ASO determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life, mental health or ability to attain, maintain, or regain maximum function.
 - b. A network provider or inpatient facility indicates that the enrollee's condition requires a more immediate response and that taking the time for a standard resolution could seriously jeopardize the enrollee's quality of life like, mental health or ability to attain, maintain, or regain maximum function.
6. Medicaid enrollee, or their designated advocate, must request an appeal within twenty (20) days of the date on the service denial (noted on the PRSN NOA notification letter).
 - Appeals must be initiated within ten (10) calendar days of the receipt of the PRSN notice for enrollees to request that their previously authorized services continue or be reinstated during the appeals process.
 - If the initial request to file an Appeal was made orally in order to establish the earliest possible filing date, a follow-up written and signed form must be received within seven (7) days.

Standard Appeal Process

1. If the enrollee is not receiving assistance from Ombuds services, Ombuds services will be offered for assistance.
 - Enrollees may have assistance from their provider or anyone of their choice, throughout the process.
2. The PRSN subcontracted ASO will document the appeal, including the date of receipt, actions taken, resolution offered, and date of notification to the enrollee.

- The ASO will attempt to identify the concern at the time of enrollee contact. The ASO will reiterate the resources, including local Ombuds services, interpreter services and toll-free numbers with adequate TTY/TTD capability, to assist individuals in filing an appeal.
3. If the appeal is done verbally, the enrollee will follow up within seven (7) days of the oral request with a written signed request. Oral requests are treated as appeals and therefore establish the earliest possible filing date for appeals.
 4. Written requests for appeal should include the name, address, how the PRSN can best contact the enrollee, reasons for appealing, and any evidence that enrollee or representatives wish to attach. The enrollee may send supporting records, letters from their mental health provider, a list identifying qualified witnesses, or other information that explains services should be provided. Enrollees may request information from their mental health provider.
 - The investigation may begin prior to receipt of the appeal written and signed request form.
 5. The PRSN ASO will acknowledge a request for an appeal in writing and begin an investigation within one (1) working day of receipt of a written and signed appeal request (for Standard Reviews).
 - The written acknowledgement will include notice to the enrollee or representative that previously authorized services will continue or be reinstated during the appeals process at the enrollees or representative's request if:
 - a. The appeal is filed in a timely manner
 - b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
 - c. Services were requested by an authorized community mental health agency
 - d. The enrollee requests an continuation of services and benefits
 - e. The original period covered by the original authorization has not expired at the time of the request for continuation of benefits.
 - The written acknowledgment will also include notice for any circumstances in which the enrollee may be asked to pay for the services received during the appeals process if the decision is not in their favor.
 6. The ASO standard appeal process shall include:
 - Staff involved in the appeal process are/were not involved in previous decision-making of the case, with expertise in the mental health specialty, and whose specialty matches the attending provider's specialty as a clinical peer.

- All outpatient and voluntary inpatient service denials will reviewed by a certified physician or psychiatrist, who is certified in the relevant clinical specialty (i.e. child and adolescent), was not involved in the previous determination, nor is a subordinate of a previous decision maker.
 - Identified review staff may request involvement from the ASO Quality Improvement Committee members. This is at the discretion of the staff member.
 - An appeal process will take into account all clinical documents, records, or other information submitted by the individual requesting the appeal, physician, provider, and/or facility relating to the case.
 - An appeal process may include contacting the attending provider for additional information and/or clarification of existing information.
 - An opportunity for the individual, or their advocate, to review their case file, including medical records and other documents and records considered (before and) during the appeal process.
 - An opportunity for the individual, or their advocate, to provide a brief presentation or written material regarding the stated matter of concern. The PRSN could facilitate and coordinate a video tele-conference connection for this purpose.
 - Ensure there are provisions to address retaliation against the individual requesting the Appeal.
7. The following timeframes apply for completing the standard appeal process:
- The ASO must provide the appeal decision within forty-five (45) days from the established filing date.
 - The PRSN ASO may extend the forty-five (45) day timeframe up to fourteen (14) calendar days if:
 - a. The enrollee provider acting on behalf of the individual requests the extension and there is written agreement
 - b. The PRSN shows (to the satisfaction of the State, upon its request) that there is a need for additional information and how the delay is in the enrollee's interest
 - c. Give the individual written notice of the reason for the decision to extend the timeframe and inform the individual (or their designated advocate) of the right to file a grievance, if they disagree with the decision; and
 - d. Issue and carry out the determination as expeditiously as the individual's health condition requires and no later than the date of the extension expires

8. The decision shall be followed-up and provided in writing to the individual, facility (i.e. hospital), and network provider; with a copy sent to the PRSN office. The notice shall include:
 - The reason for the decision
 - The results of the resolution process and the date it was completed,
 - Titles and qualification of all individuals participating in the appeal,
 - Reference the plan provision or clinical criteria on which the decision is based,
 - Notice that the specific criteria and copies of materials reviewed can be provided free of charge, upon request.
 - The support s available if there is any concern of retaliation
 - Information about the right to request an Administrative Fair Hearing and how to do so if the enrollee believes there's been a violation of the Washington Administrative Code, does not agree to the appeal resolution, or if the PRSN fails to meet the timelines for disposition or extension of the appeal.
 - The right to request continued benefits while the hearing is pending and how to make the request; and notice that the enrollee may be responsible for the costs of those continued benefits if the hearing decisions upholds the original action.
 - For denied service decisions resolved in favor of the enrollee, information about how to the enrollee may obtain services, support available to assist in obtaining service, and information that enrollees must initiate services within sixty (60) days.
9. The ASO will have formal procedures for utilization action decisions that are upheld or reversed, including written notification to the enrollee, the network provider, PRSN and other entities involved.
10. An individual, or their designated advocate, may also access an Administrative Fair Hearing if:
 - The PRSN did not provide a written response within the allowed time frames; or
 - There is a belief that there has been a violation of WA State Department of Social and Health Services rules.
11. The Administrative Fair Hearing process is accessed through the WA State Office of Administrative Hearings (1-800-583-8271).
 - An individual, or their designated advocate, must request a Fair Hearing within twenty (20) days after receiving the appeal resolution.
 - An individual may request an expedited Fair Hearing.

Expedited Appeal Process

1. Expedited appeals may be requested when the enrollee, provider or other representative believe that taking the time for a standard resolution could seriously jeopardize the enrollee's life, mental health or ability to attain, maintain, or regain maximum functioning.
2. The expedited appeal process shall meet the additional requirements listed below:
 - a. Requests for expedited resolution may be initiated orally and are not required to be followed by a written signed request by the enrollee or representative.
 - b. The PRSN ASO will make a decision on the enrollee's request for expedited appeal and provide notice, as expeditiously as the enrollee's mental health condition requires, within three (3) working days or sooner based on the medical necessity of the enrollee. The PRSN ASO will also make reasonable efforts to provide oral notice.
 - c. The PRSN ASO may extend the three (3) working days timeframe by up to fourteen (14) calendar days if:
 - The enrollee or provider acting on behalf of the individual requests the extension and there is written agreement
 - If the PRSN ASO extends the timeframes, when the enrollee does not request an extension, the PRSN will give the individual written notice of the reason for the delay.
 - The PRSN ASO will provide the enrollee a reasonable opportunity to present evidence, and allegations of fact, in person (via video teleconference) as well as in writing and inform the enrollee of the limited time available for expedited resolution.
 - The PRSN ASO will ensure that retaliation or punitive action is not taken against an enrollee or provider who requests an expedited resolution or supports an enrollee's appeal
 - If the PRSN ASO denies a request for an expedited resolution of an appeal, it will transfer the appeal to the timeframe for a standard resolution; and make reasonable efforts to give enrollee prompt oral notice of the denial, followed up with two (2) calendar days with a written notice, and inform the enrollee of their right to file a grievance regarding the denial of expediency.

