



GRIEVANCE & APPEALS SELF STUDY TRAINING GUIDE

I have received the LifeWays *GRIEVANCE & APPEALS SELF STUDY TRAINING GUIDE*. I understand that I will be accountable for the information contained in the guide. If I have questions I may contact LifeWays or my employer for clarification. I also understand that this training acknowledgement will be maintained as evidence of my participation in the Grievance & Appeals training program.

Instructions: Upon completion of the training module forward this training confirmation page and the pre and post tests to your employer to maintain evidence of completion.

Name (please print): _____

My signature below indicates that I:

- Completed the Grievance & Appeals Training, including the Pre and Post Tests, on ____/____/____.
- Understand that if I have any questions regarding the training subject matter I may contact LifeWays or my employer for clarification.
- Have achieved functional competency in the training subject matter.

Employee Signature: _____ Date: _____

INSTRUCTIONS

1. Complete the Pre-Test. How well do you think you did?
2. To find out, read the training module thoroughly.
3. Complete the Post-Test. Do you think you did better this time around?
4. To find out, compare your answers with those on the Answer Key.
5. Finally, complete the Training Acknowledgement Sheet (Page 1) and forward along with the Pre and Post-Tests to your employer to maintain evidence of receiving the training.

Grievance & Appeals Training Module Pre-Test

Instructions: Please indicate whether the statement is true or false.

#	Statement	Answer
1	A decision that adversely impacts a Medicaid beneficiary's claim for services due to a denial or limited authorization of a requested service, including the type or level of service is called an "Action".	
2	If a person is denied entry into the mental health system or hospitalization that person should just file a regular grievance.	
3	Non-Medicaid consumers can request a fair hearing if LifeWays fails to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service.	
4	Services provided to a beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Support waiver, and/or Section 1915(b)(3) of the Social Security Act are called "Action" Services.	
5	The Administrative Law Judge can appear in person for the hearing if it is requested in writing otherwise the ALJ will be by phone conference.	
6	An Appeal can be filed at any given time	
7	Medicaid recipients have 60 days to request a State Fair Hearing.	
8	Medicaid Consumers/Guardians or parents of minors have to first file a local appeal and must wait to see if it's denied before they can file (request) a state fair hearing.	
9	Anyone can file an appeal.	
10	The Administrative Law Judge can appear in person for the hearing if it is requested in writing otherwise the ALJ will be via phone conference.	

How well did you do? Please read the following Training Module and find out.

Grievance & Appeals Training Module

This training will explain both the grievance and appeals processes that are available to the consumers we serve.

The training provides basic information about consumers' rights to Grievance and Appeals so that you can help consumers understand their rights and the places/people that can give the consumer/guardian help if it is needed

Grievance and Appeals Introduction

Since the 1990s, both the federal government and the state of Michigan have laws that give consumers, guardians, or parents of minors the right to challenge when something happens with their services and they disagree with it.

The federal government set up these rights for consumers with Medicaid.

The state sets up similar rights for people who do not have Medicaid.

These rights apply to the consumers we serve in the community mental health and substance abuse systems.

Grievance and Appeals Options

There are four basic options*** consumers have to express concerns with their services:

- Second opinion
- Grievance (always local)
- Local Level Appeal (called a Local Dispute Resolution Process for both Medicaid and Non- Medicaid consumers).
- State Level Appeal (called a Medicaid Fair Hearing for Medicaid consumers)

*** These options would occur when their concerns are not related to a possible violation of their rights that the Office of Recipient Rights would handle.

Type of Appeal or Grievance	Who can use this process?	Standards
State Fair Hearing and Expedited Resolution	Medicaid Consumers	42 CFR & Technical Requirements
Local Appeals and Expedited Appeal	All LifeWays Consumers	42 CFR & Technical Requirements
Local Grievances	All LifeWays Consumers	42 CFR & Technical Requirements
Recipient Rights Complaints	All LifeWays Consumers	Michigan Mental Health Code
Second (2 nd) Opinion	All LifeWays Consumers	Michigan Mental Health Code

The purpose of the grievance and appeals process is to give consumers ways they can:

- 1) Ask for and receive a second opinion
- 2) Ask for an appeal if the services they want are denied, limited, or taken away.
- 3) File a grievance if they are not happy with other parts of their services/supports.

