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[NCQA RR2](#)

## Member Grievance

### POLICY

It is the policy of the Detroit Wayne Mental Health Authority (DWMHA) that Enrollee/Members receiving behavioral health services have access to the grievance process consistent with the Michigan Department of Health and Human Services, (MDHHS) and Center for Medicare and Medicaid Services (CMS) requirements, contracts, policy guidelines and technical advisories.

As the Pre-Paid Inpatient Health Plan (PIHP) and Community Mental Health Services Program (CMHSP) for the Detroit Wayne County area, the DWMHA has established and adheres to the grievance process defined below.

### PURPOSE

To provide procedural and operational guidance to DWMHA, the Access Center, Service Providers, Crisis services vendor, and for the development and consistent processing of member grievances.

### APPLICATION

1. The following groups are required to implement and adhere to this policy: All DWMHA Staff, Contractual Staff, Access Center, Network Service Providers, and Crisis services vendor.
2. This policy serves the following populations: Adults, Children, I/DD, SMI, SEI/SED, SUD, Autism
3. This policy impacts the following contracts/service lines: Medicaid, MI-HEALTH LINK, SUD, Autism, Grants, and General Fund.

### KEYWORDS

1. Grievance

### STANDARDS

1. DWMHA ensures that the grievance process is:
  - a. Timely.
  - b. Fair to all parties, which includes:
    - i. Enrollee/Member

- ii. Enrollee/Member's authorized or legal representative
    - iii. Provider and provider's staff
  - c. Administratively simple.
  - d. Objective and credible.
  - e. Accessible and understandable to Enrollees/Members and providers.
  - f. Subject to quality improvement review.
  - g. Developed in a manner to ensure that the individual staff who assist Enrollee/Member with the grievance process shall be free from discrimination and/or punitive action.
  - h. Developed in a manner to ensure that the grievance process does not interfere with the delivery of the Enrollee/Member's services.
  - i. Developed in a manner to ensure that an Enrollee/Member who files a grievance shall be free from discrimination and/or retaliation.
  - j. A structured grievance process to promote the resolution of Enrollee/Member's concerns about services.
2. DWMHA ensures that staff and providers are compliant with the grievance requirements as evidenced by ensuring:
- a. All employees are trained on the grievance process, including rights and responsibilities, procedures, and time frames, within thirty (30) days of hire and annually thereafter.
  - b. Display of grievance forms, posters and brochures in public areas of contracted provider locations.
  - c. All Enrollee/Members are informed of their right to designate an authorized representative to act on their behalf as long as the representative is at least 18 years of age and the member has provided written permission by completing and forwarding the Appointment of Representative form to DWMHA.
  - d. The grievance process is not utilized in lieu of an Enrollee/Member's ability to file a Recipient Rights Complaint.
  - e. All necessary language in contracts is compliant with State and Federal requirements.
  - f. Standardized documents related to the Grievance Policy in the form of templates for providers to customize with their specific identifying information.
  - g. Documentation of the substance of the grievance and action(s) taken in MH-WIN.
  - h. Investigation of the substance of grievance and action(s) taken, including any aspects of clinical care involved.
  - i. All operational and/or policy changes, including reference materials and documents, is communicated with subcontractors:
    - 1. Provide technical assistance and training on the grievance process to promote the resolution of concerns as well as to support and enhance services.
    - 2. Engage subcontractors in consultative meetings to provide information and guidance in establishing and implementing grievance process policies.
3. DWMHA provides access to one or more of the following dispute resolution options. They may be utilized concurrently:

- a. Grievance
  - b. Appeal
  - c. Recipient Rights Complaint
4. Enrollees/Members may access the State Fair Hearing process only if the resolution of the grievance is not resolved within ninety (90) calendar days of the receipt of the grievance unless a fourteen (14) day extension was granted.
5. DWMHA ensures that the Enrollee/Member and/or his/her authorized/legal representative shall be:
- a. Informed at the time of initial enrollment, intake, annually, upon request, and at the time he/she expresses dissatisfaction, of the internal grievance procedures, including the right to file a grievance, the resolution process, and the time frames for standard and expedited resolutions.
  - b. Informed orally and in writing of the grievance process available and methods to file a grievance;
  - c. Informed of the right to file an expedited or standard grievance;
  - d. Informed of the right to file an internal grievance orally or in writing at any time with his/her provider at the provider location, or with DWMHA by calling 1.888.490.9698, TTY: 1.800.630.1044, or in writing to: DWMHA Customer Service Department at 707 West Milwaukee, Detroit, MI 48202 or email to the appropriate address as noted below:
    - 1. MI Health Link Enrollee/Members at [MIHealthLinkGrievances@dwmha.com](mailto:MIHealthLinkGrievances@dwmha.com)
    - 2. Or by contacting Medicare to file an external grievance at 1-800-MEDICARE (1-800-633-4227), or through the DWMHA's website at: [www.DWMHA.com](http://www.DWMHA.com) under the Customer Service tab.
    - 3. Medicaid/Healthy Michigan and Non-Medicaid Enrollee/Members at [PIHPGrievances@dwmha.com](mailto:PIHPGrievances@dwmha.com)
  - e. Informed that filing a grievance will not affect eligibility of service;
  - f. Offered reasonable assistance in completing grievance forms and in taking other procedural steps which shall include but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY and interpreter capability;
  - g. Allowed to file a grievance on behalf of the Enrollee/Member to the extent allowed under applicable Federal or State law;
  - h. Informed that with written consent, they have the right to have a provider or other authorized representative, acting on their behalf, file a Grievance to DWMHA.
  - i. Informed that a provider may file a grievance or request a state fair hearing on behalf of the Enrollee since the State permits the provider to act as the Enrollee's authorized representative in doing so.
  - j. Provided information regarding grievance rights in a format provided or approved by DWMHA at the time of initial enrollment, upon request, and/or at least annually thereafter;
  - k. Informed there is no time limit on filing a Grievance.
6. DWMHA ensures that all grievances are processed timely by:
- a. Being initiated at the time an Enrollee/Member/legal representative or an authorized representative expresses dissatisfaction with services and/or experience in receiving services;
  - b. Acknowledging upon receipt;

1. Within three (3) days for MI Health Link Enrollees/Members;
2. Within five (5) days for Medicaid and uninsured or under insured Beneficiaries
- c. Responding orally or in writing within twenty-four (24) hours to an expedited grievance for MI Health Link Enrollees/Members when:
  1. DWMHA extends the appeals time frame, or
  2. DWMHA refuses to grant a request for an expedited appeal.
7. DWMHA submits the grievance to the appropriate staff including an administrator with the authority to require corrective action, none of whom shall have been involved in the previous review or decision-making, nor a subordinate of any such individual.
8. DWMHA ensures that the individuals who make decisions on the grievance are individuals who have clinical expertise, as determined by the State, in treating the Enrollee/Member's condition or disease if the grievance involves:
  - a. Clinical issues
  - b. The denial of an expedited resolution of an appeal (of an action)
9. DWMHA completes and forwards a Status Letter to an Enrollee/Member, authorized or legal representative for a grievance pending resolution beyond thirty (30) days.
10. DWMHA processes, investigates, and resolves a grievance as expeditiously as the Enrollee/Member's health requires and in no event later than ninety (90) calendar days.
  - a. The ninety (90) day time frame may be extended up to fourteen (14) days should the Enrollee/Member/authorized or legal representative request the extension, or if the provider justifies the need for additional information and documents how the delay is in the interest of the Enrollee/Member.
  - b. If DWMHA extends the time frame for response to a grievance and it is not at the Enrollee/Member's request, DWMHA must make reasonable efforts to give the Enrollee/Member prompt oral notice of the delay.
  - c. DWMHA must give the Enrollee/Member written notice of the reason for the extended time frame within two (2) business days and inform the Enrollee/Member of the right to file a grievance if he or she disagrees with that decision.
11. DWMHA takes into account all comments, documents, records, and other information submitted by the Enrollee/Member or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
12. DWMHA proves accessibility and availability of Customer Service Grievance staff and Customer Service Representatives to discuss and provide assistance with resolving an Enrollee/Member's grievance.
13. DWMHA ensures that subcontractors provide the Enrollee/Member/authorized or legal representative the opportunity before, during, and after the grievance process to examine, free of charge, their case file, medical records and any other documents and records being considered. Further, the Enrollee/Member/authorized or legal representative may present any additional information in person as well as in writing for the decision making process.
14. DWMHA maintains an electronic tracking system (MH-WIN) to register, track and report to DWMHA's Quality Department and ICO's the following:
  - a. Number of DWMHA grievances

- b. Time frames and disposition of grievances
  - c. Substance/reason for, and the number of grievance requests by category
  - d. The number of Standard and Expedited Grievance requests
  - e. Resolution times of grievances; and
  - f. Grievance records
15. DWMHA notifies the Enrollee/Member, authorized or legal representative in writing of the disposition and the right to appeal the resolution of his/her grievance upon case closure and no later than ninety (90) calendar days from the date of receipt of the grievance.
16. DWMHA ensures that all forms and Enrollee/Member materials related to grievances are available and easily accessible, in understandable and linguistically appropriate format, via DWMHA website, IPOS meetings and at provider locations.
17. As required, DWMHA materials are compliant with all contractual, regulatory, and accreditation requirements in regards to reading level (at or below 4th grade level), font, type size, format, and language. DWMHA will meet reasonable accommodations as required by the American Disabilities Act (ADA), Limited English Proficiency (LEP), and Cultural Competency guidelines. These services are provided at no cost to the Enrollee/Member.
- a. The availability of vital written information in the prevalent non-English languages in the service area in accordance with the LEP guidelines, Center for Medicare and Medicaid Services (CMS) and/or DWMHA's contract with the Michigan Department of Health and Human Services (MDHHS). Materials will meet the most stringent guideline.
  - b. Upon request, DWMHA will provide materials in alternate formats to meet the needs of vision and/or hearing impaired Enrollee/Members, including large font (at least 16 point font), Braille, oral interpretation service, ASL, audio and visual formats.
  - c. Translation services will be made available to the Enrollee/Member, upon request.
  - d. Interpreter services and toll-free numbers that have adequate TTY and interpreter capability.
18. Contracted Providers are expected to develop their policies in alignment with DWMHA directives.

