North Sound Mental Health Administration
Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties
Improving the mental health and well being of individuals and families in our communities
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NSMHA Contract Memorandum 2014-012

Date: August 29, 2014

To: Tom Sebastian, Compass Health and Compass Whatcom
Donna Konicki, Bridgeways
Michael Watson, Lake Whatcom RTC
Kathy McNaughton, Catholic Community Services Northwest
Claudia D'Allegri, Sea Mar
Ken Stark, Snohomish County Human Services Director
Phil Smith, Volunteers of America
Cindy Paffumi, Interfaith
Sue Closser, Sunrise Services
Mitch Lykins, Pioneer Human Services
Dr. Jerry Jenkins, NWESD 189

From: Joe Valentine, Executive Director

Subject: Revised policies

Policy 1001.00 – Complaint, Grievance, Appeal, Fair Hearing and Notice – General Policy Requirements
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy August 29, 2014.

Policy 1002.00 – Complaint and Grievance
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy August 29, 2014.

Policy 1003.00 - Appeal
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy August 29, 2014.

Policy 1004.00 – Fair Hearing
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy August 29, 2014.

Full implementation of ***Policies 1001.00 through 1004.00*** should occur **no later than October 1, 2014**. This is as agreed at the meeting for Grievance System policies implementation of August 27, 2014.

Policy 1005.00 – Notice Requirements
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy August 29, 2014.

Policy 1505.00 - Authorization for Ongoing Outpatient Services
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy August 29, 2014.

Policy 1551.00 – Resiliency/Recovery Plans (Individualized Service Plans)
This policy has been through the complete review and approval process. The Executive Director signed and approved this policy August 29, 2014.

Full implementation of ***Policies 1005.00, 1505.00 and 1551.00*** should occur **no later than November 1, 2014**.

cc: Cindy Ferraro, Bridgeways
Heather Fennell, Compass Health
Kay Burbidge, Lake Whatcom RTC
Pamala Benjamin, Whatcom Counseling and Psychiatric Center
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Contract File

Effective Date: 2/5/2009; 10/9/2008: 12/8/2005; 10/9/2003, BOD Approved, Motion #03-053
Revised Date: 7/21/2014
Review Date: 7/23/2014

North Sound Mental Health Administration

Section 1000 – Administrative: Complaint, Grievance, Appeal, Fair Hearing & Notice – General Policy Requirements

Authorizing Source: See references below
Cancels:
See Also:
Providers are required to adopt or have a policy "consistent with" this policy — Approved by: Board of Directors — Date: 6/20/2004
Responsible Staff: Operations Manager — Motion #04-027
Executive Director Signature: — Date: 8/29/2014

POLICY #1001.00

SUBJECT: COMPLAINT, GRIEVANCE, APPEAL, FAIR HEARING and NOTICE – GENERAL POLICY REQUIREMENTS

PURPOSE

To outline North Sound Mental Health Administration (NSMHA) grievance, appeal, fair hearing and notice policy for both Medicaid enrollees and state-funded consumers in the North Sound Region and ensure the policy is used consistently throughout the Region. The policy will also outline the complaint processes available to others who have concerns about consumer's services.

NSMHA's policy outlines the rights, responsibilities and requirements NSMHA, consumers, providers, designees and other involved parties at all levels of the complaint, grievance, appeal and fair hearing system.

In addition, NSMHA's policy outlines the types of notices consumers will receive regarding authorization of services or disagreement with their recovery plan and NSMHA's policy regarding Notice of Action and Notice of Determination from NSMHA or its designees. The policy also outlines the use of complaint, grievance, appeal, denial and fair hearing information for continuous quality improvement.

Consumers will be informed of provider complaint and grievance contacts, NSMHA customer service, independent Ombuds services, and other supports available to them at each level of the process (See 1002 NSMHA Complaint and Grievance Policy, 1003, NSMHA Appeals Policy, 1004 NSMHA Fair Hearing Policy, 1005 Notice Requirement Policy and 1547 NSMHA Customer Services Policy for additional requirements).

GENERAL POLICY

It is the policy of NSMHA to resolve grievances and appeals at the lowest possible level, in a confidential manner and without retaliation. NSMHA's policy is to resolve or rule upon, if necessary, consumers' (see definition of "consumer" below) grievances, or appeals honoring consumer voice, choice and rights while considering the most effective clinical practices, Statewide Access to Care Standards, medical necessity, laws and Federal/State/NSMHA contractual requirements. NSMHA's policy is also to attempt to resolve complaints by others at the lowest possible level.