All staff, students, and volunteers in our system and our affiliation are responsible for making sure consumers have these rights and have information they need to act on these rights.

Second (2nd) Opinion

In accordance with section 498 of the Michigan Mental Health Code, consumers must be offered a 2nd opinion when they are denied being able to enter mental health services with a LifeWays Network Provider, or when they are denied hospitalization.

A 2nd opinion must be provided by a physician, licensed psychologist, registered professional nurse, masters level psychologist or master's level social worker.

- A 2nd opinion is given by LifeWays at no cost to the consumer
- Consumers have 30 days to request a 2nd opinion.
- For a denial of service, 2nd opinions must be done within 5 business days.
- For a denial of hospitalization, a 2nd opinion must be done within 3 business days (or in 24 hours if an emergency).
- If the request for a 2nd opinion is denied then the consumer can file a recipient rights complaint.

Grievance Process

A grievance is a consumer's ability to express when they are not happy with some part of their services or supports, and it is not related to something they could not appeal or a protected right that would be handles to Recipient Rights.

Grievances can be filed by anyone that has contact with the Community Mental Health System, including any network provider. This can include consumers, family members, providers, community members, guardians, etc.

A grievance can be filed at any time and can be filed verbally by calling LifeWays Customer Services or in writing by filing out the LifeWays Grievance/Appeals Dispute complaint form. Copies of the forms can also be found on the LifeWays website www.lifewaysmco.com Provider Corner under forms or at LifeWays Customer Services.

Once the grievance form has been received by Customer Services an acknowledgement letter will be mailed within 5 calendar days informing the complainant of who will be processing and resolving the grievance in case the consumer/guardian may want to follow up or in the event they need to contact LifeWays. The form is sent to the appropriate employee to process and resolve the grievance.

The grievance process may take up to sixty (60) calendar days for a resolution. But the LifeWays Customer Services Specialists understand this is an important part of the complainants' life and try to resolve all grievances within 15 days or as quickly as the complainants' health condition requires.

Once the grievance is resolved, Customer Services will notify the complainant in writing of the resolution which is also called a "Notice of Disposition".

Examples of a Grievance

- "I WAITED A LONG TIME TO BE SEEN"
- "I DON'T LIKE MY PSYCHIATRIST AND WOULD LIKE TO SWITCH"
- "I DON'T LIKE THE LOBBY WHERE I GET MY SERVICES- IT'S FILTHY AND GROSS"
- "I DON'T LIKE THE WAY MY PCP MEETING WENT- I FEEL LIKE IT WAS RUSHED AND I DON'T FEEL LIKE ALL MY QUESTIONS GOT ANSWERED"

Appeals

An appeal is a consumer's request to review a decision that has been made about their services/service request. An appeal can happen when:

- A consumer is denied a service they asked for; OR
- A consumer does not get the amount of services they asked for, and they are not satisfied with why they didn't get everything they asked for; OR
- It takes more than 14 days to answer a consumers request for services; OR
- It takes longer than 14 days to provide a service to a consumer when they have been approved for the service (unless the consumer agrees to a different start date); OR
- A consumer already gets a service and it is being suspended, reduced, or ended.

Consumers Appeal Rights

The Due Process Clause of the U.S. Constitution guarantees that Medicaid beneficiaries must receive "due process" whenever benefits are denied, reduced or terminated. Due Process includes:

- Prior written notice of the adverse action
- A fair hearing before an impartial decision maker
- Continued benefits pending a final decision and
- A timely decision, measured from the date the complaint is first made.