Continuation of Services during the Appeal Process

The PRSN will continue the enrollee's services/benefits if all of the following apply:

1. The enrollee or the provider files the appeal on or before the later of the following:
 - Within ten (10) calendar days of receipt of the PRSN notice, which for actions involving services previously authorized, must be delivered by a method which certifies receipt and assures delivery within three (3) calendar days of the intended effective date of the PRSN ASO proposed action
 - The intended effective date of the PRSN proposed action
2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
3. Services were requested by an authorized community mental health agency
4. The enrollee requests a continuation of services and benefits, and
5. The original period covered by the original authorization has not expired at the time of the request for continuation of benefits.

If, at the enrollee's request, the PRSN ASO continues and reinstates the enrollee's services while the appeal is pending, the services must be continued until one of the following occurs:

1. The enrollee withdraws the appeal.
2. Ten (10) days pass after the PRSN mails notice of disposition of an appeal and the resolution is not in favor of the enrollee, unless the enrollee requests a Fair Hearing (with continuation of services Fair Hearing decision is reached), or
3. The Office of Administrative Hearings issues a Fair Hearing decision adverse to the enrollee.

Enrollees who request continuation of benefits will be notified that if the final resolution of the appeal is adverse to the enrollee, the PRSN may request the enrollee to reimburse the cost of the services furnished to the enrollee while the appeal was pending.

If the PRSN fails to meet the timelines concerning any appeal, they will provide the services that are the subject of the appeal. The PRSN will pay the community mental health agency to provide these services.

Effects of Reversed Resolutions of Appeals

1. If the PRSN ASO or the state Administrative Hearing Office reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PRSN ASO must authorize and the community mental health agency must provide the disputed services promptly, as expeditiously as the enrollee's mental health condition requires.
2. If the PRSN ASO or the state Administrative Hearing Office reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the PRSN must pay for those services.
3. If the final resolution of the appeal upholds the PRSN ASO action, the regional support network may recover the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for the continuation of services and in accordance with 42 CFR 431.230.

Overseeing and Monitoring of Appeal Process

The PRSN is responsible for overseeing, is accountable for, and monitors the functions and determinations resulting from the ASO appeal process. The PRSN provides direct oversight for each appeal, at the time of the appeal, and the overall process during the annual administrative review.

MONITORING

This policy is a federal statute and contract mandate.

1. The PRSN NOA policy and procedures are routinely monitored through:
 - 100% PRSN appeal of faxed copies of NOA letters mailed
 - PRSN Authorization Tracking Log submitted by CommCare
 - Annual PRSN Provider and Subcontractor Administrative Review
 - Exhibit N Provider Agency Complaint and PRSN Grievance Tracking
 - Random checks of provider Complaint/Grievance files with a cross-reference chart review
 - Quality Management Plan activities, such as review targeted issues for trends and recommendations
 - Review of previous Provider Corrective Action Plans related to Age and Cultural Competence policy, including provider profiles related to performance on targeted indicators

- The Division conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/ youth. The MHSIP measures general consumer satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The PRSN requests over sampling of the region to gather specific catchment area data and analyze for trends.
2. If a provider/contractor performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval.



COMMUNITY NETWORK FOR BEHAVIORAL HEALTHCARE, INC.
106 W. 14th Street, Suite 1300, Kansas City, MO. 64105

[Date]

[Provider Name}
[Provider Address]
[Provider Address]

Re: [Member Name]
DOB: [Member DOB]
DCN: [Member DCN #]

Acknowledgment of Appeal

Dear [Provider Name],

Your request for an appeal was received on [Date appeal received]. We will review your request and provide our written response within 45 days from the established filing date as defined by our contract.

You may be asked to pay for the services received during the appeals process, if the decision is not in your favor

If you have any additional information you wish to provide that was not included in your original request for a grievance, you may forward it to:

Laurie Cox, LCSW
Clinical Director
CommCare
106 W. 14th St., Suite 1300
Kansas City, MO 64105

Label all mailings:

DO NOT OPEN IN MAILROOM: CONFIDENTIAL

If you have any questions, you may call me at 816-472-9012.

Sincerely,



PENINSULA RSN

COMPLAINT, GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: FAIR HEARING

Policy Number: 6.04

Reference: 42 CFR 438.214

Effective Date: 8/2004

Revision Date(s): 12/2010

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Appeal Process
- Policy: Complaint, Grievance, Appeal, and Fair Hearing General Requirements
- Policy: Complaint and Grievance
- Policy: Corrective Action Plan
- Policy: Grievance Oversight and Recordkeeping
- Policy: Notice Of Action Requirements

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to outline a standardized Fair Hearing process and requirements.

PROCEDURE

Right to Request a Fair Hearing

1. Individuals and their representatives have the right to request the Department of Social and Health Services (DSHS) pre-hearing and administrative hearing processes as described in Washington Administrative Code (WAC) 388-02 when:
 - An individual believes there has been a violation of the Washington Administrative Code (WAC)
 - An individual does not receive a favorable disposition of a grievance from the PRSN

- A Medicaid enrollee does not receive a favorable disposition of an appeal by the PRSN subcontracted Administrative Service Organization (ASO)
 - A non-Medicaid individual outpatient service episode was closed due to unavailable resources.
2. Medicaid enrollees or their representative may also request an expedited fair hearing when the enrollee or representative believes that taking the time for standard resolution would jeopardize the enrollee ability to maintain or regain maximum functioning.

Assistance with a Fair Hearing

1. The PRSN will provide assistance to individuals in pursuing a Fair Hearing.
2. Ombuds services are made available to investigate, advocate, and assist individuals throughout the Fair Hearing process at no cost.
3. Individuals may have a representative who acts on their behalf in requesting a Fair Hearing.
 - Individuals may also have representatives of their choice involved in the process.
4. There will be no retaliation against an individual who requests a Fair Hearing.
 - Individuals or their representatives may contact the PRSN directly if they experience or they have concerns about retaliation.

Timelines to File a Fair Hearing

1. If an individual does not receive a favorable disposition of a grievance or appeal (Medicaid only) by the PRSN or the PRSN subcontracted ASO, they may request a Fair Hearing.
2. The request for a Fair Hearing must be filed within twenty (20) days from the date of adverse ruling for appeals (Medicaid only) or twenty (20) days of notice of disposition / offered resolution of a grievance.
 - For appeals regarding termination, suspension or reduction of services the request for a Fair Hearing must be filed within ten (10) days from the date of the PRSN's notice of resolution of an appeal.
3. If an individual believes there has been a violation of the Washington Administrative Code (WAC) or the PRSN or providers have violated certain timelines, they may request a fair hearing at any time.
 - Individuals may call the Office of Administrative Hearings (OAH) at 1-800-583-8271 or Ombuds to inquire about qualifying for a state Fair Hearing prior to utilizing the PRSN grievance or appeals (Medicaid only) process.

4. If individuals are unhappy with the PRSN decision or offered resolution with a grievance, they may under certain circumstances request additional consideration of the grievance by the Department.
 - Requests must be made within five (5) days of receipt of the PRSN decision.

Where to Request A Fair Hearing

1. Individuals may request a Fair Hearing with the Office of Administrative Hearings (OAH) at 1-800-583-8271.

OAH is part of state government that provides fair hearings to social services provided in Washington State.

Individuals or their representatives may contact the PRSN Ombuds at (360) 692-1582 or toll free at 1- 888- 377-8174 or the PRSN at (360) 337-4604 or toll free at 1-800-525-5637 for assistance in requesting a fair hearing.

Continuation of Services during a Fair Hearing Process

1. Individuals may request that their previously authorized services or benefits continue or are reinstated during the fair hearing process, following a grievance.
 - If the fair hearing determination is not resolved wholly in the individual's favor, they may be asked to pay for those services.
2. Medicaid enrollees may, under certain circumstances request that their previously authorized services or benefits continue or are reinstated during the fair hearing process, following an appeal.