Throughout the complaint, grievance, appeal, fair hearing and notice policies, the term consumer will include both state-funded consumers and Medicaid enrollees. When the policies refer only to state-funded consumers or Medicaid enrollees, these terms will be used (See definition section below).

Consumers may pursue a grievance with a provider, formal designee, or with NSMHA. Medicaid enrollees may also appeal “actions” by NSMHA or its formal designees. Appeals of actions are pursued at NSMHA.

Consumers or their representatives may request a fair hearing if they are dissatisfied with NSMHA’s resolution of a grievance. State funded individuals may request a grievance and/or fair hearing following receipt of a Notice of Adverse Determination by NSMHA or formal designee. Medicaid enrollees may request a fair hearing if they are dissatisfied with NSMHA’s decision regarding an appeal. Consumers or their representatives may request a fair hearing at any time if they believe there has been a violation of the Washington State Department of Social and Health Services (DSHS) rules or timelines or they are dissatisfied with their services

1. Consumers will be informed of their right to initiate a grievance or request a fair hearing. Medicaid enrollees will also be informed of their right to initiate an appeal or expedited appeal. State funded consumers will receive this information through NSMHA-produced materials, and Medicaid enrollees will receive information through the Medicaid Benefits Booklet and NSMHA-produced materials at the time of their assessment. Providers will provide every enrollee at the time of an intake evaluation a copy of the Mental Health Benefits Booklet. The booklet can be downloaded from: http://www1.dshs.wa.gov/Mentalhealth/benefits.shtml. NSMHA’s complaint, grievance, appeal, fair hearing and notice policies will be published and made available to all current and potential users of NSMHA funded mental health services.
2. Consumers will receive written Notices as outlined in NSMHA’s Notice Policy 1005 that describe when they are authorized for services and also in circumstances when they are not authorized and have grievance, appeal, and second opinion/fair hearing rights.
3. NSMHA will provide customer service toll free at 1-800-684-3555 to assist callers with their options to pursue complaints, grievances, appeals, second opinions and fair hearings and will assist in distinguishing between a complaint, Third Party Insurance issue, appeal, grievance, second opinion, or request for information. NSMHA’s customer service staff will assist callers to triage their concern to the appropriate party and outline available supports for the process.
4. Independent, confidential Ombuds services are available to provide advocacy, assistance and investigation to consumers, family members and other interested parties throughout the complaint, grievance, appeal and fair hearing process in accordance with Washington Administrative Code (WAC). Ombuds services can also provide advocacy, assistance and investigation for complaints by those other than the consumer. Ombuds services may be reached toll free at 1-888-336-6164. Ombuds services will be offered to assist consumers at all levels of the process.
5. All providers and formal designees will appoint a complaint and grievance contact person to assist with the process. A list of provider/designee complaint and grievances toll free contact numbers may be maintained on NSMHA’s website at www.nsmha.org. Provider policies will contain their toll free numbers for initiation of complaints or grievances. Provider/formal designee and NSMHA staff are also available to provide consumers with assistance in completing any forms and taking other procedural steps. This includes, but is not limited to, provision of Ombuds services, interpreter services and toll-free numbers with adequate TTY/TTD capability.
6. Consumers may elect to have participation of others of their choice throughout the process. Consumers may also have a representative who assists them with the grievance, appeal, or fair hearing process with their written permission.

7. Consumers (state-funded and enrollees) may have their previously authorized services continue or be reinstated during the grievance and fair hearing process at their request. Previously authorized services will continue if the original period covered by the original authorization has not expired. Medicaid enrollees may also request their previously authorized benefits continue or be reinstated during the appeals process under certain circumstances (see NSMHA Appeals Policy). In the case of residential services, services would continue but may not be in the residential setting if there are health or safety issues. Any change would be done in consultation with NSMHA. When services are reinstated or continued due to this requirement and when grievances or appeals are not resolved in consumer's favor, in certain circumstances, they may be asked to pay for these services. Consumers will receive notice for any circumstances where they may be asked to pay for these services.
8. Complaints, grievances and appeals will be handled in a confidential manner. NSMHA's Notice of Privacy Practices will contain: a statement that individuals may grieve to NSMHA and complain to the Secretary how the individual may file a grievance with the covered entity and a statement that the individual will not be retaliated against for filing a grievance.
9. Individuals may also initiate complaints concerning noncompliance with the requirements for advance directive for psychiatric or medical care with the Department of Health at 1 360-236-2320.
10. NSMHA's customer service, complaint, grievance, appeal and fair hearing process will be age, culturally and linguistically competent. NSMHA, its formal designee and providers will provide oral or manual interpreter services or written translation free of charge in all non-English languages for all steps necessary to file a grievance or appeal and to receive complaints from others (See NSMHA's Interpreter and Translation Policy #1515 for additional requirements). Notices of Action will be available as outlined in NSMHA's Policy 1005. Oral interpretation services regarding notices will be available in all non-English languages. Notices will also be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

    NSMHA and each provider/designee will provide toll free numbers that have adequate TTY/TDD and oral or manual interpreter services. NSMHA's Oral or manual interpreter services may be reached at 1-800-684-3555 and TTY/TDD services provided by Washington Relay Services at 1-800 833-6384 or by dialing 711. In-person interpreter services are also available through NSMHA, providers and designees.