## **QUALITY ASSURANCE/IMPROVEMENT**

The DWMHA shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of services providers must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

## **COMPLIANCE WITH ALL APPLICABLE LAWS**

DWMHA and service provider staff are bound by all applicable Local, State and Federal laws, rules, regulations and policies, all Federal waiver requirements, State and County contractual requirements, policies, and administrative directives, as amended.

## **LEGAL AUTHORITY**

1. Medicare Managed Care Manual, Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care

Prepayment Plans (HCPPs), (collectively referred to as Medicare Health Plans)

2. Federal Law 42 CFR, Chapter IV, Subpart E, Sections 431.200 et seq.
3. Federal Law 42 CFR, Chapter IV, Subpart C, Sections 434.32
4. Federal Law 42 CFR, Chapter IV, Subpart F, Sections 438.400-424
5. Michigan Mental Health Code, PA 258 of 1974, as amended
6. Michigan Department of Community Health (MDCH) Managed Care Contract
7. MDCH Grievance and Appeal Technical Requirement PIHP Grievance System for Medicaid Beneficiaries, July, 2004

## RELATED POLICIES

DWMHA Policies: All DWMHA policies refer to the most recent policy at the time of writing.

1. Customer Service Enrollee/Member Appeal Policy
2. Recipient Rights Policies
3. Limited English Proficiency (LEP)
4. Cultural Competency
5. Substance Use Disorder - Recipient Rights
6. [Enrollee/Member Grievance Timeframes and Procedural Steps](#)

## RELATED DEPARTMENTS

1. Claims Management
2. Clinical Practice Improvement
3. Compliance
4. Customer Service
5. Information Technology
6. Integrated Health Care
7. Legal
8. Managed Care Operations
9. Quality Improvement
10. Utilization Management
11. Recipient Rights
12. Substance Use Disorders

## CLINICAL POLICY

YES

# INTERNAL/EXTERNAL POLICY

## EXTERNAL

### Attachments:

[Acknowledgement Letter for Medicaid & Non Medicaid.docx](#)  
[Acknowledgement Letter for MHL.docx](#)  
[Appeals and Grievance TA FY 18.pdf](#)  
[Appointment of Representative](#)  
[Clinical Consultation Request Form.doc](#)  
[Combination Letter for Medicaid and Non-Medicaid.docx](#)  
[Enrollee-Member Grievance Timeframes and Procedural Steps.pdf](#)  
[Expedited Grievance Request\\_MI Health Link.docx](#)  
[Extension Letter for Medicaid and Non-Medicaid.docx](#)  
[Extension Letter for MIHL.docx](#)  
[Grievance Log\\_Medicaid\\_Non-Medicaid.docm](#)  
[Grievance Log\\_MI Health Link.docm](#)  
[Out Of Jurisdiction for Medicaid.doc](#)  
[Out Of Jurisdiction Letter for MHL.docx](#)  
[Request Additional Info From Enrollee for MHL.docx](#)  
[Request Additional Info from Enrollee for Medicaid and Non-Medicaid.docx](#)  
[Request Additional Information from Provider for Medicaid and Non-Medicaid.doc](#)  
[Request Additional Information from Provider for MHL.doc](#)  
[Request for Review of Grievance\\_Medicaid-Healthy Michigan-Non-Medicaid.docx](#)  
[Request for Review of Grievance\\_MI Health Link.docx](#)  
[Request for Satisfaction Response for Medicaid and Non\\_Medicaid.docx](#)  
[Request for Satisfaction Response for MHL.docx](#)  
[Request for State Fair Hearing.pdf](#)  
[Resolution Letter for Medicaid and Non-Medicaid.docx](#)  
[Resolution Letter for MHL.docx](#)  
[Status Letter for Medicaid.docx](#)  
[Status Letter for MHL.docx](#)







## Acknowledgment Letter

Date

Grievance ID: XXXX

RE: Member  
Enrollee/Member ID #  
Street Address  
City, State, Zip Code

Dear Grievant:

The (PIHP/MCPN/Service Provider) Customer Service Department received your grievance on (actual date grievance was filed). You expressed dissatisfaction regarding:

(Issue info)

Thank you for bringing your concern to our attention. It is our intention to resolve your grievance prior to ninety (90) calendar days. However, up to an additional fourteen (14) days can be granted if needed in order to review additional information regarding your grievance. Please note that should the resolution of your grievance exceed ninety (90) calendar days, you may file a (SFH or an ADR). You would do so in writing and mail to the address listed below:

(SFH or ADR info)

If you have any questions, you may contact (PIHP/MCPN/Service Provider) at (Telephone Number). You may also contact Detroit Wayne Mental Health Authority Customer Service Department at 888. 490.9698 or TTY at 800.630.1044.

Sincerely,

Name of staff (Credentials)  
Title of staff



## Acknowledgment Letter

Date

Grievance ID: XXXX

RE: Member  
Enrollee/Member ID: #  
Street Address  
City, State, Zip Code

Dear Grievant:

The PIHP/MCPN/Service Provider (FILL IN) Customer Service Office received your grievance on (actual date grievance was filed). You expressed dissatisfaction regarding:

(Issue info)

Thank you for bringing your concern to our attention. It is our intention to resolve your grievance prior to ninety (90) calendar days. Up to an additional fourteen (14) days can be granted if needed in order to review additional information regarding your grievance. Please note that should the resolution of your grievance exceed ninety (90) calendar days, you may file a State Fair Hearing Request. You would do so in writing and mail to the address below:

Michigan Administrative Hearing System  
Department of Health and Human Services  
P.O. Box 30763  
Lansing MI 48909-7695

**Note:** As a Medicare member, should you have a complaint about the quality of care you have received or think coverage for your hospital stay ended too soon, you may contact KEPRO at 1.855.408.8557. DWMHA encourage you to first call our Customer Service Office at 1.888.490.9698. We will try to resolve any complaint that you might have over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints.

If you have any questions, you may contact DWMHA at 1.888.490.9698 or TTY at 1.800.630.1044. You may also contact the Medicare Grievance Hotline to file an external grievance at **1-800-MEDICARE** or **1.800.633.4227**.

Sincerely,

Name (Credentials)  
Title

**GRIEVANCE AND APPEAL TECHNICAL REQUIREMENT  
PIHP GRIEVANCE AND APPEAL SYSTEM FOR MEDICAID  
BENEFICIARIES**

**OCT. 2017**

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## I. PURPOSE AND BACKGROUND

This Technical Advisory is intended to facilitate Prepaid Inpatient Health Plan (PIHP) compliance with the Medicaid Enrollee Grievance and Appeal System requirements contained in Part 11, 6.3.1 of the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services (MDHHS). These requirements are applicable to all PIHPs, Community Mental Health Services Programs (CMHSPs) and their provider networks.

Although this technical advisory specifically addresses the federal Grievance and Appeal System processes required for Medicaid Enrollees, other dispute resolution processes available to all Mental Health consumers are identified and referenced.

Under the Due Process Clause of the U.S. Constitution, Medicaid Enrollees are entitled to "due process" whenever their Medicaid benefits are denied, reduced or terminated. Due process requires that Enrollees receive: (1) prior written notice of the adverse action; (2) a fair hearing before an impartial decision maker; (3) continued benefits pending a final decision; and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements. The Medicaid Enrollee Grievance and Appeal System provides a process to help protect Medicaid Enrollee due process rights.

Consumers of mental health services who are Medicaid Enrollees 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:

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

Medicaid Enrollees, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, Chapters 7, 7A, 4 and 4A, including:

- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.).
- Medical Second Opinion through authority of the Mental Health Code (MCL 330.1705).

## II. DEFINITIONS

The following terms and definitions are utilized in this Technical Requirement.

**Adverse Benefit Determination:** A decision that adversely impacts a Medicaid

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Enrollee's claim for services due to: (42 CFR 438.400)

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 42 CFR 438.400(b)(1).
- Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2).
- Denial, in whole or in part, of payment for a service. 42 CFR 438.400(b)(3).
- Failure to make a standard Service Authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service. 42 CFR 438.210(d)(1).
- Failure to make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization. 42 CFR 438.210(d)(2).
- 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. 42 CFR 438.400(b)(4).
- Failure of the PIHP to resolve standard appeals and provide notice within **30 calendar days** from the date of a request for a standard appeal. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).
- Failure of the PIHP to resolve expedited appeals and provide notice within **72 hours** from the date of a request for an expedited appeal. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).
- Failure of the PIHP to resolve grievances and provide notice within **90 calendar days** of the date of the request. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).
- 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 § 438.52(b)(2)(ii), to obtain services outside the network. 42 CFR 438.400(b)(6).
- Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. 42 CFR 438.400(b)(7).

**Adequate Notice of Adverse Benefit Determination:** Written statement advising the Enrollee of a decision to deny or limit authorization of Medicaid services requested, which notice must be provided to the Medicaid Enrollee on the same date the Adverse Benefit Determination takes effect. 42 CFR 438.404(c)(2).

**Advance Notice of Adverse Benefit Determination:** Written statement advising the Enrollee of a decision to reduce, suspend or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid Enrollee at least **10 calendar days prior** to the proposed date the Adverse Benefit Determination is to take effect. 42 CFR 438.404(c)(1); 42 CFR 431.211.

**Appeal:** A review at the local level by a PIHP of an Adverse Benefit Determination, as defined above. 42 CFR 438.400.

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**Authorization of Services:** The processing of requests for initial and continuing service delivery. *42 CFR 438.210(b)*.

**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.

**Enrollee:** A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program. *42 CFR 438.2*.

**Expedited Appeal:** The expeditious review of an Adverse Benefit Determination, requested by an Enrollee or the Enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the Enrollee requests the expedited review, the PIHP determines if the request is warranted. If the Enrollee's provider makes the request, or supports the Enrollee's request, the PIHP must grant the request. *42 CFR 438.410(a)*.