Offered Resolution

1. The Fair Hearing process must be completed within ninety (90) days of the date the appeal was initially filed, excluding any time taken by the enrollee to file for a Fair Hearing following receipt of the notice of disposition of appeal.

Reversed Resolution of Appeals

1. If the state Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while an appeal was pending, the PRSN or subcontracted ASO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's mental health condition requires.
2. If the state fair hearing officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the PRSN or network provider must pay for those services.
3. If the state Fair Hearing officer upholds the PRSN appeal ruling/ action, the PRSN may recover the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely

because of the requirement for continuation of services and in accordance with 42 CFR 431.230.

Additional Requirements for Fair Hearings

1. For Fair Hearings that involve appeals, parties to the Fair Hearing include the PRSN and the subcontracted ASO, the individual and their advocate (this may include but is not limited to family, friend, Ombuds, mental health primary care provider, mental health agency, or inpatient facility), or the estate representative of a deceased individual.
2. The PRSN, subcontracted ASO, community mental health agencies and staff, designees, network providers, and other contracted individuals and entities will cooperate with and promptly abide by all administrative hearing procedures and decisions.
3. The PRSN will require this cooperation in policy, contracts, and monitor requirement.

MONITORING

This policy is a federal statute and contract mandate.

1. The state fair hearing policy and procedures are routinely monitored through:
 - Tracking PRSN appeals notices and review of NOAs mailed
 - Closely monitoring appeal requests that CommCare handles on our behalf
 - Participation (as a party) in all Fair Hearings
 - Exhibit N Grievance Reports and System Tracking
 - Spot checks of provider Complaint files with a cross-reference chart review
 - Quality Management Plan activities, such as review targeted issues for trends and recommendations
 - The Division conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/youth. The MHSIP measures general consumer satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The PRSN requests over sampling of the region to gather specific catchment area data and analyze for trends.
2. If a provider/contractor performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval.



PENINSULA RSN

COMPLAINT, GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: NOTICE OF ACTION REQUIREMENTS

Policy Number: 6.05

Reference: 42 CFR 438.210, 438.404, 438.10;
WAC 388-865-0255

Effective Date: 8/2004

Revision Date(s): 5/2011

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Appeal Process
- Policy: Complaint, Grievance, Appeal, and Fair Hearing General Requirements
- Policy: Complaint and Grievance
- Policy: Corrective Action Plan
- Policy: Fair Hearing
- Policy: Grievance Oversight and Recordkeeping

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to establish a process for Medicaid enrollees to be notified of denials, intended actions, adverse actions and how to pursue appeals in a manner that gives timely, clear, and easily understood information to persons seeking and receiving publically funded mental health services.

This policy is intended to outline the definitions, PRSN procedures and responsibilities as they relate to the federal Notice of Action (NOA) regulations. The PRSN subcontracted Administrative Service Organization (ASO) is responsible for sending the PRSN NOA letter and conducting the standard and expedited NOA Appeal process.

The PRSN is responsible for overseeing, is accountable for, and monitors the functions and determinations resulting from the ASO appeal process.

The ASO may adopt more expansive definitions and procedures to ensure Medicaid recipients/enrollees receive more information and notification than required in this policy. The ASO procedure shall adhere to URAC/NCQA standards.

DEFINITIONS

Appeal is a request for review of an action. The Action definition applies to PRSN Administrative Actions.

Action is a decision by the PRSN (or their formal designee,) to:

- Deny or limit authorization of a requested service, including the type or level of service requested, to a Medicaid recipient.
- Reduce, suspend, or terminate a previously authorized service.
- Deny, in whole or in part, of payment for a service.
- Fail to provide services in a timely manner.
- Fail to resolve an appeal within thirty (30) days from receipt, unless extended by mutual agreement.

Denial is a decision to not offer an intake assessment or a decision by the PRSN (or their formal designee) to:

- Not authorize covered Medicaid mental health services to enrollee's that meet medical necessity.
- Not authorize a service within the timeframes (i.e. 14 days admission authorization), without a network provider extension request.
- Not authorize a request for inpatient services

Reduction is a decision by the PRSN (or their formal designee,) to:

- Decrease an enrollee's previously authorized covered Medicaid mental health services described in their Level of Care Guidelines.
- Decrease or change an authorized service documented in the ISP/Treatment Plan is not a reduction.

Suspension is a decision by the PRSN (or their formal designee,) to:

- Temporarily stop an enrollee's previously authorized covered Medicaid mental health services described in their Level of Care Guidelines.
- Temporarily stop or change an authorized service documented in the ISP/Treatment Plan is not a suspension.

Termination is a decision by the PRSN (or their formal designee,) to:

- Stop an enrollee's previously authorized covered Medicaid mental health services described in their Level of Care Guidelines.
- Stop or change an authorized service in the ISP/Treatment Plan is not a termination.

Continuation of Services means to continue to provide services with no changes in type of frequency, where applicable, throughout the duration of the appeal process.

PROCEDURE

The PRSN community mental health network provider agencies are responsible for assessing, establishing, and documenting medical necessity based on statewide Access to Care criteria.

The PRSN subcontracted Administrative Service Organization (ASO) is responsible for authorizing care for using the PRSN Levels of Care standards and clinical assessment documentation provided by the network agency.

Notice of Action Information Requirements

1. All notices and forms discussed in this policy are available in English, Spanish, and all other prevalent non-English language spoken in PRSN regional services area as defined by the DSHS. The template letter will be made available and translated into an individual's primary language, when requested, to meet language requirements, per CFR 438.10 (c & d).
2. PRSN and the network providers shall explain the authorization and appeal process to all persons requesting and receiving services (or their custodial caretaker) at the time of assessment and when requesting continued services in a manner that is understandable to the individual.
 - This may include the use of qualified sign-language interpreters for those persons with hearing impairments, oral explanations for individuals with visual impairments, persons with limited ability to read English or are developmentally disabled, and explanations in languages other than English.
 - Copies of all notices and forms provided persons requesting or receiving services be placed in that person's clinical record (or scanned into the electronic medical record), thereby documenting the provision. Forms, that are mailed, will be mailed in a manner that documents date sent.
3. The notice must provide all required information. Explanations provided by the PRSN and/or network provider regarding the reasons for the decision must be complete, written in commonly understood language and specific to the person receiving the services. Generic statements are not adequate.
4. All notices required by this policy are sent to :
 - The individual seeking mental health services (or their legal caretaker).

- A legal guardian or parent who is the legal custodian of a person under the age of consent.
- Notices on behalf of inpatient services are copied to the requesting network provider agency, inpatient facility, and PRSN office.

5. The PRSN NOA letter is:

- a. In writing.
- b. In the enrollee's primary language and to be easily understood.
- c. Explain the action the PRSN or the ASO has taken or intends to take.
- d. Explain the reason of the action.
- e. Provide definitions for reduction, termination, suspension, and denial.
- f. Reference to the service provision, clinical criteria, guideline, protocol, and/or statute.
- g. Provide information that the specific criteria referenced is available, upon request and free of charge.
- h. Explain the enrollee's, or the community mental health agency's right to act as an advocate, in filing an Appeal of Action.
- i. Explain the procedures for exercising the enrollee's rights.
- j. Explain the circumstances under which the expedited resolution is available.
- k. Explain the enrollee's right to have services continue pending resolution of an appeal, how to request that services be continued, and the circumstances under which the enrollee may be required to pay the costs of these services; and be mailed as expeditiously as the enrollee's mental health condition requires.