11. Complaints, grievances, appeals and fair hearings must be followed up on even if consumers are no longer receiving services.
12. There will be no retaliation or punitive action of any kind against a consumer who initiates an expedited grievance, grievance, appeal, expedited appeal, or request for fair hearing. There will be no retaliation against providers who initiate appeals or grievances on behalf of consumers. Ombuds services, providers and NSMHA staff are available to assist if concerns about retaliation occur. Consumers or their representatives (including providers) may also contact identified provider or designee complaint and grievance contacts if concerns about retaliation occur. Consumers or their representatives (including providers) may also contact NSMHA Executive Director if concerns about retaliation occur.

13. Aggregate information about types of complaints, grievances, appeals, fair hearing requests, denials and other actions will be used to analyze patterns or trends, identify system implications, identify areas' for quality improvement, outline plans to address system implications or trends, and improve the RSN system. Information will also be used as part of NSMHA's quality strategy. Information about individual complaints, grievances, appeals, or fair hearings that have system implications or patterns or clusters of complaints, grievances, appeals, or fair hearings may also be used for quality improvement.
14. The definitions below will apply to Policy 1001 Complaint, Grievance, Appeal and Fair Hearing General Policy Requirements, Policy 1002 Complaint and Grievance, Policy 1003 Appeals, Policy 1004 Fair Hearing and Policy 1005 Notice Requirement.

DEFINITIONS

Action

Actions in the context of PIHP services means:

1. NSMHA (or formal designee) decisions to:

    a. Deny or limit authorization of a requested service, including type or level of service and any service denial based on Access to care;
    b. Reduce, suspend, or terminate a previously authorized service; or
    c. Deny in whole or in part, payment for a service.

2. Unresolved disagreement with the treatment plan by the enrollee as discussed with their Behavioral Health Agency (BHA) (formerly known as Community Mental Health Agency (CMHA)).
3. The failure to:

    a. Provide services in a timely manner as defined by the state;
    b. Act within timeframes provided in 42 CFR 438.408 (b) including:

        i. The disposition of grievances within 30 days from receipt at NSMHA or provider unless extended by NSMHA or Medicaid enrollee;
        ii. The disposition of an appeal within 45 days from receipt at NSMHA, unless extended by NSMHA or the Medicaid enrollee;
        iii. The disposition of an expedited appeal (if accepted) within 3 working days of receipt at NSMHA unless extended by NSMHA or the Medicaid enrollee.

The denial, suspension, reduction, and termination of services are defined as follows:

Denial - The decision by NSMHA or its formal designees not to authorize a covered Medicaid mental health service that has been requested by a provider or inpatient provider on behalf of an eligible Medicaid Enrollee. It is also a denial if an intake is not provided upon request by a Medicaid enrollee.

Suspension – The decision by NSMHA or its formal designee to temporarily stop an enrollee's previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. The clinical decision by a BHA to temporarily stop or change a covered service in the Individualized Service Plan (ISP) is not a suspension.

Reduction – The decision by NSMHA to decrease an enrollee's previously authorized covered Medicaid mental health service described in our Level of Care Guidelines. The clinical decision by a BHA to decrease or change a covered service in the ISP is not a reduction.

Termination – The decision by NSMHA or its formal designee to stop an enrollee's previously authorized covered Medicaid mental health services described in our Level of Care Guidelines. The clinical decision by a BHA to stop or change a covered service in the ISP is not a termination.

(For inpatient services NSMHA or designee will not reduce, suspend, or terminate previously authorized services.)

Appeal

An **appeal** is a request by a Medicaid enrollee or provider, with written consent to NSMHA for review of an action outlined in a written notice of action. A representative assisting an enrollee with their appeal may also initiate an appeal with the enrollee's written permission. For appeals involving inpatient services, inpatient providers may also request an appeal on behalf of the consumer with the enrollee's written consent.

An **expedited appeal** is a request by a Medicaid enrollee, provider (with written consent), or authorized representative assisting the enrollee with their appeal to NSMHA with written consent for expedited review of an action outlined in a written notice of action. For appeals involving inpatient services, inpatient providers may also request an expedited appeal on behalf of the enrollee with the enrollee's written consent.