**Grievance:** Enrollee's expression of dissatisfaction about PIHP/CMHSP service issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the Enrollee, failure to respect the Enrollee's rights regardless of whether remedial action is requested, or an Enrollee's dispute regarding an extension of time proposed by the PIHP to make a service authorized decision. *42 CFR 438.400*.

**Grievance Process:** Impartial local level review of an Enrollee's Grievance.

**Grievance and Appeal System:** The processes the PIHP implements to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them. *42 CFR 438.400*.

**Medicaid Services:** Services provided to an Enrollee under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

**Notice of Resolution:** Written statement of the PIHP of the resolution of a Grievance or Appeal, which must be provided to the Enrollee as described in *42 CFR 438.408*.

**Recipient Rights Complaint:** Written or verbal statement by a Enrollee, or anyone acting on behalf of the Enrollee, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

**Service Authorization:** PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to *42 CFR 438.210*.

**State Fair Hearing:** Impartial state level review of a Medicaid Enrollee's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

### **III. GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS**

Federal regulation (*42 CFR 438.228*) requires the State to ensure through its contracts with PIHPs, that each PIHP has a grievance and appeal system in place for Enrollee's that complies with Subpart F of Part 438.

The Grievance and Appeal System must provide Enrollees:

- An Appeal process (one level, only) which enables Enrollees to challenge Adverse Benefit Determinations made by the PIHP or its agents.
- A Grievance Process.
- The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints.
- Access to the State Fair Hearing process to further appeal an Adverse Benefit Determination, after receiving notice that the Adverse Benefit Determination has been upheld by the PIHP level Appeal.
- Information that if the PIHP fails to adhere to notice and timing requirements as outlined in PHIP Appeal Process, the Enrollee is deemed to have exhausted the PIHP's appeals process. The Enrollee may initiate a State fair hearing.
- The right to request, and have, Medicaid covered benefits continued while a local PIHP Appeal and/or State Fair Hearing is pending.
- With the written consent from the Enrollee, the right to have a provider or other authorized representative, acting on the Enrollee's behalf, file an Appeal or Grievance to the PIHP, or request a State Fair Hearing. The provider may file a grievance or request a state fair hearing on behalf of the Enrollee since the State permits the provider to act as the Enrollee's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so.

### **IV. NOTICE OF ADVERSE BENEFIT DETERMINATION**

A PIHP is required to provide timely and "adequate" notice of any Adverse Benefit Determination. *42 CFR 438.404(a)*.

A. Content & Format: The notice of Adverse Benefit Determination must meet the following requirements: (*42 CFR 438.404(a)-(b)*)

1. Enrollee notice must be in writing, and must meet the requirements of 42 CFR 438.10 (i.e., "...manner and format that may be easily understood and

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is readily accessible by such enrollees and potential enrollees,” meets the needs of those with limited English proficiency and or limited reading proficiency);

2. Notification that *42 CFR 440.230(d)* provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures;
3. Description of Adverse Benefit Determination;
4. The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;
5. Notification of the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee’s Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);
6. Notification of the Enrollee’s right to request an Appeal, including information on exhausting the PIHP’s single local appeal process, and the right to request a State Fair Hearing thereafter;
7. Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal;
8. Notification of the Enrollee’s right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the Enrollee may be required to pay the costs of the continued services (only required when providing “Advance Notice of Adverse Benefit Determination”);
9. Description of the procedures that the Enrollee is required to follow in order to exercise any of these rights; and
10. An explanation that the Enrollee may represent him/herself or use legal counsel, a relative, a friend or other spokesman.

B. Timing of Notice: (*42 CFR 438.404(c)*)

1. Adequate Notice of Adverse Benefit Determination:

- a. For a denial of payment for services requested (not currently provided), notice must be provided to the Enrollee at the time of the action affecting the claim. *42 CFR 438.404(c)(2)*.



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- b. For a Service Authorization decision that denies or limits services notice must be provided to the Enrollee within 14-days following receipt of the request for service for standard authorization decisions, or within 72-hours after receipt of a request for an expedited authorization decision. *42 CFR 438.210(d)(1)-(2); 42 CFR 438.404(c)(3)&(6).*
- c. For Service Authorization decisions not reached within 14-days for standard request, or 72-hours for an expedited request, (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire. *42 CFR 438.404(c)(5).*
  - NOTE, however, that the PIHP may be able to extend the standard Service Authorization timeframe in certain circumstances (*42 CFR 438.210(d)(1)(ii)*). If so, the PIHP must: (i) provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and (ii) issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. *42 CFR 438.404(c)(4).*

2. Advance Notice of Adverse Benefit Determination:

- a. Required for reductions, suspensions or terminations of previously authorized/ currently provided Medicaid Services.
- b. Must be provided to the Enrollee at least ten (10) calendar days prior to the proposed effective date. *42 CFR 438.404(c)(1); 42 CFR 431.211.*
- c. Limited Exceptions: The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, IF (*42 CFR 431.213; 42 CFR 431.214*)
  - i. The PIHP has factual information confirming the death of an Enrollee;
  - ii. The PIHP receives a clear written statement signed by an Enrollee that he no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the Enrollee understands that this must be the result of supplying that information;
  - iii. The Enrollee has been admitted to an institution where he is ineligible under the plan for further services;

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- iv. The Enrollee's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address;
- v. The PIHP establishes that the Enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
- vi. A change in the level of medical care is prescribed by the Enrollee's physician;
- vii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act;
- viii. The date of action will occur in less than 10 calendar days.
- ix. The PIHP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the Enrollee (in this case, the PIHP may shorten the period of advance notice to 5 days before the date of action).

**C. Required Recipients of Notice of Adverse Benefit Determination:**

- 1. The Enrollee must be provided written notice. *42 CFR 438.404(a); 42 CFR 438.210(c).*
- 2. The requesting provider must be provided notice of any decision by the PIHP to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. Notice to the provider does NOT need to be in writing. *42 CFR 438.210(c).*
- 3. If the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an adverse benefit determination, and requires a written notice of action.

**V. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT**

- A. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the PIHP MUST continue the Enrollee's benefits if all of the following occur: *42 CFR 438.420*

- 1. The Enrollee files the request for Appeal timely (within 60 calendar days

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from the date on the Adverse Benefit Determination Notice); *42 CFR 438.402(c)(2)(ii)*;

2. The Enrollee files the request for continuation of benefits timely (on or before the latter of (i) 10 calendar days from the date of the notice of Adverse Benefit Determination, or (ii) the intended effective date of the proposed Adverse Benefit Determination). *42 CFR 438.420(a)*; and
3. The period covered by the original authorization has not expired.

B. Duration of Continued or Reinstated Benefits (*42 CFR 438.420(c)*). If the PIHP continues or reinstates the Enrollee's benefits, at the Enrollee's request, while the Appeal or State Fair Hearing is pending, the PIHP must continue the benefits until one of following occurs:

1. The Enrollee withdraws the Appeal or request for State Fair Hearing;
2. The Enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after PIHP sends the Enrollee notice of an adverse resolution to the Enrollee's Appeal;
3. A State Fair Hearing office issues a decision adverse to the Enrollee.

C. If the final resolution of the Appeal or State Fair Hearing upholds the PIHP's Adverse Benefit Determination, the PIHP may, consistent with the state's usual policy on recoveries and as specified in the PIHP's contract, recover the cost of services furnished to the Enrollee while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements. *42 CFR 438.420(d)*.

D. If the Enrollee's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.

E. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations. *42 CFR 438.424(b)*

F. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a)*.

## **VI. PIHP APPEAL PROCESS**

A. Upon receipt of an adverse benefit determination notification, federal regulations

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42 CFR 400 et seq., provide Enrollees the right to appeal the determination through an internal review by the PIHP. Each PIHP may only have one level of appeal. Enrollees may request an internal review by the PIHP, which is the first of two appeal levels, under the following conditions:

1. The Enrollee has **60 calendar days** from the date of the notice of Adverse Benefit Determination to request an Appeal. *42 CFR 438.402(c)(2)(ii)*.
2. The Enrollee may request an Appeal either orally or in writing. Unless the Enrollee requests and expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal. *42 CFR 438.402(c)(3)(ii)*.

NOTE: Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal). *42 CFR 438.406(b)(3)*.

3. In the circumstances described above under the Section entitled “Continuation of Benefits,” the PIHP will be required to continue/reinstate Medicaid Services until one of the events described in that section occurs.

**B. PIHP Responsibilities when Enrollee Requests an Appeal:**

1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)*.
2. Acknowledge receipt of each Appeal. *42 CFR 438.406(b)(1)*.
3. Maintain a record of appeals for review by the State as part of its quality strategy. *42 CFR 438.416*.
4. Ensure that the individual(s) who make the decisions on Appeals: *42 CFR 438.406(b)(2)*.
  - a. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual;
  - b. When deciding an Appeal that involves either (i) clinical issues, or (ii) a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the Enrollee’s condition or disease.
  - c. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or

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considered in the initial Adverse Benefit Determination.

5. Provide the Enrollee a reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing, and inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals; *42 CFR 438.406(b)(4)*.
6. Provide the Enrollee and his/her representative the Enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. *42 CFR 438.406(b)(5)*.
7. Provide opportunity to include as parties to the appeal the Enrollee and his or her representative, or the legal representative of a deceased Enrollee's estate; *42 CFR 438.406(b)(6)*.
8. Provide the Enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one.

C. Appeal Resolution Timing and Notice Requirements:

1. Standard Appeal Resolution (timing): The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed **30 calendar days** from the day the PIHP receives the Appeal.
2. Expedited Appeal Resolution (timing):
  - a. Available where the PIHP determines (for a request from the Enrollee) or the provider indicates (in making a request on the Enrollee's behalf or supporting the Enrollee's request) that the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. *42 CFR 438.410(a)*.
  - b. The PIHP may not take punitive action against a provider who requests an expedited resolution or supports an Enrollee's appeal. *42 CFR 438.410(b)*.
  - c. If a request for expedited resolution is denied, the PIHP must:
    - i. Transfer the appeal to the timeframe for standard resolution. *42 CFR 438.410(c)(1)*.