Notification Timeframes

1. For utilization management decisions regarding a denial or limit of a request for standard authorization of services:
 - The PRSN ASO will mail notice as expeditiously as the individual's health condition requires, not exceeding fourteen (14) days following receipt of the request for services, with a possible extension of up to fourteen (14) additional calendar days if:
 - a. The individual requesting the services requests an extension, or
 - b. The network provider or ASO justifies a need for an extension and how the extension is in the person's best interest. PRSN will provide a written notice of the reason to extend the timeframe and will inform the person of their grievance and appeal rights if they do not agree with the decision.

For extensions, the determination will be provided as expeditiously as the individual's health condition requires and no later than the date the extension expires.

- c. Service authorization decisions not reached in accordance with the timeframes established per contract constitutes a denial and an Action, which is subject to Appeal.

- The PRSN ASO will mail the written notice by priority mail.
- The PRSN ASO may determine that following the standard timeframes could seriously jeopardize the life, health, or ability to attain, maintain, or regain maximum functioning of the person making the request. A PRSN ASO must make an authorization decision within three (3) business days after the receipt for request of service.

The PRSN ASO may extend the three (3) day time period by up to fourteen (14) calendar days if the request is made by the person requesting the services, or if the authorization decision and extension is in the person's interest.

2. For utilization management decisions regarding termination, suspension, or reduction of previously authorized Medicaid covered services:
 - The PRSN ASO will mail notice at least ten (10) days prior to the effective date of action.
3. For utilization management decisions regarding cases of probable fraud:
 - The notice may shorten the period of advance notice to 5 days before the date of the action if there are facts indicating that action should be taken because of probable fraud by the client and the facts have been verified, if possible, through secondary sources.
4. For utilization management decisions regarding denial of payment, the notice shall be provided at the time of any action effecting the payment.
5. The ASO will send the PRSN NOA to enrollees and effected parties with a copy mailed to the PRSN office for 100% review.
6. Notice may be provided on the date of the change/intended action in the following circumstances:
 - Confirmation of the individual's death.
 - The individual has been admitted to a public institution precluding the eligibility for the service.
 - The individual has moved out of the catchment/service area.

Requesting an Appeal

An enrollee, or their designated advocate, must request a PRSN NOA Appeal within twenty (20) days of the date on the PRSN NOA letter. Appeals must be initiated within ten (10) calendar days of the receipt of the PRSN notice to enrollees to request that their previously authorized services continue or be reinstated during the appeals process.

- If the initial request to file an Appeal was made orally in order to establish the earliest possible filling date, a PRSN Appeal request form will be sent to the enrollee. The form must be returned and signed as a follow-up to oral filings within seven (7) days.

MONITORING

1. This policy is a federal and contract mandate. This policy will be monitored through use of PRSN:
 - Annual PRSN Provider and Subcontractor Administrative Review
 - PRSN Trainings
 - Exhibit N Grievance Report and Tracking
 - 100% PRSN review of all service denial and NOA letters
 - The Division conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/ youth. The MHSIP measures general consumer satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The PRSN requests over sampling of the region to gather specific catchment area data and analyze for trends.
2. If a provider/contractor performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval. Reference PRSN Corrective Action Plan Policy.

NOTICE OF ACTION ABOUT YOUR MENTAL HEALTH SERVICES 3-06

To: (Name and Address)

Date:

From: CommCare, on behalf of the Peninsula Regional Support Network (PRSN)
106 W. 14th Street, Suite 1300
Kansas City, MS 64105

This is to let you know about an action we are planning to take concerning your Medicaid-funded mental health services that you requested or are currently receiving.

Your mental health center services at _____ will be: _____ (CMHA)

- **DENIED** EFFECTIVE DATE _____
- **REDUCED TO** _____ **FROM** _____ **EFFECTIVE DATE** _____
- **SUSPENDED** EFFECTIVE DATE _____
- **TERMINATED** EFFECTIVE DATE _____

The reason for this decision is:

- You are no longer a resident in the PRSN service area.
- You do not meet PRSN Level of Care criteria because _____
- Other: _____

The decision is based on law 42 CFR 438. However, you are entitled to a second opinion.

CONTACT REGARDING THIS NOTICE: CommCare, toll free at (877) 777-1388

IF YOU DON'T AGREE WITH THIS DECISION, you have the right to appeal. If you choose this right, you have twenty¹ (20) calendar days from the date this notice was mailed to request or file an appeal. Your mental health provider may also file an appeal on your behalf when you ask them in writing. To request or file an appeal, you need to contact: CommCare, toll free at (877) 777-1388 or send your appeal to the address listed above.

If you make your request verbally, you will be asked to put it in writing within seven (7) days. If your request is not put in writing, we will consider the request incomplete and not take further action. You may refile your appeal within twenty (20) days from the original receipt of the notice.

IF YOU NEED HELP FILING AN APPEAL you may contact the PRSN Ombuds Services toll free at 1-888-377-8174 or (360) 692-1582. The Ombuds Service is available at no charge to assist you or your representative throughout the appeal process. If you are hard of hearing or deaf, or have trouble with speech, please contact us through the Telecommunication Relay Service at 1-800-833-6384 or dial 711. The Relay Service will be able to provide you with the correct phone number. If you need interpreter services they will be provided to you.

You may also include other persons of your choice to assist you during the appeal process. If you want someone to assist you, you and your authorized representative must sign, date, and send us a statement naming that person to act for you.

What happens after I file an appeal? CommCare reviews your appeal and provides a written decision within 45 days. For additional information, please see the "Important Information about Your Appeal Rights" listed on the back of the letter.

¹ If you want to continue to receive your current services during the appeal process, you must file your request within ten (10) calendar days of the receipt of this notice of action.

Denial: The decision not to offer an intake is a denial. The decision by a PRSN, or their formal designee, not to authorize covered Medicaid mental health services that meet medical necessity is a denial.

Suspension: The decision by a PRSN, or other formal designee, to temporarily stop your previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The decision by a Community Mental Health Agency to temporarily stop or change a covered service in the Individualized Service Plan is not a suspension.

Reduction: The decision by a PRSN to decrease an your previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The decision by a Community Mental Health Agency to decrease or change a covered service in the Individualized Service Plan is not a reduction.

Termination: The decision by a PRSN, or their formal designee, to stop an your previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The decision by a Community Mental Health Agency to stop or change a covered service in the Individualized Service Plan is not a termination.

There Are Two Kinds of Appeals You Can File

* **Standard (45 days)** You or your mental health care provider acting on your behalf can ask for a standard appeal. We must give you a decision no later than 45 days after we get your appeal. We may not extend this time past 45 days.

* **Expedited (Fast, 3 working days)** You or your mental health care provider can ask for a fast appeal if you or your mental health care provider believe that your life, health or major ability to function could be seriously harmed by waiting for a standard appeal. We must decide your appeal no later than 3 working days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- If your mental health care provider asks for an expedited appeal for you, or supports you in asking for one, and they indicate that waiting 45 days could seriously harm your health, we will automatically give you a fast appeal.
- If you ask for an expedited appeal without support from your mental health care provider, we will decide if your health requires one. If we do not agree with you, we will decide your appeal within 45 days.

How Do I File An Appeal?

For a Standard Appeal: You, your mental health provider, authorized representative, or an Ombuds should mail or deliver your written appeal to the address below. You may file verbally but, it must be followed in writing within 7 days.

For a Fast Appeal: You, your mental health provider, authorized representative, or an Ombuds should contact us by telephone or fax at the numbers listed below.

Can I Continue to Receive Services? If you are currently receiving services, your services will be continued during the appeal process when:

- Your appeal is filed within 10 days from the NOA mailed date.
- Your appeal involves the reduction, suspension or termination of previously authorized covered Medicaid mental health services;
- The current period covered by the authorization has not expired, and the Notice of Action was mailed to you timely
- You have requested an extension.

If our decision is not your favor, you may be asked to pay for the services you received during the appeal or hearing.

What Do I Include With My Appeal?