Complaint

A **complaint** is dissatisfaction with a consumer's mental health services, by those other than the consumer. For a child under the age of 13, or for a child age 13 or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians.

Complaints may be from parents of adult children, a community member, or other involved parties.

Consumer/State Funded Consumer/Medicaid Enrollee

Consumers are individuals, who have applied for, are eligible for, have received NSMHA funded mental health service from NSMHA service network. This definition includes Medicaid enrollees and state funded consumers.

For a child under the age of 13, or for a child age 13 or older whose parents or legal representatives are involved in the treatment plan, the definition of consumer includes parents or legal representatives.

Consumers may utilize the grievance, appeal and fair hearing process as defined above. Consumers may also authorize others to assist them with their grievances and appeals. Guardians may initiate grievances or appeals for adults on a case-by-case basis without further consent.

(Throughout the policy, the term "Consumer" will be used to describe the above group).

Medicaid enrollees are Medicaid recipients with a mental health benefit who are currently enrolled in a Prepaid Inpatient Health Plan (PIHP).

(Throughout the policy, the term "Medicaid enrollee" or "enrollee" will be used to describe the above group.

State-funded consumers are individuals who have applied for, are eligible for, or who have received NSMHA funded mental health service from NSMHA service network who are not Medicaid enrollees.

(Throughout the policy, the term "State-funded consumer" will be used to describe the above group).

<u>Family</u>
For adult consumers, family is those the consumer defines as family or those appointed/assigned (e.g., guardians, siblings, caregivers and significant others) to the consumer.

For children, family is a child's biological parents, adoptive parents, foster parents, guardian, legal custodian authorized pursuant to Title 26 RCW, a relative with whom a child has been placed by DSHS or a tribe.

<u>Fair Hearing</u>
A **fair hearing** means a hearing before the Washington State Office of Administrative Hearings (OAH) in accordance with WAC 388-02. "Fair hearing" is synonymous with administrative hearing.

<u>Grievance</u>
For Medicaid enrollees, grievances are an expression of dissatisfaction about any matter other than an "action" as defined in NSMHA's policy. **For state-funded consumers**, grievances are an expression of dissatisfaction about any matter other than access to an intake assessment unless NSMHA state-funded criteria are met. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships, such as, rudeness of a provider or employee or failure to respect the enrollee's rights).

A **Grievance** may be pursued at the provider/designee level (level 1) and/or NSMHA level (level 2). Grievances may be filed verbally or in writing.

An **Expedited grievance** is a request for a more immediate response to a grievance. Expedited grievances may be pursued at the provider/formal designee or NSMHA level.

<u>Grievance System</u>
The term **grievance** is also used to refer to the overall system that includes grievances at provider/designee level (level 1) and NSMHA Level (Level 2), appeals at NSMHA and access to the State fair hearing process. The state grievance system also includes Notices of Action and Ombuds cases.

<u>Notice of Action and Notice of Adverse Determination</u>
Medicaid enrollees will receive a written Notice of Action outlining an action NSMHA or its formal designees have taken or are planning to take concerning Medicaid-funded mental health services. The Notice of Action will outline a Medicaid Enrollee's right to a second opinion and process to appeal these actions.

State-funded consumers will receive a written Notice of Adverse Determination regarding adverse service determinations within available resources. The Notice of Adverse Determination will outline the right to request a second opinion, grievance/fair hearing and the process for doing so.

BHA)/Provider/Inpatient Provider/Formal Designee

A **provider** is any NSMHA contracted BHA licensed to provide mental health services covered in NSMHA's PIHP and SMHC Program Agreement or a provider contracted to provide crisis services or crisis line services covered under the SMHC Program Agreement. An **inpatient provider** is any community inpatient facility that may be utilized for psychiatric hospitalization as certified and authorized by NSMHA's formal designee. A **formal designee** is an entity contracted by NSMHA to make authorization decisions on behalf of NSMHA.

ADDITIONAL GRIEVANCE SYSTEM REQUIREMENTS

NSMHA, formal designees, providers and any other contracted individuals and agencies shall comply with all requirements outlined in NSMHA's policies 1001-1005 and in references cited below. Providers and formal designees will adopt NSMHA's policies or develop Complaint, Grievance, Appeal, Notice Requirements and Fair Hearing Policies consistent with NSMHA's Policy. To ensure NSMHA's policy is consistently applied throughout the region, NSMHA will monitor these policies, complaint and grievance files and processes through processes including administrative audits. The development of a regional database or forms will also be used to monitor grievance system requirements.