Consumers of mental health services who are Medicaid beneficiaries eligible for Specialty Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid beneficiaries who participate in managed care. Grievance and appeal process requirements for Medicaid beneficiaries were significantly expanded through federal regulations implementing the Balanced Budget Act (BBA) of 1997.

Medicaid beneficiaries have rights and dispute resolution protections under federal authority of the Social Security Act, including:

- State fair hearings through authority of 42 CFR 431.200 et seq.
- Local appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Receiving Notice of Appeal Rights

Whenever something is going to happen with a consumer's services/supports (this is called an "action"), that consumer (and the guardian or parent if it applies) must be given a written notice of what is happening.

Consumers only need to do something with the notice if they disagree with what is happening with their services. If they are okay with what's happening with their services, they don't have to do anything.

Filing an Appeal

The consumer, guardian, or parent of a minor or an advocate that has written consent from the consumer can file an appeal. Appeals can be filed on the local level by contacting LifeWays Customer Services, or request a State Fair Hearing (Medicaid recipients only). A State Fair Hearing can be requested by filing out the Request for Hearing form which would have been included along with the denial notice letter. Non Medicaid consumers can only file an appeal on the local level.

Local Appeal Process for Medicaid Recipients

A local appeal is presented to a LifeWays employee that has the clinical expertise to make a decision on the consumers' services but has not been a part of the decision yet.

LifeWays has a customer friendly process that allows us to advocate for the consumers needs. Assistance is available for the filing process by contacting a Customer Services Specialist. Local appeals must be filed within 45 days from the date of the denial notice. An acknowledgement letter will be mailed out to the consumer/guardian or parent of a minor within 5 business days. The local appeal process may take up to 45 calendar days to receive a Notice of Disposition (resolution). But LifeWays Customer Services Specialists understand this is an important part of the consumers' life and try to resolve all appeals as quickly as the consumers health condition requires.

The consumer has the right to request an expedited or "faster" hearing if waiting the 45 days for a standard appeal would seriously jeopardize the consumers life or health or the ability to attain, maintain, or regain maximum function. If requested and accepted the consumer will receive a response to the local appeal within three (3) calendar days.

Any inquiries about filing an appeal will be treated as the filing date to establish the earliest possible filing date.

State Fair Hearing Process

Consumers with Medicaid can request a Medicaid fair hearing before an Administrative Law Judge (ALJ). The request for hearing form along with a self address stamped envelope will accompany the notice of denial letter. All requests must be sent to the State Office of Administrative Hearings and Rules. Additional Request for Hearing forms can be obtained through LifeWays Customer Services. A state fair hearing must be requested within 90 days from the date of the denial notice. A state fair hearing can be started along with the local appeal or before or after as long as it is within the 90 day period.

The Tribunal (the department that manages hearings at the state) sets the schedule for when a hearing will take place. All parties involved in the hearing meet at the LifeWays building in Jackson except the Administrative Law Judge (ALJ). A hearing can either happen over the phone (the judge is on the phone via conference), or at a hearing with the judge present, in-person. At the in person hearing the judge comes directly to LifeWays where the appeal-able action occurred to hear the case. Only the person who requested a hearing can ask to have the date changed or hearing cancelled.

A person must ask for an in person hearing; if they don't request an in person hearing they will get a phone hearing. It is also possible to do the hearing via phone conference with all parties involved but will also needed to be requested in advance.

The consumer can also ask someone to be their Authorized Hearing Representative (AHR) at the State Fair Hearing. This can be anyone they choose. The AHR will present their case at the appeal hearing. The consumer must say in writing who they choose as their AHR. They can still come to the hearing with their AHR.

The judge completes an impartial review of the action taken by LifeWays and gives a written decision. The judge will send his/her decision in writing to both the consumer and LifeWays. The judge's decision is legally binding for both parties.

Note: The consumer may ask that their services remain in place while the appeal or state fair hearing is in process. The request must be made to Customer Services within 12 days of the date of the original decision letter. Additionally, the following must be true for the services to continue:

- The services authorization has not expired.
- The decision regarding the services is a reduction, suspension, or termination of what is currently received.