You should include: your name, address, reasons for appealing, and any evidence you wish to attach. You may send in supporting records, letters from your mental health provider, a list identifying qualified witnesses, or other information that explains why we should provide the service. Call your mental health provider if you need this information to help you with your appeal.

You may send this information to the CommCare or present this information in person at your local CMHA.

WHAT HAPPENS AFTER I FILE AN APPEAL?

People from CommCare who were not involved in the decision review your appeal and provides a written decision within 45 days unless an extension has been requested.

What Happens Next? After CommCare makes a decision about your appeal and you do not agree with the Appeal decision, you may ask for a fair hearing through the State Office of Administrative Hearings (1-800-583-8271). You must request a fair hearing within 20 days after you receive the Appeal decision. You may also access a fair hearing if:

- CommCare, on behalf of the PRSN did not provide a written response within the allowed time frames; or
 - You believe there has been a violation of WA State Department of Social and Health Services rules.
- Your services may be continued during the Administrative Hearing Process.

Contact Information:

If you need information or help, call CommCare toll free at (877) 777-1388.

Other Resources to Help You:

PRSN Ombuds Service, toll free (888) 377-8174.

WA State Department of Social and Health Services
Office of Administrative Hearings
P. O. Box 42488
Olympia, WA 98504-2488.
1-800-583-8271

A: [Name of Medicaid Enrollee]/ Representative (if relevant) **Fecha:**
Address
Address

De: [Name of PIHP]
[Address]
Address

La presente nota es para hacerle saber la acción que planeamos realizar con respecto a sus servicios de salud mental pagados por Medicaid, que usted solicitó o que está recibiendo actualmente.

Sus (describa los servicios) _____ **serán:**

- NEGADOS**
A PARTIR DE LA FECHA _____
- REDUCIDOS A** _____ **DE** _____
- A PARTIR DE LA FECHA** _____
- SUSPENDIDOS**
A PARTIR DE LA FECHA _____
- TERMINADOS**
A PARTIR DE LA FECHA _____

La razón para esta decisión es:

- Usted ya no es un residente del área de servicio.
- Usted no cumple con el criterio de necesidad médica porque (especifique la razón exacta) _____.
- Otra: _____

Sin embargo, usted tiene derecho a una segunda opinión.

PERSONA CONTACTO EN LO QUE CONCIERNE A ESTE AVISO: [Nombre y teléfono]

SI USTED NO ESTÁ DE ACUERDO CON ESTA DECISIÓN, usted tiene el derecho de apelar. Si escoge este derecho, tiene veinte¹ (20) días calendario, a partir de la fecha de envío por correo de este aviso, para solicitar o presentar una apelación. Su proveedor de salud mental también puede presentar una apelación en su beneficio cuando usted se lo pide por escrito. Para pedir o presentar una apelación, necesita comunicarse con: _____ llamando al 1-800-_____ o enviar su apelación a la dirección indicada arriba.

SI NECESITA AYUDA PARA PRESENTAR UNA APELACIÓN puede comunicarse con [PIHP name] del Ombuds Service (Servicio de defensor del pueblo) llamando al 1-800-_____. El servicio Ombuds es gratis y está disponible para ayudarlo a usted o su representante en el proceso de apelación. Si tiene problemas para escuchar o hablar o es sordo o mudo, comuníquese usando Telecommunication Relay Service llamando al 1-800-833-6384 o marque 711. El servicio Telecommunication Relay Service podrá darle un número de teléfono correcto. Si necesita el servicio de un intérprete, ellos se lo proveerán.

También, otras personas de su elección pueden ayudarlo en el proceso de apelación. Si desea que alguien más lo ayude, usted y su representante autorizado deben firmar, fechar y enviar una declaración nombrando a la persona que actuará por usted.

Antes de presentar una apelación, lea “Información Importante sobre sus Derechos de Apelación” en la siguiente página.

¹ Si desea continuar recibiendo los servicios actuales durante el proceso de apelación, debe presentar su pedido dentro de los diez (10) días calendario de haber recibido este aviso de acción.

INFORMACIÓN IMPORTANTE SOBRE SUS DERECHOS DE APELACIÓN

Rechazo: La decisión de no ofrecer una entrada es un rechazo. La decisión del PIHP, o de su designado formal, de no autorizar los servicios de salud mental de Medicaid que cumplen con la necesidad médica es un rechazo.

Suspensión: La decisión de un PIHP o de su designado formal de temporalmente suspender los servicios de salud mental de Medicaid descritos en sus Level of Care Guidelines (Normas de Nivel de Cuidado). La decisión de Community Mental Health Agency (Agencia de Salud Mental de la Comunidad) de temporalmente detener o cambiar un servicio cubierto en el Individualized Service Plan (Plan de Servicios individualizado) no es una suspensión.

Reducción: La decisión de un PIHP de disminuir su servicio previamente autorizado y cubierto por los servicios de salud mental de Medicaid, descritos en sus Normas de Nivel de Cuidado. La decisión de una Agencia de Salud Mental de la Comunidad de disminuir o cambiar un servicio cubierto en el Plan de Servicios Individualizados no es una reducción.

Terminación: La decisión de un PIHP, o su designado formal, de detener sus servicios de salud mental de Medicaid previamente autorizados, descritos en sus Normas de Nivel de Cuidado. La decisión de una Agencia de Salud Mental de la Comunidad de detener o cambiar un servicio cubierto en el Plan de Servicios Individualizados no es una terminación.

Hay dos tipos de apelación que usted puede presentar

Estándar (45 días) Usted o su proveedor de servicios de salud mental, en su beneficio, puede pedir una apelación estándar. Nosotros debemos darle una respuesta o decisión no más de 45 días después de haber recibido su apelación. (Podemos extender este tiempo hasta 14 días, si usted solicita una extensión o si nosotros necesitamos información adicional y la extensión lo beneficia a usted.)

Acelerada (rápida, 3 días hábiles) Usted o su proveedor de servicios de salud mental pueden solicitar una apelación acelerada si usted o su proveedor de salud mental creen que su vida, salud o su habilidad de funcionar pueden verse en serio peligro por esperar el tiempo necesario para una apelación estándar. Nosotros debemos decidir su apelación no más de 3 días hábiles después de haber recibido su apelación. (Podemos extender este tiempo hasta 14 días, si usted solicita una extensión o si nosotros necesitamos información adicional y la extensión lo beneficia a usted.)

- Si su proveedor de salud mental pide una apelación acelerada en su beneficio o lo apoya para que usted lo haga, y ellos indican que 45 días podrían seriamente poner en peligro su salud, automáticamente le daremos una apelación acelerada.
- Si solicita una apelación acelerada sin el apoyo de su proveedor de salud mental, nosotros decidiremos si su salud requiere una. Si no estamos de acuerdo con usted, nosotros tomaremos una decisión sobre su apelación dentro de los 45 días.

¿Cómo presento una apelación?

Para una apelación estándar: Usted, su proveedor de salud mental, representante autorizado, o un representante Ombuds debe enviar por correo o presentar una apelación escrita en la

dirección abajo indicada. Puede presentar una apelación verbal, pero debe estar seguida de una escrita.

Para una apelación acelerada: Usted, su proveedor de salud mental, representante autorizado, o un representante Ombuds debe comunicarse con nosotros por teléfono o fax a los números indicados abajo.

¿Cómo puedo continuar recibiendo mis servicios? Si usted actualmente está recibiendo servicios, sus servicios continuarán durante el proceso de apelación cuando:

- Su apelación fue presentada dentro de los 10 días de la fecha de envío del PIHP.
- Su apelación involucra una reducción, suspensión o terminación de los servicios de salud mental de Medicaid.
- El periodo actual de cobertura autorizado ha vencido, y el Notice of Action (Aviso de Acción) fue enviado a usted a tiempo.
- Usted pidió una extensión.