NSMHA will oversee the provider/formal designees' complaint and grievance process. NSMHA, providers, formal designees, subcontractors and any other contracted individuals and agencies will cooperate with and promptly abide by all complaint, appeal, grievance and fair hearing decisions. NSMHA will require this in contracts and will monitor compliance with this requirement.

The providers/formal designees, Ombuds and NSMHA will assist with methods to collect information for quality improvement efforts, monitoring and oversight of system requirements and to assist NSMHA in complying with Grievance system reporting requirements to DBHR.

The providers/formal designees, Ombuds Services and NSMHA will submit semi-annual reports to NSMHA within 15 days of the end of the semi-annual period and comply with methods to report information. Semi-annual reports will include a review of all data including complaint data and:

1. A summary and analysis of the implications of the data;
2. Identification of system implications;
3. Identification of areas for further study and review or quality improvement;
4. A summary of how information related to complaints, grievances, appeals, or fair hearings was used on provider/designee quality management plan; and
5. Measures that may be taken to address quality improvement or undesirable patterns.

The providers, formal designees and NSMHA will also utilize complaint, grievance, denial, appeal and fair hearing information to analyze trends or identify areas for quality improvement through strategies outlined in the NSMHA Quality Management Plan

NSMHA, providers, formal designees will not charge consumers or their representatives for copies of their records requested for the complaint, grievance, appeal, or fair hearing process.

NSMHA, providers, formal designees and Ombuds will keep full records of complaints, grievance, appeals and NSMHA will keep records of fair hearings for at least 6 years.

Records of complaints, grievances, or appeals will be kept in confidential files separate from clinical records. These records will not be disclosed without the consumer's written authorization, except as necessary to resolve the complaint, grievance, or appeal to DSHS if a fair hearing is requested, or for review as part of the state quality strategy. Complaint, grievance and appeal records maintained by NSMHA are included in NSMHA's defined designated record set.

The requirements outlined in Policy 1001 Complaint, Grievance, Appeal, Fair Hearing and Notice – General Policy Requirements apply to – Policy 1002 Complaint and Grievance, Policy 1003 Appeal, Policy 1004 Fair Hearing and Policy 1005 Notice Requirements.

REFERENCES

1. Federal 1915 (b) Capitated Waiver Renewal and Proposal for a Section 1915(b) Capitated Waiver Program Waiver Renewals-
2. State Mental Health Program Agreement (SMHC) and Prepaid Inpatient Health Plan Program Agreement (PIHP) contracts between The State of Washington DSHS and NSMHA including the Community Psychiatric Inpatient Instructions and Requirements
3. 45 CFR Health Insurance Portability and Accountability Act (HIPAA).
4. WAC 388-865, 388-02, 182 550 2600
5. NOTICE OF ACTION TEMPLATE-Medicaid-Funded Mental Health Services-Washington State DBHR.
6. Washington Medicaid Mental Health Benefits Booklet-DBHR.
7. 42 CFR 438 Subpart F, (400-424), 438.100, 210, 218, 228, 230, 242

ATTACHMENTS

None

Effective Date: 2/5/2009; 12/8/2005; 6/29/2004, Approved by BOD, Motion #04-027
Revised Date: 7/21/2014
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North Sound Mental Health Administration

Section 1000 – Administrative: Complaint and Grievance

Authorizing Source: See references Policy 1001
Cancels:
See Also:
Providers must adopt or have a policy "consistent with" this policy | Approved by: Board of Directors Motion #04-027 | Date: 6/29/2004
Responsible Staff: Operations Manager
Executive Director Signature: | Date: 8/29/2014

POLICY # 1002.00

SUBJECT: COMPLAINT AND GRIEVANCE

PURPOSE

To outline the North Sound Mental Health Administration (NSMHA), provider and formal designee complaint and grievance processes and requirements (See Policy 1001-Complaint, Grievance, Appeal, Fair Hearing and Notice - General Policy Requirements, Policy 1003-Appeal, Policy 1004-Fair Hearing and Policy 1005 Notice Requirement for information about additional policy requirements).

DEFINITIONS

A ***complaint*** is a statement of dissatisfaction with a consumer's mental health services by those other than the consumer. For a child under the age of 13, or for a child age 13 or older whose parents or legal representatives are involved in the treatment plan, the definition of consumer includes parents or legal representatives.

Complaints may be from parents of adult children, a community member or other involved parties.

A ***grievance*** is an expression of dissatisfaction. Grievances may be initiated verbally or in writing by consumers or their authorized representatives. An **e*xpedited grievance*** is a request for a more immediate response to a grievance by the consumer/authorized representative.