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- ii. Make reasonable efforts to give the Enrollee prompt oral notice of the denial. *42 CFR 438.408(c)(2), 438.410(c)(2).*
  - iii. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision. *42 CFR 438.408(c)(2), 438.410(c)(2).*
  - iv. Resolve the Appeal as expeditiously as the Enrollee's health condition requires but not to exceed 30 calendar days.
- d. If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than **72-hours** after the PIHP receives the request for expedited resolution of the Appeal. *42 CFR 438.408.*
3. Extension of Timeframes: The PIHP may extend the resolution and notice timeframe by up to **14 calendar days** if the Enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the Enrollee's interest. *42 CFR 438.408(c).*
- a. If the PIHP extends resolution/notice timeframes, it must complete all of the following: *42 CFR 438.408(c)(2)*
    - i. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;
    - ii. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision.
    - iii. Resolve the Appeal as expeditiously as the Enrollee's health condition requires and not later than the date the extension expires.
4. Appeal Resolution Notice Format:
- a. The PIHP must provide Enrollees with written notice of the resolution of their Appeal, and must also make reasonable efforts to provide oral notice in the case of an expedited resolution. *42 CFR 438.408(d)(2).*
  - b. Attached to this agreement are recommended notice templates for grievance and appeals. They are titled, Exhibit A "Notice of Adverse

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Benefit Determination”, Exhibit B “Notice of Receipt of Appeal/Grievance”, Exhibit C Notice of Appeal Approval”, and Exhibit D “Notice of Appeal Denial”. These templates incorporate the information needed to meet the requirement of grievance and appeal recordkeeping in 42 CFR 438.416. Specifically, 42 CFR 438.416 indicates the State must require the PIHP maintain records with (at minimum) the following information:

- (1) A general description of the reason for the appeal or grievance.
- (2) The date received.
- (3) The date of each review or, if applicable, review meeting.
- (4) Resolution at each level of the appeal or grievance if applicable.
- (5) Date of resolution at each level, if applicable.
- (6) Name of the covered person for whom the appeal or grievance was filed.

Further this recordkeeping must be “accurately maintained in a manner accessible to the state and available upon request to CMS.”

IF the PIHP chooses not to use the recommended notice templates the alternatives used by the PIHP must include the required information under 42 CFR 438.416 as noted above.

- c. Enrollee notice must meet the requirements of *42 CFR 438.10* (i.e., “...in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees,” meets the needs of those with limited English proficiency and or limited reading proficiency).

5. Appeal Resolution Notice Content: 42 CFR 438.408(e)

- a. The notice of resolution must include the results of the resolution and the date it was completed.
- b. When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee’s:
  - i. Right to request a state fair hearing, and how to do so;
  - ii. Right to request to receive benefits while the state fair hearing is pending, and how to make the request; and
  - iii. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination

## VII. GRIEVANCE PROCESS

- A. Federal regulations provide Enrollees the right to a grievance process to seek resolution to issues that are not Adverse Benefit Determinations. (*42 CFR 438.228*)



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B. Generally:

1. Enrollees must file Grievances with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances.
2. Grievances may be filed at any time by the Enrollee, guardian, or parent of a minor child or his/her legal representative. *42 CFR 438.402(c)(2)(i)*.
3. Enrollee's access to the State Fair Hearing process respecting Grievances is only available when the PIHP fails to resolve the grievance and provide resolution within **90 calendar days** of the date of the request. This constitutes an "Adverse Benefit Determination", and can be appealed to the MDHHS Administrative Tribunal using the State Fair Hearing process. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1)*.

C. PIHP Responsibility when Enrollee Files a Grievance:

1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)*.
2. Acknowledge receipt of the Grievance. *42 CFR 438.406(b)(1)*.
3. Maintain a record of grievances for review by the State as part of its quality strategy.
4. Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination. *42 CFR 434.32*
5. Ensure that the individual(s) who make the decisions on the Grievance:
  - a. Were not involved in any previous level review or decision-making, nor a subordinate of any such individual. *42 CFR 438.406(b)(2)(i)*.
  - b. When the Grievance involves either (i) clinical issues, or (ii) denial of expedited resolution of an Appeal, are individual(s) who have appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.
  - c. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination



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**D. Grievance Resolution Timing and Notice Requirements**

1. **Timing of Grievance Resolution:** Provide the Enrollee a written notice of resolution not to exceed **90 calendar days** from the day the PIHP received the Grievance.
2. **Format and Content of Notice of Grievance Resolution:**
  - a. Enrollee notice of Grievance resolution must meet the requirements of 42 CFR 438.10 (i.e., "...in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).
  - b. The notice of Grievance resolution must include:
    - i. The results of the Grievance process;
    - ii. The date the Grievance process was concluded;
    - iii. Notice of the Enrollee's right to request a State Fair Hearing, if the notice of resolution is more than **90-days** from the date of the Grievance; and
    - iv. Instructions on how to access the State Fair Hearing process, if applicable .

**VIII. STATE FAIR HEARING APPEAL PROCESS**

- A. Federal regulations provide an Enrollee the right to an impartial review by a state level administrative law judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances:
  1. After receiving notice that the PIHP is, after Appeal, upholding an Adverse Benefit Determination. *42 CFR 438.408(f)(1)*;
  2. When the PIHP fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals, as described in *42 CFR 438.408. 42 CFR 438.408(f)(1)(i)*.
- B. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the Enrollee, free to Enrollee, independent of State and PIHP, and not extend any timeframes or disrupt continuation of benefits). *42 CFR 438.408(f)(1)(ii)*.
- C. The PIHP may not limit or interfere with an Enrollee's freedom to make a request for a State Fair Hearing.
- D. Enrollees are given **120 calendar days** from the date of the applicable notice of resolution to file a request for a State Fair Hearing. *42 CFR 438.408(f)(2)*.

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- E. The PIHP is required to continue benefits, if the conditions described in Section V, MEDICAID SERVICES CONTINUATION OR REINSTATEMENT are satisfied, and for the durations described therein.
- F. If the Enrollee's services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the Adverse Benefit Determination.
- G. The parties to the State Fair Hearing include the PIHP, the Enrollee and his or her representative, or the representative of a deceased Enrollee's estate. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.
- H. Expedited hearings are available.

Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at:

[www.Michigan.gov/mdhhs>>Assistance Programs>>Medicaid>>Medicaid Fair Hearings](http://www.Michigan.gov/mdhhs>>Assistance Programs>>Medicaid>>Medicaid Fair Hearings) [http://www.michigan.gov/mdhhs/0,5885,7-339-71547\\_4860-16825--,00.html](http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html)  
OR

Department of Licensing and Regulatory Affairs  
Michigan Administrative Hearing System Fair Hearing  
[http://www.michigan.gov/lara/0,4601,7-154-10576\\_61718\\_77732---,00.html](http://www.michigan.gov/lara/0,4601,7-154-10576_61718_77732---,00.html)

## **IX. RECORDKEEPING REQUIREMENTS**

The PIHP is required to maintain records of Enrollee Appeals and Grievances, which will be reviewed by the PIHP as part of its ongoing monitoring procedures, as well as by State staff as part of the State's quality strategy.

A PIHP's record of each Grievance or Appeal must contain, at a minimum:

- A. A general description of the reason for the Grievance or Appeal;
- B. The date received;
- C. The date of each review, or if applicable, the review meeting;
- D. The resolution at each level of the Appeal or Grievance, if applicable;
- E. The date of the resolution at each level, if applicable;
- F. Name of the covered person for whom the Grievance or Appeal was filed.

PIHPs must maintain such records accurately and in a manner accessible to the State and available upon request to CMS.

## Appointment of Representative

Name of Party	Medicare or National Provider Identifier Number
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### Section 1: Appointment of Representative

**To be completed by the party seeking representation if the Medicare beneficiary or the provider or the supplier:**

I appoint this individual, \_\_\_\_\_ to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security Act (the "Act") and related provisions of title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

### Section 2: Acceptance of

**Appointment To be completed by the representative:**

I, \_\_\_\_\_, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an \_\_\_\_\_  
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

### Section 3: Waiver of Fee for Representation

**Instructions: This section must be completed if the representative is required to or chooses to waive their fee for representation** (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing \_\_\_\_\_ before the Secretary of the Department of Health and Human Services.

Signature	Date
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## Section ☐: Waiver of Payment for Items or Services at Issue

**Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a ☐uestion of liability under section ☐☐☐☐☐a ☐☐☐☐of the Act☐**

(Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under ☐1879(a)(2) of the Act is at issue.

Signature	Date
-----------	------

Form CMS-1696 (Rev 06/12)

## Charging of ☐ees for Representing Beneficiaries Before the Secretary of the Department of Health and Human Services

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of the Department of Health and Human Services (DHHS) (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council review, or a proceeding before an ALJ or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR ☐405.910(f).

The form, ☐Petition to Obtain Representative Fee☐elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation

## Authori☐ation of ☐ee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

## Conflict of Interest

Sections 203, 205 and 207 of title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

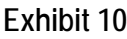
## Where to Send This Form

Send this form to the same location where you are sending (or have already sent): (1) your appeal if you are filing an appeal, (2) grievance if you are filing a grievance, or (3) initial determination or decision if you are requesting an initial determination or decision.

If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227).

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.



To: \_\_\_\_\_  
 From: \_\_\_\_\_  
 Consultation Submission Date: \_\_\_\_\_  
 Request Response by: \_\_\_\_\_  
 Member Name: \_\_\_\_\_ MHWIN ☐ \_\_\_\_\_  
 Grievance ID☐ \_\_\_\_\_ Incident Date: \_\_\_\_\_  
 Service Provider: \_\_\_\_\_ Phone ☐ \_\_\_\_\_

Clinical Issue: ☐ Yes ☐ No  
Quality of Care: ☐ Yes ☐ No

Reason for requesting a Clinical Consultation:

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.

CS Director Initials: \_\_\_\_\_ Date: \_\_\_\_\_





## Acknowledgement/Resolution Letter

Date

Grievance ID: XXXX

RE: Member  
Enrollee/Member ID #  
Street Address  
City, State, Zip Code

Dear Grievant:

The (PIHP/MCPN/Service Provider) Customer Service Office received your grievance on (date). Your grievance was resolved on (date).