Si nuestra decisión no es a su favor, se le puede pedir que usted pague por los servicios recibidos durante el proceso de apelación o la audiencia.

¿Qué debo incluir en mi apelación?

Usted debe incluir: su nombre, dirección, las razones por las cuales hace una apelación y cualquier evidencia que desee adjuntar. Puede enviar registros, cartas de su proveedor de salud mental, una lista de testigos calificados, u otra información que explique por qué nosotros deberíamos proveerle el servicio. Llame a su proveedor de salud mental si necesita esta información, para que lo ayude en su apelación.

Puede enviar esta información al PIHP o presentarla en persona.

¿QUÉ SUCEDE DESPUÉS DE QUE HAYA PRESENTADO LA APELACIÓN? Gente de PIHP que no haya estado involucrada en la decisión revisa su apelación y provee una decisión escrita dentro de los 45 días, a menos que se haya solicitado una extensión.

¿Qué sucede después? Después que el PIHP toma una decisión sobre su apelación y usted no está de acuerdo con la decisión tomada por el PIHP, puede pedir una audiencia imparcial (Fair Hearing) a través de State Office of Administrative Hearings (1-800-583-8271). Puede pedir una audiencia imparcial dentro de los 20 días después de haber recibido la decisión del PIHP. También puede tener acceso a una audiencia imparcial si:

- El PIHP no provee una respuesta escrita dentro del período de tiempo permitido; o
- Usted cree que ha habido una violación de las normas del WA State Department of Social and Health Services (Departamento de Servicios Sociales y Salud del estado de Washington).

Sus servicios pueden continuar durante el proceso de la Audiencia Administrativa.

Información:

Si necesita información o ayuda, llame al 1-800

Otros recursos para que lo ayuden:

PIHP Ombuds Service: 1-800-

WA State Department of Social and Health Services Office of Administrative Hearings
P. O. Box 42488

Olympia, WA 98504-2488
1-800-583-8271

PIHP Exhibit N Notice of Action Appeals Report 05-06

PIHP PENINSULA RSN

Report Period _____

		ADULTS			
		Resolutions			
Expedited Appeals	Resolution within 3 working days	Wholly in favor of Enrollee	Partially in favor of Enrollee	Appeal Denied	
	Referred to Standard Appeals				
	Denials				
	Reduction				
	Suspensions				
	Terminations				
Total					

		CHILDREN			
		Resolutions			
Expedited Appeals	Resolution within 3 working days	Wholly in favor of Enrollee	Partially in favor of Enrollee	Appeal Denied	
	Referred to Standard Appeals				
	Denials				
	Reduction				
	Suspensions				
	Terminations				
Total					

		Resolutions			
		Resolution within 45 days	Wholly in favor of Enrollee	Partially in favor of Enrollee	Appeal Denied
Denials					
Reduction					
Suspensions					
Terminations					
Total					

		Resolutions			
		Resolution within 45 days	Wholly in favor of Enrollee	Partially in favor of Enrollee	Appeal Denied
Denials					
Reduction					
Suspensions					
Terminations					
Total					

		Resolutions			
		Resolution within 59 days	Wholly in favor of Enrollee	Partially in favor of Enrollee	Appeal Denied
Denials					
Reduction					
Suspensions					
Terminations					
Total					

		Resolutions			
		Resolution within 59 days	Wholly in favor of Enrollee	Partially in favor of Enrollee	Appeal Denied
Denials					
Reduction					
Suspensions					
Terminations					
Total					

Date Notified by CommCare	Date Appeal Filed	Client Name	Type of Action	Outcome



PENINSULA RSN

COMPLAINT, GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: GRIEVANCE-COMPLAINT FILING
PROCEDURE FOR PRSN FOR PROVIDERS **Policy Number:** 6.06

Reference: DSHS and Provider Contracts

Effective Date: 2/2000

Revision Date(s): 11/2010

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Monitoring of Contractors

PURPOSE

The Peninsula Regional Support Network (PRSN) provides a filing procedure for network providers and subcontractors in the event that they have a complaint or grievance against the PRSN.

DEFINITIONS

A complaint is an agency-based issue of dissatisfaction with some aspect of mental health services that a client (or their designated advocate) expresses verbally or in writing.

A grievance is an issue of dissatisfaction that a client (or their designated advocate) expresses at the RSN level. All verbal grievances must be followed-up with a written and signed statement within seven (7) days.

- Issues of dissatisfaction related to Medicaid *actions* (authorization decisions) are resolved through the RSN appeal process.

Grievances filed by the PRSN providers involve issues related to the overall system.

PROCEDURE

Informal Process:

1. Contact the PRSN Regional Administrator to discuss the complaint/grievance and attempt a resolution on an informal basis
2. If you are not satisfied with the resolution, contact:
Attn: Assistant Director, Personnel and Human Services Kitsap County
614 Division Street MS-23
Port Orchard, WA 98366-4676

Formal Process:

1. If the complaint/grievance is not resolved to the contractor/subcontractors satisfaction on an informal basis, submit a formal written appeal, within thirty (30) days, detailing the complaint/grievance to the:

Chairperson of the PRSN Executive Board
c/o Director, Personnel and Human Services Kitsap County
614 Division Street MS-23
Port Orchard, WA 98366-4676
2. The chairperson will convene an Appeal Review Board comprised of a member from the PRSN Advisory Board, a member of the Executive Board, and the Director of Kitsap County Personnel and Human Services.
 - The Complainant/Grievant will receive written disposition regarding his/her appeal within 30 days of filing the appeal.
3. The PRSN assures that there will be no retaliation, formal or informal, against any contractor, subcontractor, or individual associated with the agency filing or participating in the complaint/grievance process.

MONITORING

This policy is a contract mandate.

Due to the nature of this policy the Board Chair, or their designated alternate (such as the QUIC), will instruct the PRSN how this policy will be monitored.



PENINSULA RSN

COMPLAINT, GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: COMPLAINT & GRIEVANCE OVERSIGHT
AND RECORDKEEPING

Policy Number: 6.07

Reference: 42 CFR 438.416;
DSHS Contract - Exhibit N

Effective Date: 9/2005

Revision Date(s): 11/2010

Approved by: PRSN Executive Board

CROSS REFERENCES

- Form: Exhibit N Forms
- Form: PRSN Authorization Tracking Log
- Form: Quarterly Agency Complaint Tracking Form
- Policy: Exhibit N Report Instructions

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to establish a centralized process for recording and providing oversight to track all complaints, grievances, appeals/ denials, and Fair Hearings.

DEFINITIONS

A complaint is an agency-based issue of dissatisfaction with some aspect of mental health services that a client (or their designated advocate) expresses verbally or in writing.

A grievance is an issue of dissatisfaction that a client (or their designated advocate) expresses at the RSN level. All verbal grievances must be followed-up with a written and signed statement within seven (7) days.

- Issues of dissatisfaction related to Medicaid *actions* (authorization decisions) are resolved through the RSN appeal process.

Appeal means a request for review of an action. An Action in the context of Medicaid services includes:

- The denial or limited authorization of a requested service
- The reduction, suspension, or termination of a previously authorized service
- The denial in whole or in part, of payment for a service
- The failure of the PRSN to act within the timeframes provided in section 42 CFR 438(b) or
- For a resident of a rural area with only one managed care organization (MCO), the denial of an enrollee's request to exercise his or her right, under section 42 CFR 438.52 (b) (2) (ii), to obtain services outside the network

DSHS Administrative Fair Hearing means a hearing conducted through the auspices of the state Office of Administrative Hearings in accordance with Washington Administrative Code (WAC) 388-02. An issue of dissatisfaction must complete the PRSN Grievance/and Grievance Appeal process prior to requesting an Administrative Fair Hearings. The term Fair Hearing is synonymous with Administrative Hearing.