For Medicaid enrollees ***grievances*** are an expression of dissatisfaction about any matter other than an "action" as defined in Policy 1001. For state-funded consumers, ***grievances*** are an expression of dissatisfaction about any matter other than initial eligibility of routine services unless NSMHA criteria for state funded criteria is met. (Possible subjects for grievances include, but are not limited to: the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider, employee, or failure to respect the enrollee's rights).

POLICY

Providers and NSMHA will maintain a complaint process to receive, investigate if needed and address concerns about a consumer's services that are not clearly endorsed by the consumer. Complaints may be from parents of adult children, other family members, or other involved parties.

Grievances are distinguished from complaints in that a grievance is the consumer's dissatisfaction. Consumers may have others assist them with their grievances (authorized representatives) with their written consent. Grievances will be accepted by authorized representatives if there is evidence the consumer endorses the expressed dissatisfaction.

If the consumer does not endorse the concerns, they may be processed through the Complaint Process.

Ombuds services are available to provide advocacy, assistance and investigation to consumers, family members and other interested parties throughout the process. Ombuds services work to assist in resolving complaint and grievances at the lowest possible level. Ombuds services may assist callers with complaints and grievances through the provider/formal designee or NSMHA process.

Consumers, their representatives, family and other individuals may contact Ombuds services for assistance with the grievance or complaint process. Complaints or grievances may also be initiated directly with the provider/formal designee or with NSMHA.

Each provider and designee will have *an identified complaint and grievance contact* to receive complaints and grievances. Consumers, their representatives or other individuals may initiate grievances with these contacts. They may also initiate complaints or grievances directly with their Mental Health Care Provider (MHCP) or other provider/designee staff.

Consumers and their representatives may also initiate grievances with *NSMHA through NSMHA Customer Service and others may initiate complaints.*

Individuals with complaints or grievances will first be encouraged to file their complaint or grievance directly with the provider to seek a resolution. Providers, Ombuds and NSMHA will be available to provide support for consumers and others to address the complaint or grievance directly with the provider. For complaints or grievances triaged through NSMHA customer services, NSMHA may request follow up information from the provider.

As consumers or their representatives variously contact the RSN, providers, or Ombuds regarding grievances, the grievance will be formally filed at either the Provider or RSN level. Although consumers may elect to file their grievance directly with NSMHA, they will be encouraged to file their grievance directly with their provider. NSMHA staff will document complaints or grievances triaged to providers/designees as customer service. (The provider/designee will document the complaint or grievance).

COMPLAINT PROCEDURE

A. Provider/Designee Complaint Procedure

1. Provider/formal designee will provide assistance to the individual with the complaint.
2. If the individual is not receiving assistance from Ombuds services, Ombuds services will also be offered for assistance if indicated.
3. Staff will attempt to resolve complaints informally, quickly and to the caller's satisfaction.
4. Staff will investigate complaints and attempt to resolve them to the person's satisfaction. Releases of information may be needed to exchange Protected Health Information (PHI) if the complaint involves PHI. Complaints may result in quality improvements even if this information cannot be shared with the individual with the complaint.
5. Staff will attempt to resolve complaints within 30 days. For all complaints, staff will relay the disposition to the person within 30 days and document the date of disposition.

For all complaints staff will also document each type of complaint, including: date of receipt, actions taken, resolution and date the person with the complaint is notified of the disposition. For complaints not resolved to the person's satisfaction, the provider/formal designee will also notify the person they may initiate a complaint with NSMHA or contact Ombuds for assistance.

B. NSMHA Complaint Procedure-Complaints processed by NSMHA

1. NSMHA staff will provide assistance to the caller.
2. If the caller is not receiving assistance from Ombuds services, Ombuds services will be offered for assistance if indicated.
3. Staff will attempt to resolve complaints informally, quickly and to the caller's satisfaction. Staff will investigate complaints and attempt to resolve them to the person's satisfaction. Releases of information may be needed to exchange PHI if the complaint involves PHI. Complaints may result in quality improvements even if this information cannot be shared with the individual with the complaint.
4. NSMHA may request any follow up or information from the provider as needed regarding the complaint.
5. NSMHA's Privacy Officer will be informed of any complaint relating to NSMHA's Privacy practices. The Privacy Officer will document all Privacy complaints received and their disposition.
6. Staff will attempt to resolve complaints within 30 days. For all complaints, staff will relay the disposition to the person within 30 days and document the date of disposition.
7. For all complaints, staff will also document each type of complaint including: date of receipt, actions taken, resolution and date the person with the complaint is notified of the disposition.