(Issue Info).

(Resolution Info)

Per our conversation, on (date), you expressed (satisfaction or dissatisfaction response) with the resolution). Thank you for bringing your concerns to our attention.

This grievance was resolved within five days. However, we still would like for you to know that if the resolution of this grievance had exceeded 90 calendar days, you could have filed a (SFH or an ADR). You would do this by writing and mailing your request to the address listed below:

(MFH or ADR address)

Should you have any questions about this correspondence, please contact the (MCPN/Service Provider) Customer Service Office at (MCPN/Service Provider). You may also contact Detroit Wayne Mental Health Authority at 1-888-490-9698).

Sincerely,

Staff Name  
Title of Staff





Current Status: Active

PolicyStat ID: 4976279



Origination: 12/2016  
Last Approved: 05/2018  
Last Revised: 05/2018  
Next Review: 05/2019  
Owner: Winifred Williamson  
Policy Area: Customer Service  
References: MDHHS - EQR VII, NCQA RR1, NCQA RR2

## Enrollee/Member Grievance Timeframes and Procedural Steps

### PROCEDURE PURPOSE

To provide procedural and operational guidance to DWMHA, the Access Center, Crisis services vendor, MCPNs, and Service Providers for the development and consistent processing of an enrollee/member's grievance.

### EXPECTED OUTCOME

*DWMHA, the Access Center, Crisis services vendor, MCPNs, and Service Provider's Grievance staff will understand the time frames and process flow for grievances received from members with MI Health Link, Medicaid or Non-Medicaid.*

### PROCEDURE

1. Time frame for filing a grievance:
  - a. There is no time limit for filing a grievance.
  - b. The standard time frame of resolution is ninety (90) calendar days.
2. Response to a Grievance:
  - a. All grievances, whether they are received verbally or in writing, will be responded to in writing, including quality of care grievances.
  - b. Acknowledgment of the receipt MI Health Link grievances is required within three (3) calendar days.
  - c. Acknowledgment of the receipt of a Medicaid and Non-Medicaid grievance is required within five (5) calendar days.
  - d. A Combination Letter (Acknowledgement/Resolution Letter) is required for Medicaid and Non-Medicaid grievances resolved within five (5) calendar days.
3. MI Health Link grievances requiring a response within twenty-four (24) hours of receipt are:
  - a. Expedited grievances
  - b. Grievances where DWMHA extends the appeals time frame or DWMHA refuses to grant a request for an expedited appeal.

4. DWMHA Grievance staff is responsible for processing, investigating and resolving all MI Health Link grievances as expeditiously as the case requires, based upon the Enrollee/Member's health, and no later than ninety (90) calendar days.
5. DWMHA/MCPN/Provider's CSGC is responsible for processing, investigating and resolving all Non-Medicaid grievances as expeditiously as the case requires, and no later than sixty (60) calendar days of the receipt of the grievance.
6. DWMHA/MCPN/Provider's CSGC is responsible for processing, investigating and responding to a Medicaid grievance as expeditiously as the case requires, based upon the beneficiary/enrollee/member's health, and no later than ninety (90) calendar days of receipt of grievance.
  - a. The ninety (90) calendar day time frame may be extended up to fourteen (14) calendar days should the enrollee/member/authorized or legal representative, or the estate representative of a deceased enrollee/member requests the extension or if the provider justifies the need for additional information and documents how the delay is in the interest of the enrollee/member.
  - b. If the extension is granted, the enrollee/member/authorized or legal representative will be notified of this delay in writing.
  - c. Grievances pending resolution beyond thirty (30) calendar days requires a status update.
7. DWMHA, MCPN and Service Provider Grievance Coordinator will provide local resolution by discussing the grievance with the enrollee/member/authorized or legal representative.
8. An enrollee/member/authorized or legal representative may request a State Fair Hearing should the resolution of the grievance exceeds ninety (90) calendar days.
9. A beneficiary/enrollee/member without Medicaid may request an Alternative Dispute Resolution should the resolution of the grievance exceed sixty (60) calendar days.
10. Methods to file:
  - a. By calling DWMHA/MCPN/Provider's CSGC;
  - b. Submit a grievance in writing to DWMHA/MCPN/Provider's CSGC;
    1. By phone
    2. In person,
    3. United States Postal Service,
    4. Email
    5. Fax
11. All parties involved in the grievance process shall be free from discrimination and/or retaliation.
12. The enrollee/member/authorized or legal representative, or estate representative of a deceased enrollee/member shall be informed that filing a grievance will not affect service eligibility.
13. The DWMHA/MCPN/Provider's Customer Service Grievance Coordinator (CSGC) documents the grievance in MHWIN at the time an enrollee/member/authorized or legal representative expresses dissatisfaction with services.
  - a. DWMHA/MCPN/Providers CSGC is responsible for monitoring MHWIN daily for processing grievances.
  - b. DWMHA CSGC/CSGS will also monitor daily for receipt of new grievances via email [PIHPGrievances@dwmha.com](mailto:PIHPGrievances@dwmha.com) and [mihealthgrievances@dwmha.com](mailto:mihealthgrievances@dwmha.com).

- c. DWMHA/MCPN/Providers CSGC will initiate the processing of a grievance upon receipt.
  - d. DWMHA's CSGC/CSGS will provide local resolution by discussing the grievance with the enrollee/member/authorized or legal representative, or estate representative of a deceased enrollee/member in an attempt to resolve the grievance immediately.
  - e. DWMHA/MCPN/Provider CSGC reviews each grievance for clinical/quality of care issues and/or recipient rights violations.
  - f. The CSGC reviews the grievance and supporting information with clinical review staff regarding presence or absence of clinical or quality of care issues.
    - 1. If there are no identified clinical or quality of care issues, the CSGC/CSGS processes the grievance without further clinical consultation.
    - 2. If there are clinical or quality of care issues identified, the CSGC completes a Clinical Consultation Form and the complaint is reviewed by the Chief Medical Officer as expeditiously as possible.
    - 3. If a clinical or quality of care issue is substantiated, the Chief Medical Officer makes recommendations about areas of potential process or service improvement.
      - i. The DWMHA/MCPN/Provider is responsible for ensuring that appropriate measures are implemented to prevent recurrent issues.
      - ii. DWMHA/MCPN/Provider is then monitored through the monitoring process.
  - g. DWMHA/MCPN/Provider CSGC will coordinate or refer any suspected recipient rights violation to DWMHA's Office of Recipient Rights (ORR).
    - 1. The enrollee/member/authorized or legal representative, or estate representative's permission is not required for suspected rights violations of abuse and/or neglect.
    - 2. The enrollee/member/authorized or legal representative, or estate representative's permission is required for other suspected rights violations.
14. The DWMHA/MCPN/Provider CSGC shall request any missing information and/or additional details from the Provider or enrollee/member/authorized or legal representative as expeditiously as possible and enter the additional information into MHWIN. Request for additional information/details from the enrollee/member may be done by:
- a. Phone
  - b. Fax
  - c. Secure email
  - d. Letter
15. DWMHA/MCPN/Provider CSGC will send a Request for Additional Information Letter to the enrollee/member/authorized or legal representative, or estate representative after three unsuccessful telephone attempts to contact him/her.
16. DWMHA/MCPN CSGC will send the Provider a Request for Additional Information Letter in the event that the additional information requested is not received in a timely manner. The CSGC will require the provider to submit the requested information by the next business day.
17. All pertinent information related to resolving the grievance shall be uploaded as an attachment to the grievance record.

18. In resolving the grievance, DWMHA/MCPN/Provider CSGC shall discuss the grievance with the appropriate staff who has the authority to require corrective action, none of whom shall have been involved in the previous review or decision-making.
19. DWMHA/MCPN/Provider's CSGC shall ensure that the individuals who make decisions on the grievance are health care professionals with same or similar clinical expertise in treating the enrollee/member's condition or disease if the grievance involves:
  - a. Clinical issues
  - b. The denial of an expedited resolution of an appeal (adverse benefit determination)
20. The CSGC obtains all pertinent information to resolve the grievance and documents information in MHWIN.
  - a. Upon completion of the resolution, the CSGC shall contact the enrollee/member/authorized or legal representative to discuss his/her satisfaction by:
    1. Phone
    2. Letter after three unsuccessful telephone attempts
    3. If the MI Health Link enrollee/member, authorized or legal representative, or estate representative of a deceased enrollee/member is not satisfied with the resolution, the Customer Service Grievance Coordinator shall inform him/her that he/she has ten (10) calendar days to request a review of the adverse grievance findings by requesting a Level One Appeal.
21. The enrollee/member, authorized or legal representative will be notified in writing of the disposition and the right to appeal the resolution of his/her grievance upon case closure and no later than ninety (90) calendar days from the date of receipt of the grievance.
22. All resolution letters will be carefully reviewed for content, spelling and grammar to ensure that the communication is clear, concise, accurate, and at an appropriate level of understanding. The content of the Resolution Letter shall include:
  - a. Statement of the complaint;
  - b. Substance/ reason for complaint;
  - c. Action(s) taken to resolve the grievance;
  - d. Results of the grievance process;
  - e. Date the grievance process was concluded;
  - f. Enrollee/member's right to request a State Fair Hearing if the notice of disposition is more than ninety (90) days from the date of the request for a grievance;
  - g. How to access the State Fair Hearing process.
23. State Fair Hearings
  - a. Federal Regulations provide Medicare and Medicaid enrollee/members, authorized or legal representatives, or the estate representative of a deceased enrollee/member the right to an impartial review (State Fair Hearing) by a state administrative law judge, of a decision (action) made by the local agency or its agent:
    1. Medicaid enrollee/member/authorized or legal guardian, or the estate representative of a deceased enrollee/member have the right to request a State Fair Hearing when DWMHA/MCPN/Provider makes an adverse benefit determination:

- i. Denial or limited authorization of a requested service;
  - ii. Reduction, termination, suspension of a previously authorized service; or a denial of a payment of service;
  - iii. Failure to make an authorization decision within fourteen (14) days-standard; within 72 hours-expedited;
  - iv. Failure to provide services within fourteen (14) calendar days of agreed-upon date;
  - v. Failure to act on a request for an appeal within sixty (60) calendar days-standard; within 72 hours-expedited; or
  - vi. Failure to provide disposition of a grievance within ninety (90) calendar days.
2. Enrollee/members, authorized or legal representative are provided up to 120 calendar days from the date of the adverse benefit determination notice to file a State Fair Hearing. State Fair Hearings must be submitted in writing.
3. The enrollee/member/authorized or legal representative, or estate representative of a deceased enrollee may file for a State Fair Hearing by using a Request for Hearing Form or on any paper. Request for State Fair Hearing Forms are available at the MCPN/Service Provider or at:

**DWMHA Customer Service**

**707 W. Milwaukee St.**

**Detroit, MI 48202**

**Phone: 1.888.490.9698 or 313.833.3232**

**TDD/TTY 1.800.630.1044**

**Fax: 313.833.2217 or 313.833.4280**

**www.dwmha.com**

- i. Written State Fair Hearing Request should be forwarded to the following address:

**Michigan Administrative Hearing System for the**

**Department of Health and Human Services**

**P.O. Box 30763**

**Lansing, MI 48909-9951**

4. **Note:** Non-Medicaid enrollee/members do not have access to the State Fair Hearing Process, unless the entity responsible for resolving the grievance fails to respond to the grievance within ninety (90) calendar days. This constitutes an action and can be appealed through the Department of Health and Human Services Administrative Division of Program Development, Consultation and Contracts Bureau of Community Mental Health Services. Attention: Request for MDHHS Level Dispute Resolution, Lewis Cass Building, 6th Floor, Lansing, MI 48193.

24. The grievance is considered closed when:

- a. The complaint has been resolved.
- b. DWMHA/MCPN/Provider takes the appropriate action to implement the decision; or
- c. The enrollee/member/authorized or legal representative withdraws the grievance.

25. Upon completion of the resolution, the DWMHA/MCPN/Provider's CSGC shall conduct an audit of the grievance record for compliance with federal and state guidelines.
26. Upon completion of the audit, DWMHA/MCPN/Provider's CSGC shall complete the Case File Sheet and upload it as an attachment to the grievance record.
27. The MCPN/Provider CSGC shall assign the grievance record to DWMHA for compliance review, approval, and closure.
  - a. DWMHA's CSGC/CSGS will approve and close the grievance if the record is in full compliance.
  - b. DWMHA's CSGC/CSGS will reassign the grievance to the MCPN/Provider and request a POC, should the grievance record not be in full compliance. Upon acceptance of the POC, the grievance will be approved and closed by DWMHA's CSGC/CSGS.
28. DWMHA/ MCPN/Provider's CSGC shall aggregate the grievance data quarterly and annually tracking trends, patterns, and opportunities for improvement in the delivery of service.
29. Quarterly and annual grievance reports are forwarded to the DWMHA's QI Department for review of grievance activities and opportunities for continuous quality and organizational improvements.

## PROCEDURE MONITORING & STEPS

Who monitors this procedure:	India Crockett and Barbara Hedgepeth
Department:	Customer Service
Frequency of monitoring:	Daily
Reporting provided to:	Administration and Quality (QISC)
<b>Comments:</b> Daily monitoring of MH-WIN and Quarterly Reporting to QISC .	

### Attachments:

No Attachments

### Approval Signatures

Approver	Date
Michele Vasconcellos: Director, Customer Service	05/2018
Winifred Williamson	05/2018



Date  
RE: Member

Grievance ID: XXXX

---

## EXPEDITED GRIEVANCE NOTICE

**This notice informs you about your right to file an expedited grievance**

\_\_\_\_\_ You are receiving this notice because we are denying your request for a fast (expedited) decision about your request for a service.

\_\_\_\_\_ You are receiving this notice because we are denying your request for a fast (expedited) appeal for a service.

**Your request has been transferred to our regular processing time frame.**

You can file an expedited grievance whenever we do not provide a fast decision about your initial request for a service, or your request to appeal our denial of a service.

**This notice informs you about your right to file an expedited grievance**

\_\_\_\_\_ You are receiving this notice because we need to take extra days (take an extension) to decide on your request for a service.

\_\_\_\_\_ You are receiving this notice because we need to take extra days (take an extension) to consider your appeal for a service.

**An extension allows us up to 14 additional calendar days to make our decision about your request.**

**What happens during an expedited grievance?**

We must decide within 24 hours if our decision to deny or delay making an expedited decision in your case puts your life or health at risk.

If we determine that we should have expedited your request we will do so immediately and notify you of our decision.

**Please call us at Detroit Wayne Mental Health Authority Customer Service Unit at 1.888.490.9698 or TTY 1.800.630.1044 if you want to file an expedited grievance, or would like more information.**

**You can also call 1-800-MEDICARE for more information about the expedited grievance process.**



**Notice of DWMHA's Decision to Extend the Deadline for Making a Decision Regarding a Grievance**

Date

Grievance ID: XXXX

RE: Member  
Member ID #  
Street Address  
City, State, Zip Code

Dear Grievant:

This letter is in response to your grievance received on (date grievance was received).

Based upon review, we are extending the time frame for making a decision until (date of 14 calendar days from date of this letter) due to (Request by Enrollee or DWMHA needs additional information).

(explain why the delay is in the best interest of the enrollee)

Should you have any questions, please contact Detroit Wayne Mental Health Authority Customer Service Department at 1-888-490-9698 Monday through Friday between the hours of 8:00 a.m. and 4:30 a.m. TTY users should call 1-800-630-1044.

Thank you for your concern.

Sincerely,

Staff (Credentials)  
Title





**Notice of DWMHA's Decision to Extend the Deadline for Making a Decision Regarding a Grievance**

Date:

Grievance ID

RE: Member  
Enrollee/Member ID#  
Street Address  
City, State, Zip Code

Dear Grievant:

This letter is in response to your grievance received on (date grievance was received).

Based upon review, we are extending the time frame for making a decision until (date of 14 calendar days from date of this letter) due to (Request by Enrollee or DWMHA needs additional information).

(explain why the delay is in the best interest of the enrollee)

Should you have any questions, please contact Detroit Wayne Mental Health Authority Customer Service Office at 1-888-490-9698 Monday through Friday between the hours of 8:00 a.m. and 4:30 a.m. TTY users should call 1-800-630-1044.

Thank you for your concern.

Sincerely,

Staff (Credentials)  
Title



Detroit Wayne Mental Health Authority  
Grievance Log  
Monthly Reporting period:

Grievance Number	Date of Receipt	Date of Acknowledgement	MHWIN ID #	Medicare#	Medicaid#	Service Provider	Issue(s)	Status	Expedited Grievance Y/N	Resolution Date	Enrollee Satisfaction Y/N



Detroit Wayne Mental Health Authority

Grievance Log  
Monthly Reporting period:

Grievance Number	Date of Receipt	Date of Acknowledgement	MHWIN ID #	Medicare#	Medicaid#	Service Provider	Issue(s)	Status	Expedited Grievance Y/N	Resolution Date	Enrollee Satisfaction Y/N



Detroit Wayne  
Mental Health Authority

707 Milwaukee St.  
Detroit, MI 48202-2943  
Phone: (313) 833-2500  
[www.dwmha.com](http://www.dwmha.com)

FAX: (313) 833-2156  
TDD: (800) 630-1044 RR/TDD: (888) 339-5588

Out of Jurisdiction

Date

Grievance ID: XXXX

RE: Member  
Enrollee/Member ID #  
Street Address  
City, State, Zip Code

Dear Grievant::

(PIHP/MCPN/Service Provider) received your request for a review of a grievance on (date). Your concerns are important to us and we would like to assist you in getting your **complaint** resolved. However, upon further review of your **complaint**, it has been determined to be out of (PIHP/MCPN/Service Provider) jurisdiction. Therefore, to further assist you with the resolution of your complaint, we will need to refer you to:

**(Out of Jurisdiction text)**

Please contact the agency **or department** listed above to receive additional assistance with your complaint. Should you have any questions regarding this letter or if we may be of further assistance, please contact (PIHP/MCPN/Service Provider) at (phone number).

Sincerely,

Staff **(Credentials)**  
Title

**Board of Directors**

Herbert C. Smitherman, Jr., MD, Chairperson  
Marsha Bianconi  
Constance Rowley

Dr. Cheryl Munday, Vice-Chairperson  
Angelo Glenn  
Dr. Iris Taylor

Timothy Killeen, Treasurer  
Bernard Parker  
Terence Thomas

Dr. Cynthia Tauieg, Secretary  
Frank Ross  
Heather Underwood

**Thomas Watkins, President/CEO**



## Out of Jurisdiction

Date

Grievance ID:XXXX

RE: Member  
Enrollee/Member ID:  
Street Address:  
City, State zip

Dear Grievant:

PIHP/MCPN/Service Provider received your request for a review of a grievance on (date). Your concerns are important to us and we would like to assist you in getting your complaint resolved. However, upon further review of your complaint, it has been determined to be out of DWMHA's jurisdiction. Therefore, to further assist you with the resolution of your complaint, we will need to refer you to:

(Insert info from OOJ txt)

Please contact the agency or department listed above to receive additional assistance with your complaint. You may also contact MI Health Link Ombudsman Program at 1-888-746-6456. Should you have any questions regarding this letter or if we may be of further assistance, please contact Detroit Wayne Mental Health Authority at the following toll-free number: 1 (888) 490-9698 or TTY 800.630.1044.

Sincerely,

Staff (Credentials)  
Title



**Request for Additional Information**  
Member

Date

Grievance ID: XXXX

RE: Member  
Member ID #  
Street Address  
City, State, Zip Code

Dear Grievant:

The Detroit Wayne Mental Health Authority (DWMHA) has attempted to contact you regarding the grievance you submitted on (date). We would like to thank you for bringing your concerns to our attention and would like to process your grievance in a timely manner. The DWMHA has attempted to contact you either by mail, telephone or both regarding your complaint on the following dates (date of 1<sup>st</sup> attempt) and (date of 2<sup>nd</sup> attempt).