However, the consumer may be required to repay the cost of the continued services if:

- The original decision is upheld.
- The appeal or hearing request is withdrawn.
- The consumer/guardian or the chosen representative (AHR) does not attend the hearing.

Local Appeal For Non-Medicaid Consumers

Non-Medicaid consumers cannot file a State Fair Hearing but can file a local appeal by contacting LifeWays Customer Services by phone, or by filling out one of the grievance/appeals complaint forms and mailing it to the LifeWays office. Local appeals must be filed within 45 days of receiving the denial notice. An acknowledgement letter will be mailed out to the consumer/guardian or parent of a minor within 5 business days. The local appeal process may take up to 45 calendar days to receive a Notice of Disposition (resolution). But LifeWays Customer Services Specialists understand this is an important part of the consumers' life and try to resolve all appeals as quickly as the consumers health condition requires. Any inquiries about filing an appeal will be treated as the filing date to establish the earliest possible filing date.

Access to Records

Consumers have the right to access their records in order to prepare for their appeal. They can have copies of their record without being charged for it. If the amount to be copied would be a financial or cost to the agency, or take a lot of staff time, the agency may try to charge for it. You can help the consumer by contacting the Office of Recipient Rights to see if there should be a charge.

DEFINITIONS

Action: A decision that adversely impacts a Medicaid beneficiary's claim for services due to:

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

- Failure to make an expedited authorization decision within **three (3) working days** from the date of receipt of a request for expedited service authorization.
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the PIHP.
- Failure of the PIHP to act within **45 calendar days** from the date of a request for a standard appeal.
- Failure of the PIHP to act within **three (3) working days** from the date of a request for an expedited appeal.
- Failure of the PIHP to provide disposition and notice of a local grievance/complaint within **60 calendar days** of the date of the request.

Additional Mental Health Services: Supports and services available to Medicaid beneficiaries who meet the criteria for specialty services and supports, under the authority of Section 1915(b)(3) of the Social Security Act. Also referred to as “**B3**” waiver services.

Adequate Notice of Action: Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid **services requested**. Notice is provided to the Medicaid beneficiary **on the same date** the action takes effect, or at the time of the signing of the individual plan of services/supports.

Advance Notice of Action: Written statement advising the beneficiary of a decision to reduce, suspend or terminate Medicaid services **currently provided**. Notice to be provided / mailed to the Medicaid beneficiary at least **12 calendar days prior** to the proposed date the action is to take effect.

Appeal: Request for a review of an “action” as defined above.

Authorization of Services: The processing of requests for initial and continuing service delivery.

Beneficiary: An individual who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid services through a PIHP/CMHSP.

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

Expedited Appeal: The expeditious review of an action, requested by a beneficiary or the beneficiary’s provider, when the time necessary for the normal appeal review process could seriously jeopardize the beneficiary’s life or health or ability to attain, maintain, or regain maximum function. If the beneficiary requests the expedited review, the PIHP determines if the request is warranted. If the beneficiary’s provider makes the request, or supports the beneficiary’s request, the PIHP must grant the request.

Fair Hearing: Impartial state level review of a Medicaid beneficiary’s appeal of an action presided over by a DCH Administrative Law Judge. Also referred to as “Administrative Hearing”.

Grievance: Medicaid Beneficiary’s expression of dissatisfaction about PIHP/CMHSP service issues, **other than an action**. Possible subjects for grievances include, but

are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the beneficiary.

Grievance Process: Impartial local level review of a Medicaid Beneficiary's grievance (expression of dissatisfaction) about PIHP/CMHSP service issues **other than an action.**

Grievance System: Federal terminology for the overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process.

Local Appeal Process: Impartial local level PIHP review of a Medicaid beneficiary's appeal of an action presided over by individuals not involved with decision-making or previous level of review.

Medicaid Services: Services provided to a beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Support waiver, and/or Section 1915(b)(3) of the Social Security Act

Notice of Disposition: Written statement of the PIHP decision for each local appeal and/or grievance, provided to the beneficiary.