GRIEVANCE PROCEDURE-PROVIDER

A. Level 1 Grievances-Provider/Formal Designee Level Grievances

1. Provider or formal designee will provide assistance to the individual with the grievance.
2. If the consumer or representative is not receiving assistance from Ombuds services, Ombuds services will be offered for assistance.
3. Grievances may be initiated orally or in writing. Grievance timelines begin when the individual, authorized representative or Ombuds reports a grievance to the provider. Ombuds and authorized representatives' would need a Release of Information (ROI) to exchange information per Health Insurance Portability and Accountability Act (HIPAA) rules and regulations.
4. Requests for grievances should include the consumer name, how the provider/designee can best contact the consumer, the consumer and representatives' phone number and address, the nature of the grievance and types of concerns, person's desired options for resolution and any information consumers or others wish to submit.

5. Provider or formal designee will provide verbal acknowledgement (may be by telephone) of receipt of the grievance within one (1) business day and mail a written acknowledgement within five (5) business days of receipt of the grievance.
6. The written acknowledgement will include: date grievance was filed, summary of expressed concerns about NSMHA funded services and person's desired options for resolution. The written acknowledgement will also include: notice to the consumer or representative that previously authorized services will continue or be reinstated during the grievance process at the consumer or representative's request and notice for any circumstances in which the consumer may be asked to pay for the cost of those benefits if the grievance upholds the original decision.
7. Provider/designee will notify NSMHA in writing they have received a grievance within two (2) business days of receipt of the grievance and indicate date they received the grievance. Providers will also provide dates of acknowledgment to the consumer/representatives and indicate if Ombuds is involved. In addition, providers will identify whether they received the grievance orally or in writing.
8. Staff will attempt to resolve grievances informally, quickly and to the consumer's satisfaction.
9. Staff who has the authority to resolve the grievance or require corrective action will participate in the process and offer a face-to-face meeting if needed with the consumer and others of their choice to discuss the grievance. Providers will offer a face-to-face meeting if they think it is needed to resolve the grievance to the consumer's satisfaction. Provider's will also offer a meeting if requested by the consumer, representative, or Ombuds. Consumers may also provide additional information in writing about their grievance.
10. Individuals who make decisions on grievances will not be involved in any previous level of decision-making of the same issue.
11. For grievances that involve clinical issues or medical necessity, qualified mental health care professionals who have the appropriate clinical expertise will make the decision.
12. Consumers and their representatives (with appropriate releases) may examine their consumer record, including medical records and any other documents and records considered during the grievance process.
13. For all grievances staff will document each category of issue including: date of receipt, actions taken, resolution and date of resolution to the consumer or representative.
14. Provider or formal designee will investigate the grievance, attempt to resolve grievance to the consumer's satisfaction and mail a written notice of resolution to the consumer and representative (with a copy to the NSMHA), as expeditiously as the enrollee's mental health condition requires, not to exceed 30 days of receipt of the grievance.
15. Providers and designees will document the date of distribution to all parties and include this on the copy to NSMHA.
16. The written notice of resolution will include: reason for the decision, results of the resolution process, date it was completed, process and available supports if the consumer has any concerns about retaliation.

The written response will also include the right and process to pursue the grievance with NSMHA, right for previously authorized services to continue or be reinstated during the NSMHA grievance process at the consumer or consumer representative's request and notice for any circumstances in which consumer may be asked to pay for the cost of those benefits if grievance upholds original decision.

17. Providers or formal designees will issue a report upon request to NSMHA within 30 days of the decision for grievances
18. Staff with the authority to assure implementation of agreements or decisions will provide follow up.

B. Level 1-Provider Level Expedited Grievances-Additional Requirements

If an expedited grievance is requested and the provider/designee determines (or the NSMHA or another NSMHA provider or inpatient provider indicates in making the request on the consumer's behalf or supporting the consumer's request), that taking the time for a standard resolution could seriously jeopardize the consumer's life, health, or ability to attain, maintain or regain maximum function, the provider/designee will meet the additional requirements below:

1. Provider, network, or formal designee will make a decision on the request for expedited resolution and provide written notice of resolution as expeditiously as the consumer's mental health condition requires, within three (3) working days. They will also make reasonable efforts to provide oral notice.
2. Provider, network, or formal designee will provide the consumer a reasonable opportunity to provide information and inform the consumer of the limited time available for expedited resolutions.
3. Provider, network, or formal designee and NSMHA will ensure retaliation or punitive action is not taken against a consumer who requests an expedited resolution.
4. If the provider/designee denies a request for expedited resolution of a grievance, it will transfer the grievance to the timeframe for standard resolution and make reasonable efforts to give the consumer prompt oral notice of the denial. Previously authorized services and crisis services can continue during the grievance process to allow for time to process concerns in a non-expedited manner in most cases.