However, we are in need of additional information prior to initiating your grievance. Please contact us by (date of 10 business days from date of letter), to further discuss your dissatisfaction.

If the Detroit Wayne Mental Health Authority does not hear from you by (date of 10 business days from date of this letter), we will conclude that you no longer wish to file a grievance and the grievance will be considered resolved and closed.

Sincerely,

Staff (Credentials)  
Title



**Request for Additional Information**  
Service Provider

Date

Grievance ID XXXX

Name of Staff  
Service Provider  
Street Address  
City, State, Zip Code  
Enrollee/Member ID#:

Dear **(FILL IN Name of MCPN/Service Provider Contact):**

The Detroit Wayne Mental Health Authority (DWMHA) Customer Service Department is contacting you in regards to (Grievance ID). In an attempt to process this grievance, additional information is required. Attempts to obtain this information from your agency on (date of 1<sup>st</sup> attempt) and (date of 2<sup>nd</sup> attempt) were unsuccessful. It is imperative that this information be submitted by your agency in order to complete the processing of this grievance. Therefore, this letter serves as our final attempt to obtain this information from you.

Your assistance in this matter would be greatly appreciated. Please contact DWMHA at 1-888-490-9698 within 1 business day of receipt of this letter to further discuss our request. We appreciate your immediate attention to this matter. Your cooperation is valued. Should you need further clarification, please do not hesitate to contact this office.

Sincerely,

Name of staff  
Title of staff

cc: (If Applicable)



Request for Additional Information  
Service Provider

Date

Grievance ID: XXXX

Name of Staff  
MCPN/Service Provider  
Street Address  
City, State, Zip Code  
RE: Member ID#:

Dear MCPN/Service Provider (FILL IN):

The (DWMHA/MCPN) Customer Service Department is contacting you in regards to (Grievance ID). In an attempt to process this grievance, additional information is required. Attempts to obtain this information from your agency on (date of 1<sup>st</sup> attempt) and (date of 2<sup>nd</sup> attempt) were unsuccessful. It is imperative that this information be submitted by your agency in order to complete the processing of this grievance. Therefore, this letter serves as our final attempt to obtain this information from you.

Your assistance in this matter would be greatly appreciated. Please contact (PIHP/MCPN) at (Phone number) within 1 business day of receipt of this letter to further discuss our request. We appreciate your immediate attention to this matter. Your cooperation is valued. Should you need further clarification, please do not hesitate to contact this office.

Sincerely,

Name of Staff  
Title of Staff

cc: (If Applicable)





Request for Additional Information  
Member

Date

Grievance ID: XXXX

RE: Member  
Member ID #  
Street Address  
City, State, Zip Code

Dear Grievant:

The (PIHP/MCPN/Service Provider) has attempted to contact you regarding the grievance you submitted on (date). . We would like to thank you for bringing your concerns to our attention and would like to process your grievance in a timely manner. The (PIHP/MCPN/Service Provider) has attempted to contact you either by mail, telephone or both regarding your complaint on the following dates (date of 1<sup>st</sup> attempt) and (date of 2<sup>nd</sup> attempt).

However, we are in need of additional information prior to initiating your grievance. Please contact us by (date of 10 business days from date of this letter), to further discuss your dissatisfaction.

If the (PIHP/MCPN/Service Provider) does not hear from you by (date of 10 business days from date of this letter), we will conclude that you no longer wish to file a grievance and the grievance will be considered resolved and closed.

Sincerely,

Staff (Credentials)  
Title



**Detroit Wayne Mental Health Authority**  
**Customer Service Division**  
**Request for Review of Grievance**

Please give this completed form to any Customer Service staff. If you need help completing this form, contact a Customer Service Representative at 1-888-490-9698. Once completed, this form can be mailed to:

Detroit Wayne Mental Health Authority  
Attn: Grievance Coordinator  
Customer Service  
707 West Milwaukee  
Detroit, MI. 48202  
[PIHPGrievances@dwmha.com](mailto:PIHPGrievances@dwmha.com)

**Section 1: To be completed by the Member or an Authorized Representative**

Name	Telephone Number	MHWIN ID Number
Address	Interpreter Services Required:  Yes _____ No _____	Date of Birth
City:  State:  ZIP	Insurance:  ( ) Medicare & Medicaid ( ) Medicaid ( ) Healthy Michigan ( ) Other _____	MCPN/Service Provider

Summary of Complaint/Dissatisfaction (Please describe why you are not satisfied with your service).

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

**Section 2: To be completed by the Grievance Coordinator of Designated Staff.**

Name of Reviewer:	Telephone Number
-------------------	------------------



Referred to: <input type="checkbox"/> Service Provider <input type="checkbox"/> Office of Recipient Rights <input type="checkbox"/> MCPN <input type="checkbox"/> Health Care Professional	Grievance Category: Type of Grievance:  Walk-in ( <input type="checkbox"/> ) Telephone ( <input type="checkbox"/> ) Written ( <input type="checkbox"/> )
--	---



**Detroit Wayne Mental Health Authority**  
**Customer Service Division**  
**Request for Review of Grievance**

Please give this completed form to any Customer Service staff. If you need help completing this form, contact a Customer Service Representative at 1-888-490-9698. Once completed, this form can be mailed or email to:

Detroit Wayne Mental Health Authority  
Attn: Grievance Coordinator  
Customer Service  
707 West Milwaukee  
Detroit, MI. 48202  
[MIHealthlinkgrievances@dwmha.com](mailto:MIHealthlinkgrievances@dwmha.com)

Or

You may file an external grievance by calling **1-800-MEDICARE** or **1-800-633-4227**

Or

[www.dwmha.com](http://www.dwmha.com) and click **on** the Medicare Complaint Form

**Section 1: To be completed by the Member or an Authorized Representative**

Name	Telephone Number	MHWIN ID Number
Address	Interpreter Services Required:  Yes _____ No _____	Date of Birth
City:  State:  ZIP	Insurance:  ( ) Medicare & Medicaid ( ) Medicaid ( ) Healthy MI ( ) Other _____	MCPN/Service Provider

Summary of Complaint/Dissatisfaction (Please describe why you are not satisfied with your service).



Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

Section 2: To be completed by the Grievance Coordinator of Designated Staff.

Name of Reviewer:	Telephone Number
Referred to: ( ) Service Provider ( ) Office of Recipient Rights ( ) MCPN ( ) Health Care Professional	Grievance Category: Type of Grievance:  Walk-in ( ) Telephone ( ) Written ( )



## Request for Satisfaction Response to Grievance

Date

Grievance ID: XXXX

RE: Member

Member ID #

Street Address

City, State, Zip Code

Dear Enrollee/Member/Legal Representative:

The (PIHP/MCPN/Service Provider) has attempted to contact you regarding the grievance you submitted on (date). (PIHP/MCPN/Service Provider) has attempted to contact you either by mail or by telephone regarding your satisfaction with the resolution of your complaint. Unsuccessful attempts were made via mail, telephone or both on the following dates (date of 1<sup>st</sup> attempt Customer Satisfaction) and (date of 2<sup>nd</sup> attempt under Customer Satisfaction). To date we have been unsuccessful in obtaining a response from you regarding your satisfaction of the resolution submitted by (PIHP/MCPN/Service Provider). I am submitting this letter to you as a request for your satisfaction response to the resolution completed by (PIHP/MCPN/Service Provider).

(PIHP/MCPN/Service Provider) would appreciate a response from you by (10 calendar days from date of this letter). If the (PIHP/MCPN/Service Provider) does not hear from you by (10 calendar days from date of this letter), we will conclude that you are satisfied with the outcome of the grievance. The grievance will be considered resolved and closed.

---

Grievant Signature

Date

\_\_\_\_\_ I am satisfied with the outcome of the resolution completed by (PIHP/MCPN/Service Provider).

\_\_\_\_\_ I am not satisfied with the outcome of the resolution by the (PIHP/MCPN/Service Provider).

If you are not satisfied with the outcome resolution, please contact (PIHP/MCPN/Service Provider at (phone number of PIHP/MCPN/Service Provider).

Sincerely,

Name of staff

Title of staff

cc: (If Applicable)



## Request for Satisfaction Response to Grievance

Date

Grievance ID: XXXX

RE: Member  
Member ID #  
Street Address  
City, State, Zip Code

Dear Enrollee/Member/Legal Representative:

The Detroit Wayne Mental Health Authority (DWMHA) has attempted to contact you regarding the grievance you submitted on (date). DWMHA has attempted to contact you either by mail or by telephone regarding your satisfaction with the resolution of your complaint. Unsuccessful attempts were made via mail, telephone or both on the following dates (date of 1<sup>st</sup> attempt) and (date of 2<sup>nd</sup> attempt).

To date we have been unsuccessful in obtaining a response from you regarding your satisfaction of the resolution submitted by DWMHA. I am submitting this letter to you as a request for your satisfaction response to the resolution completed by DWMHA

DWMHA would appreciate a response from you by (10 calendar days from date of this letter). If DWMHA does not hear from you by (10 calendar days from date of this letter), we will conclude that you are satisfied with the outcome of the grievance. The grievance will be considered resolved and closed.

---

Grievant Signature

Date

\_\_\_\_\_ I am satisfied with the outcome of the resolution completed by Detroit Wayne Mental Health Authority.

\_\_\_\_\_ I am not satisfied with the outcome of the resolution by the Detroit Wayne Mental Health Authority.  
If you are not satisfied with the outcome resolution, please contact Detroit Wayne Mental Health Authority Customer Service Department at 1-888-490-9698.