Recipient Rights Complaint: Written or verbal statement by a consumer, or anyone acting on behalf of the consumer, alleging a violation of a Michigan Mental Health Code protected right.

Grievance & Appeals Training Module Post-Test

Instructions: Please indicate whether the statement is true or false.

#	Statement	Answer
1	A decision that adversely impacts a Medicaid beneficiary's claim for services due to a denial or limited authorization of a requested service, including the type or level of service is called an "Action".	
2	If a person is denied entry into the mental health system or hospitalization that person should file just a regular grievance.	
3	Non-Medicaid consumers can request a fair hearing if LifeWays fails to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service.	
4	Services provided to a beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Support waiver, and/or Section 1915(b)(3) of the Social Security Act are called " Action" Services.	
5	The Administrative Law Judge can appear in person for the hearing if it is requested in writing otherwise the ALJ will be by phone conference.	
6	An Appeal can also be filed at any given time	
7	Medicaid recipients have 60 days to request a State Fair Hearing.	
8	Medicaid Consumers/Guardians or parents of minors have to first file a local appeal and must wait to see if it's denied before they can file (request) a state fair hearing.	
9	Anyone can file an appeal.	
10	The Administrative Law Judge can appear in person for the hearing if it is requested in writing otherwise the ALJ will be via phone conference.	

When you have finished the Post -Test please check your answers with those on the following answer key. How well did you do? If you have questions, please contact LifeWays or your employer.

Grievance & Appeals Training Module Answer Key

#	Statement	Answer
1	A decision that adversely impacts a Medicaid beneficiary's claim for services due to a denial or limited authorization of a requested service, including the type or level of service is called an "Action".	True
2	<p>If a person is denied entry into the mental health system or hospitalization that person should file just a regular grievance.</p> <p><i>Consumers must be offered a 2nd Opinion when they are denied entry into Mental Health Services with a LifeWays Network Provider, or when they are denied hospitalization. This is a requirement of the Mental Health Code.</i></p>	False
3	Non-Medicaid consumers can request a fair hearing <u>if</u> LifeWays <u>fails</u> to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service.	True
4	<p>Services provided to a beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Support waiver, and/or Section 1915(b)(3) of the Social Security Act are called "Action" Services.</p> <p><i>Services provided to a beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Support waiver, and/or Section 1915(b)(3) of the Social Security Act are called "Medicaid" Services.</i></p>	False
5	<p>The Administrative Law Judge can appear in person for the hearing if it is requested in writing otherwise the ALJ will be by phone conference.</p> <p><i>In order for the ALJ to appear in person, that consumer/guardian or representative will need to request it in writing. If not requested, the hearing will be phone conference.</i></p>	True
6	<p>An Appeal can be filed at any given time.</p> <p><i>Appeals must be filed within 45 days from the date of the denial notice.</i></p>	False
7	<p>Medicaid recipients have 60 days to request a State Fair Hearing.</p> <p><i>A state fair hearing must be requested within 90 days from the date of the denial notice. A state fair hearing can be started along with the local appeal or before or after as long as it is within the 90 day period.</i></p>	False
8	<p>Medicaid Consumers/Guardians or parents of minors have to first file a local appeal and must wait to see if it's denied before they can file (request) a state fair hearing.</p> <p><i>A state fair hearing can be started along with the local appeal or before or after as long as it is within the 90 day period. They do not have to wait until they receive the decision if they file a local appeal.</i></p>	False
9	<p>Anyone can file an appeal.</p> <p><i>Only the consumer, guardian, or parent of a minor or an advocate that has written consent from the consumer can file an appeal.</i></p>	False
10	<p>The Administrative Law Judge (ALJ) can appear in person for the hearing if it is requested in writing otherwise the ALJ will be via phone conference.</p> <p><i>In order for the ALJ to appear in person, that consumer/guardian or representative will need to request it in writing. If not requested, the hearing will be via phone conference.</i></p>	True