PROCEDURE

1. Standard procedure for establishing a centralized process for recording and providing oversight to agency complaints and PRSN grievances shall include:
 - a. The PRSN compiles the following reports:
 - Quarterly Agency Complaint Forms
 - Monthly Ombuds Activity Sheet
 - Six-month Exhibit N- Medicaid, non-Medicaid, and Appeals Forms
 - Monthly PRSN Denial and Appeal Tracking Report
2. All written complaints will be recorded by the network agencies and Ombuds on the quarterly agency complaint form (combined Medicaid/ non-Medicaid forms) and submit to the PRSN quarterly for QUIC review.
3. The Exhibit N form compiles the number of formal grievances to the PRSN, appeals requests through the contracted Administrative Service Organization (ASO), Office of Administrative Hearings Fair Hearings, and the Department.
 - a. The Exhibit N form tracks the PRSN system-wide information, in a consistent and standardized way.
 - The form provides the information in aggregate for Medicaid recipients and non-Medicaid recipients for adult and children's services.
 - The form includes the number and nature of the issues reported throughout the PRSN system.
 - The form includes timeframes within the matter of concern was resolved or disposed.

- The number and nature of how the issues were resolved (i.e. meditation).
 - b. The PRSN provides a summary report and analysis of the data for six-month trends identifying findings and plausible explanations. The PRSN includes information about how the system will adjust given the findings, including what measures may be taken to address undesirable patterns.
4. The PRSN Quality Improvement Committee (QUIC) provides the oversight to the complaints, grievances, appeal and Fair Hearing filed. The PRSN QUIC reviews the PRSN compiled Exhibit N summary report and forms submitted to the Department. The QUIC will identify trends and establish procedural steps to resolve trends.
 - The QUIC may appoint subcommittees to address specific trends, such as the PRSN Utilization Management (UM) Committee for access issues or the PRSN clinical directors for dignity and respect issues.
 - The QUIC may require PRSN corrective action.
 5. The PRSN subcontractor for authorization of services (ASO) shall keep a separate tracking log for outpatient, inpatient, and residential authorizations requested and the determination. The tracking sheet shall indicate when an appeal was conducted.
 6. The PRSN shall maintain these records for at least six (6) years after the completion of the complaint/grievance issue. The records will be kept in confidential files, apart from the clinical record.

MONITORING

This policy is a federal statute and contract mandate.

1. The PRSN Grievance Oversight and Tracking policy and procedures are routinely monitored through:
 - 100% PRSN review of faxed copies of NOA letters mailed
 - PRSN Authorization Tracking Log submitted by CommCare
 - Annual PRSN Provider and Subcontractor Administrative Review
 - Exhibit N Agency Complaint and PRSN Grievance Tracking
 - Random checks of provider Complaint files with a cross-reference chart review
 - Quality Management Plan activities, such as review targeted issues for trends and recommendations, such as the biennial ancillary provider satisfaction survey.

- Review of previous Provider Corrective Action Plans related to Age and Cultural Competence policy, including provider profiles related to performance on targeted indicators
 - The Department conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/ youth. The MHSIP measures general consumer satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The PRSN requests over sampling of the region to gather specific catchment area data and analyze for trends.
2. If a provider/contractor performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval.

Agency Name _____

Contact Name: _____

Contact Phone #: _____ (Month and Year)

Total Unduplicated
Number of Adult Cases

Total Unduplicated
Number of Child Cases

Occurrence	CMHA Complaints	Outstanding
Adult (21 Yrs. and over)		
Access to Outpatient		
Dignity and Respect		
Quality/ Appropriateness		
Phone calls not returned		
Service -- Intensity, Not Available, Coordination		
Consumer Rights		
Physicians & Medications		
Financial & Admin Svs		
Transportation		
Emergency Services		
Access to Inpatient		
Violation of Confidentiality		
Participation in Treatment		
Other		
Total	0	0

Occurrence	CMHA Complaints	Outstanding
Children (0-20 Yrs.)		
Access to Outpatient		
Dignity and Respect		
Quality/ Appropriateness		
Phone calls not returned		
Service -- Intensity, Not Available, Coordination		
Consumer Rights		
Physicians & Medications		
Financial & Admin Svs		
Transportation		
Emergency Services		
Access to Inpatient		
Violation of Confidentiality		
Participation in Treatment		
Other		
Total	0	0

Resolutions	CMHA Complaints	Outstanding from Last Period
Adult (21 Yrs. and over)		
Info/Referral		
Referral to QRT		
Conciliation/Mediation		
Arbitration		
Fair Hearing		
Other		
Not Pursued		
Total	0	0

Resolutions	CMHA Complaints	Outstanding from Last Period
Children (0-20 Yrs.)		
Info/Referral		
Referral to QRT		
Conciliation/Mediation		
Arbitration		
Fair Hearing		
Other		
Not Pursued		
Total	0	0



PENINSULA RSN

COMPLAINT, GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: EXHIBIT N REPORT INSTRUCTIONS

Policy Number: 6.08

Reference: DSHS Contract- Exhibit N

Effective Date: 7/2005

Revision Date(s): 11/2010

Approved by: PRSN Executive Board

CROSS REFERENCES

- Form: Appeal Forms
- Form: Exhibit N- Medicaid and Non- Medicaid

PURPOSE

The Center for Medicare and Medicaid Services (CMS, formerly known as HCFA) requires the Department to report the frequency of grievances, appeals and Fair Hearings separately for children and adults for each half of the federal fiscal year. The report is also made available to individual RSNs for their review, analysis and for incorporation of the findings into local quality management functions.

The Exhibit N forms and instructions are developed and distributed by the Department.

DEFINITIONS

Case means a formal documentation of a complaint, grievance or Fair Hearing request and subsequent efforts to resolve the expression of dissatisfaction. A case **is counted only once** even though it may involve more than one type of complaint or more than one provider agency. It may begin as a Complaint and continue through the Grievance and Fair Hearing levels but will still be counted as one case.

A grievance is an issue of dissatisfaction that a client (or their designated advocate) expresses at the RSN level. All verbal grievances must be followed-up with a written and signed statement within seven (7) days.

- Issues of dissatisfaction related to Medicaid *actions* (authorization decisions) are resolved through the RSN appeal process.

Appeal means a request for review of an action.

An Action in the context of Medicaid services includes:

- The denial or limited authorization of a requested services
- The reduction, suspension, or termination of a previously authorized service
- The denial in whole or in part, of payment for a service
- The denial of requested inpatient services
- The failure of the PRSN to act within the timeframes provided in section 42 CFR 438(b) or
- For a resident of a rural area with only one managed care organization (MCO), the denial of an enrollee's request to exercise his or her right, under section 42 CFR 438.52 (b) (2) (ii), to obtain services outside the network

DSHS Administrative Fair Hearing means a hearing conducted through the auspices of the state Office of Administrative Hearings in accordance with Washington Administrative Code (WAC) 388-02. An issue of dissatisfaction must complete the PRSN Grievance/and Grievance Appeal process prior to requesting a DSHS Administrative Fair Hearings. The term Fair Hearing is synonymous with Administrative Hearing.

PROCEDURE

1. Due Dates

The PRSN is required to submit all the Exhibit N reporting forms, along with an analysis narrative to MHD for each time period listed below:

<u>Time Period</u>	<u>Due Date</u>
Ocotber1 through March 31	May 15
April 1 through September 30	November 15

2. Required Fields

RSN Name, Contact Name, Contact Person's Phone Number and Reporting Period

Cases

The total unduplicated number of cases, for adults and for children, is required. Please see the definition of "Case" and the example for more information on how to count cases.

Services provided to adults and children and counted separately.

Outstanding

At the end of the report period, some cases will not be resolved or closed. Enter the number of unresolved cases in the Outstanding column in the corresponding row that reflects the type of the case.

Resolutions

A case should be reported in the Resolutions section when it is closed or when it progresses to a higher level, i.e. Grievance or Fair Hearing.