Sincerely,

Name of staff  
Title of staff

cc: (If Applicable)

**REQUEST ☐ OR STATE ☐ AIR HEARING**

Michigan Department of Health and Human Services  
Michigan Administrative Hearing System  
PO Box 30763  
Lansing, MI 48909

Telephone Number: 800-648-3397

Fax: 517-763-0146

This form is for enrollees in a Managed Care Health Plan, MI Health Link ☐ Plan, Community Mental Health Services Program (CMHSP)/Prepaid Inpatient Health Plan (PIHP), or MI Choice Waiver Program

**SECTION ☐ – To be completed by the PERSON REQUESTING A STATE ☐ AIR HEARING**

Enrollee Name	Enrollee Telephone Number	Enrollee Social Security Number	
Address (No. & Street, Apt. No.)	City	State	Zip Code
Enrollee or Legal Guardian Signature	Enrollee Medicaid ID Number	Date Signed	

☐ Managed Care Health Plan    ☐ MI Health Link (for Medicaid benefits only)    ☐ CMHSP/PIHP    ☐ MI Choice Waiver

Name of Health Plan, CMHSP/PIHP or Waiver Agency that took the action: \_\_\_\_\_

Date of Notice of Appeal Decision (please include a copy of the notice): \_\_\_\_\_

☐ As of today's date, I have not received a Notice of Appeal Decision. I sent in an Internal Appeal on: \_\_\_\_\_

**I am asking for a State ☐ Air Hearing because:** Use additional paper if needed.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have physical or other conditions requiring special arrangements for you to attend or participate in a hearing ☐

☐ **No**

☐ **Yes** (If yes, please explain here.) \_\_\_\_\_

**SECTION ☐ – Have you chosen someone to represent you at the hearing ☐**

Has someone agreed to represent you at a hearing <input type="checkbox"/>
<input type="checkbox"/> <b>No</b>
<input type="checkbox"/> <b>Yes</b> (If Yes, have the representative complete and sign Section 3.)

**SECTION ☐ – Authorized Hearing Representative Information**

Name of Representative (Please Print)	Representative Telephone Number	Relationship to Enrollee	
Address (No. & Street, Apt. No.)	City	State	Zip Code
Representative Signature	Date Signed		

**SECTION ☐ – To be completed by the AGENCY involved in the action being disputed by the enrollee**

Name of AGENCY	AGENCY Contact Person Name		
<b>Detroit Wayne Mental Health Authority</b>	<b>Pamela J. Oehmke, LMSW</b>		
AGENCY Address (No. & Street, Apt. No.)	AGENCY Telephone Number		
<b>707 W. Milwaukee</b>	<b>313 344 9099</b>		
City	State	Zip Code	State Program or Service being provided to Enrollee
<b>Detroit</b>	<b>MI</b>	<b>48202</b>	

This form is also available online at: [http://www.michigan.gov/mdhhs/0,5885,7-339-71547\\_4860-16825--,00.html](http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html) or [www.michigan.gov/LARA](http://www.michigan.gov/LARA) ☐ MI Administrative Hearing System ☐ Benefit Services.



## REQUEST ☐ OR STATE ☐ AIR HEARING

This form is for enrollees in a Managed Care Health Plan, MI Health Link Plan (☐ for Medicaid benefits only), Community Mental Health Services Program (CMHSP)/Prepaid Inpatient Health Plan (PIHP), or MI Choice Waiver Program

### INSTRUCTIONS

A State Fair Hearing is an impartial review of a decision made by the Michigan Department of Health and Human Services, or one of its contract agencies, that an enrollee believes is wrong.

**If you are enrolled in a Managed Care Health Plan ☐ MI Health Link ☐ CMHSP/PIHP ☐ or MI Choice Waiver program you MUST finish their internal appeal process before you can ask for a State ☐ Air Hearing ☐ If you do not receive a Notice of Appeal Decision within the mandated timeframe ☐ you may also ask for a State ☐ Air Hearing ☐ You may also send in your signed hearing request in writing on any paper. This form is also available online at: [www.michigan.gov/mdhhs](http://www.michigan.gov/mdhhs) ☐ Assistance Programs ☐ Medicaid ☐ Medicaid Fair Hearings or [www.michigan.gov/LARA](http://www.michigan.gov/LARA) ☐ MI Administrative Hearing System ☐ Benefit Services.**

**If you asked for your benefits to continue during the internal appeal process and you want them to continue during the State ☐ Air Hearing process ☐ you must ask for the State ☐ Air Hearing and Michigan Administrative Hearing System (MAHS) must receive your request within ☐ calendar days of the date on the Notice of Appeal Decision ☐**

### General Instructions:

- Read ALL instructions before completing the attached form.
- This form should not be used for a request for a hearing related to:
  - Public Assistance (Medicaid eligibility, cash assistance, food assistance, or other assistance programs). For these hearing types, you must use form DHS-18, Request for Hearing available online at [http://www.michigan.gov/documents/FIA-Pub18\\_14356\\_7.pdf](http://www.michigan.gov/documents/FIA-Pub18_14356_7.pdf).
  - A decision that does not involve a managed care entity on a Medicaid service or your application for a MI Choice Waiver program. For these hearing types you must use form DCH-0092, Request for Hearing for Medicaid Enrollees or Waiver Applicants available online at: [www.michigan.gov](http://www.michigan.gov) ☐ Assistance Programs ☐ Medicaid ☐ Medicaid Fair Hearings or [http://www.michigan.gov/mdhhs/0,5885,7-339-71547\\_4860-16825--,00.html](http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html).
- Please attach a copy of the Notice of Appeal Decision that you received from your managed care organization.
- Complete **Section ☐** using the name of the enrollee (even if the enrollee has a guardian or is a minor).
- Complete **Section ☐** and ☐ only if you want someone to represent you at the hearing.
- Complete **Section ☐** if the agency who took the action you are appealing did not fill this out.
- Please make a copy of this completed form for your records.
- If you have any questions, call:  or toll free at .
- After you complete this form, mail or fax (**no email**) to:

### MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES MICHIGAN ADMINISTRATIVE HEARING SYSTEM

PO BOX   
LANSING MI   
Fax:

- You may choose to have another person represent you at a hearing.
  - This person can be anyone you choose but he/she must be at least 18 years of age.
  - You MUST give this person written and signed permission to represent you.
  - You may give written permission by checking **Yes in Section ☐ and having the person who is representing you complete Section ☐ You MUST still complete and sign Section ☐**
  - Your guardian or conservator may represent you. **A copy of the court order naming the guardian must be included with this request or it cannot be processed ☐**

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

If you do not understand this, call the Michigan Department of Health and Human Services at 877-833-0870.  
Si no entiende esta información comuníquese al Michigan Department of Health and Human Services al 877-833-0870.  
إذا كنت لا تفهم هذا، فعليك الاتصال بـ Michigan Department of Health and Human Services (وزارة الصحة والخدمات الإنسانية) على رقم الهاتف 877-833-0870.

Completion: Is Voluntary



## Resolution Letter

Date

Grievance ID: XXXX

RE: Member  
Enrollee/Member ID #  
Street Address  
City, State, Zip Code

Dear Grievant:

The (PIHP/MCPN/Service Provider) Customer Service Department received your grievance on (date).  
Your grievance was resolved on (date).

Content shall include:

- a.) Name, credentials and/or title of the staff involved in resolving the grievance;
- b.) Substance/reason for complaint;
- c.) Step(s) taken to resolve each issue;
- d.) Results of the grievance process;

Per our conversation on (date and time), you expressed (satisfaction or dissatisfaction). Should you have any questions about this correspondence, please contact the (PIHP/MCPN/Service Provider) Customer Service Department at (Phone Number of PIHP/MCPN/Service Provider). Please note, if this process has exceeded **90** days, you can file a (SFH or ADR) request. You would do so in writing and mail to the address listed below:

(MFH or ADR info)

If you have any questions, you may call (PIHP/MCPN/Service) Customer Service Department at (phone number).

Sincerely,

Name of staff and Credentials  
Title of staff



## Resolution Letter

Date

Grievance ID: XXXX

Re: Member  
Enrollee/Member ID: #  
Street Address  
City, State, Zip Code

Dear Grievant:

The PIHP/MCPN/Service Provider Customer Service Department received your grievance on (date).  
Your grievance was resolved on (date).

Content shall include:

- a.) Name, credentials and/or title of the staff involved in resolving the grievance;
- b.) Substance/reason for complaint;
- c.) Step(s) taken to resolve each issue;
- d.) Results of the grievance process;

Per our conversation on (date and time), you expressed (satisfaction or dissatisfaction). Should you be unhappy with the outcome of the resolution to your grievance, you have up to ten (10) calendar days from the date of this letter to request a review of the findings. You may also contact the Medicare Grievance Hotline to file an external grievance at **1-800-MEDICARE** or **1-800-633-4227**. Please note, if this process has exceeded **90** days, you can file a State Fair Hearing. You would do so in writing and mail to the address listed below:

Michigan Administrative Hearing System  
Department of Health and Human Services  
P.O. Box 30763  
Lansing MI 48909-7695

If you have any questions, you may call Detroit Wayne Mental Health Authority Customer Service Department at 1(888) 490-9698. TTY users should call 1.800.630.1044.

Sincerely,

Name

Staff and Credentials  
Title



## Status Letter

Date

Grievance ID XXXX

RE: Member  
Enrollee/Member ID #  
Street Address  
City, State, Zip Code

Dear Grievant:

The (PIHP/MCPN/Service Provider) Customer Service Department received your grievance on (date).

This letter is a thirty (30) day status report to inform you that the resolution of your grievance has not been completed but will be resolved within the required sixty (90) days.

If you have any questions regarding your grievance, contact the (PIHP/MCPN/Service Provider) at (phone number of PIHP/MCPN/Service Provider).

Sincerely,

Staff (Credentials)  
Title



## Status Letter

Date

Grievance ID XXXX

RE: Member  
Enrollee/Member ID #  
Street Address  
City, State, Zip Code

Dear Grievant:

The Detroit Wayne Mental Health Authority Customer Service Department received your grievance on (date).

This letter is a thirty (30) day status report to inform you that the resolution of your grievance has not been completed but will be resolved within the required ninety (90) days.

If you have any questions regarding your grievance, contact the Detroit Wayne Mental Health Authority Customer Service Department at 1-888-490- 9689. TTY users should call 1-800-630-1044

Sincerely,

Name of staff (CREDENTIALS)  
Title of staff