Totals

The total number of Resolutions (lower portion of the report) Complaints, Grievances and Fair Hearings plus the total number of Outstanding cases (upper portion of the report) should equal the total number of Complaints, Grievances and Fair Hearings in the upper portion of the report.

Occurrence		Complaints	Grievances	Fair Hearings	Outstanding
<i>Adult (21 Yrs. and over)</i>					
Total		15	2	1	1

Resolutions		Complaints	Grievances	Fair Hearings	Outstanding from Last Period
<i>Adult (21 Yrs. and over)</i>					
Total		14	2	1	4

The sum of these 4 cells is equal to the sum of these three cells

Resolutions + Outstanding = total Complaints, Grievances and Fair Hearings

Outstanding From Last Period

This column should be used to report cases that were tallied in the Outstanding column of the Occurrences portion of the report in the previous report period.

In some cases, the number of “Outstanding from Last Period” will equal the number of Outstanding in the previous report. In some cases, it will not. It does not have to.

This feature of the report is an indicator of the number of cases that are resolved within six (6) months or less.

3. Collecting Numbers

- Grievances: The PRSN will compile the requested and processed Grievances at the PRSN level for PIHP and state funded services numbers to complete the grievance columns.

- Appeals: The PRSN will request the number of PIHP requested and processed Appeals for PIHP individuals from CommCare. These numbers are compiled to complete the Appeals form.

4. Exhibit N Analysis

- The PRSN will analyze the Exhibit N forms, over time, and compile a narrative report of the noted trends and outliers.
- The report will include possible explanations for outliers and trends.
- The report will include QUIC activities to the reporting time period and planned activities, if applicable.

5. Department Requested Revisions

- The Department reviews each submitted Exhibit N report. Upon request, the PRSN will provide any additional follow-up information or revised reports with an explanation of the reporting error, as well as a corrective plan to address/ prevent on-going reporting errors.

6. QUIC Oversight

The Quality Improvement Committee (QUIC) provides the oversight and monitoring of the PRSN compliant, grievances, and appeals tracking and resolutions.

The QUIC is provided quarterly network complaints, Ombuds trends, PIHP grievances and appeal reports at the quarterly meeting.

The QUIC also is provided and discusses the Exhibit N report, the meeting after the report and forms are submitted to the Department as a contract deliverable.

The PRSN or the QUIC may require PRSN further action and/or network provider specific corrective action.

Exhibit P 05 Report - PIHP - Medicaid Funded Individuals Only

PIHP Name _____ Contact Name: _____
 Contact Phone #: _____

Reporting Period: _____
 (Month and Year)

Total Unduplicated Number of Adult Cases

Occurrence	CMHA Grievances	PRSN Grievances	Fair Hearings	Outstanding	Denials
Adult (21 Yrs. and over)					
Access to Outpatient					
Dignity and Respect					
Quality/ Appropriateness					
Phone calls not returned					
Service -- Intensity, Not Available, Coordination					
Consumer Rights					
Physicians & Medications					
Financial & Admin Svs					
Transportation					
Emergency Services					
Access to Inpatient					
Violation of Confidentiality					
Participation in Treatment					
Other					
Total	0	0	0	0	0

Total Unduplicated Number of Children Cases

Occurrence	CMHA Grievances	PRSN Grievances	Fair Hearing	Outstanding	Denials
Children (0-20 Yrs.)					
Access to Outpatient					
Dignity and Respect					
Quality/ Appropriateness					
Phone calls not returned					
Service -- Intensity, Not Available, Coordination					
Consumer Rights					
Physicians & Medications					
Financial & Admin Svs					
Transportation					
Emergency Services					
Access to Inpatient					
Violation of Confidentiality					
Participation in Treatment					
Other					
Total	0	0	0	0	0

Resolutions	CMHA Grievances	PRSN Grievances	Fair Hearings	Outstanding from Last Period	
Adult (21 Yrs. and over)					
Info/Referral					
Referral to QRT					
Conciliation/Mediation					
Arbitration					
Fair Hearing					
Other					
Not Pursued					
Total	0	0	0	0	0

Resolutions	CMHA Grievances	PRSN Grievances	Fair Hearing	Outstanding from Last Period	
Children (0-20 Yrs.)					
Info/Referral					
Referral to QRT					
Conciliation/Mediation					
Arbitration					
Fair Hearing					
Other					
Not Pursued					
Total	0	0	0	0	0

Exhibit N 05 Report -- RSN -- State Funded Individuals Only

RSN Name _____ Contact Name: _____ Reporting Period: _____
 Contact Phone #: _____ (Month and Year)

Total Unduplicated Number of Adult Cases

Total Unduplicated Number of Children Cases

Occurrence	CMHA Grievances	PRSN Grievances	Fair Hearings	Outstanding
Adult (21 Yrs. and over)				
Access				
Dignity and Respect				
Quality/ Appropriateness				
Phone calls not returned				
Service -- Intensity, Not Available, Coordination				
Consumer Rights				
Physicians & Medications				
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services				
Violation of Confidentiality				
Participation in Treatment				
Other				
Total	0	0	0	0

Occurrence	CMHA Grievances	PRSN Grievances	Fair Hearing	Outstanding
Children (0-20 Yrs.)				
Access				
Dignity and Respect				
Quality/ Appropriateness				
Phone calls not returned				
Service -- Intensity, Not Available, Coordination				
Consumer Rights				
Physicians & Medications				
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services				
Violation of Confidentiality				
Participation in Treatment				
Other				
Total	0	0	0	0

Resolutions	CMHA Grievances	PRSN Grievances	Fair Hearings	Outstanding from Last Period
Adult (21 Yrs. and over)				
Info/Referral				
Referral to QRT				
Conciliation/Mediation				
Arbitration				
Fair Hearing				
Other				
Not Pursued				
Total	0	0	0	0

Resolutions	CMHA Grievances	PRSN Grievances	Fair Hearing	Outstanding from Last Period
Children (0-20 Yrs.)				
Info/Referral				
Referral to QRT				
Conciliation/Mediation				
Arbitration				
Fair Hearing				
Other				
Not Pursued				
Total	0	0	0	0

PIHP Exhibit N Notice of Action Appeals Report 05-06

PIHP PENINSULA RSN

Report Period _____

Expedited Appeals	ADULTS		Resolutions		
	Resolution within 3 working days	Wholly in favor of Enrollee	Partially in favor of Enrollee	Appeal Denied	
Referred to Standard Appeals					
Denials					
Reduction					
Suspensions					
Terminations					
Total					

Expedited Appeals	CHILDREN		Resolutions		
	Resolution within 3 working days	Wholly in favor of Enrollee	Partially in favor of Enrollee	Appeal Denied	
Referred to Standard Appeals					
Denials					
Reduction					
Suspensions					
Terminations					
Total					

Standard Appeals			Resolutions		
	Resolution within 45 days	Wholly in favor of Enrollee	Partially in favor of Enrollee	Appeal Denied	
Denials					
Reduction					
Suspensions					
Terminations					
Total					

Standard Appeals			Resolutions		
	Resolution within 45 days	Wholly in favor of Enrollee	Partially in favor of Enrollee	Appeal Denied	
Denials					
Reduction					
Suspensions					
Terminations					
Total					

Standard Appeals			Resolutions		
	Resolution within 59 days	Wholly in favor of Enrollee	Partially in favor of Enrollee	Appeal Denied	
Denials					
Reduction					
Suspensions					
Terminations					
Total					

Standard Appeals			Resolutions		
	Resolution within 59 days	Wholly in favor of Enrollee	Partially in favor of Enrollee	Appeal Denied	
Denials					
Reduction					
Suspensions					
Terminations					
Total					

Date Notified by CommCare	Date Appeal Filed	Client Name	Type of Action	Outcome