If consumer is dissatisfied with resolution from a provider/designee grievance (Level 1), they may initiate a grievance with NSMHA (Level 2).

Level 2 – NSMHA Level Grievances

1. NSMHA will provide assistance to the individual with the grievance.
2. If the consumer or their representative is not receiving assistance from Ombuds services, Ombuds services will be offered for assistance.
3. Grievances may be initiated orally or in writing. Grievance timelines begin when the individual, authorized representatives or Ombuds reports a grievance to NSMHA.
4. NSMHA staff will document the grievance including: date of receipt, actions taken, resolution by NSMHA and date of notification to the consumer.

5. Requests for grievances should include: consumer name, how NSMHA can best contact the consumer, consumer's and representatives phone number and address, nature of the grievance and concerns, desired options for resolution and any information the consumers or others wish to submit.
6. NSMHA will provide verbal acknowledgement (maybe by telephone) of receipt of the grievance within one (1) business day and mail a written acknowledgement within five (5) business days of receipt of the grievance.
7. Written acknowledgement will include: date the grievance was filed, summary of the expressed concerns about NSMHA funded services and person's desired options for resolution. Notice to the consumer or representative, will also include previously authorized services will continue or be reinstated during the grievance process at the consumer or representative's request and notice for any circumstances in which consumer may be asked to pay for the cost of those benefits if the grievance upholds the original decision.
8. For grievances involving a provider or designee, NSMHA will notify the involved provider/designee within two (2) business days of receipt of a grievance.
9. Providers/designees will provide NSMHA a copy of the consumer record and a copy of the grievance file and any additional information as requested
10. NSMHA individuals who make decisions on grievances will not be involved in previous level of decision-making of the same issue. NSMHA will provide a Grievance Committee to make decisions on consumer grievances. The grievance committee will be comprised of:

    a) NSMHA staff not involved in previous level of decision-making of the same issue. For grievances that involve clinical issues, medical necessity or grievances about the denial of an expedited resolution of an appeal, qualified MHCPs who have the appropriate clinical expertise will participate on the committee and make the decisions.
    b) Staff with the authority to resolve the grievance or require corrective action will participate in the process. NSMHA will offer a face-to-face meeting with the consumer, provider and others of their choice to gather information about the grievance if needed.
    c) Provider staff will send a representative to a grievance meeting.
    d) The committee may also include NSMHA's Medical Director, (licensed, Board certified psychiatrist) or another psychiatrist. Grievances regarding adverse authorization decisions for inpatient services will include a licensed, Board certified psychiatrist.

11. Consumers, Ombuds and their representatives will provide information about the nature of the grievances and desired options for resolution at the time of the grievance, when possible, to NSMHA and the provider (for grievances that involve providers). The consumer, Ombuds, or representatives will provide all additional documentation about these concerns within 10 days to NSMHA and provider. Other involved parties will provide all documentation 5 days in advance of a meeting or as requested to allow for review by the grievance committee. Providers or designees will be required to provide a written response for grievances involving a provider or designee if requested by NSMHA.

12. For all grievances, staff will document each type of issue including: date of receipt, actions taken, resolution and date of resolution to the consumer or representative.
13. NSMHA will investigate the grievance and mail a written notice of resolution as expeditiously as the consumer's mental health condition requires, not exceeding 30 calendar days from the receipt of the grievance.
14. NSMHA may extend the timeframes for resolution of grievances by up to 14 calendar days if:

    a) Consumer requests the extension;

    OR

    b) NSMHA shows to the satisfaction of DBHR upon its request, that there is need for additional information and how the delay is in the consumer's interest.

    For extensions requested by the consumer, NSMHA will provide written notice of the request and related dates. For extensions not requested by the consumer, NSMHA will give the consumer written notice of the reason for the delay.

15. Notices of resolution will include: reason for the decision, results of the resolution process, date it was completed and process and available supports if the enrollee has any concerns about retaliation. The notice of resolution will also include: right and process to request a fair hearing if the consumer is not satisfied with the resolution, right to request a fair hearing at any time if they believe there has been a violation of DSHS rules, right to request to continue to receive benefits while the hearing is pending and notice for any circumstances in which consumer may be asked to pay for the cost of those benefits if the hearing decision upholds the original decision.
16. For grievances regarding services to state-funded consumers that are resolved in favor of the consumer the notice of resolution will include: information about how the consumer may obtain services, supports available to assist in obtaining service and information that consumers must initiate services within 60 days.
17. For grievances that involve a provider or designee, providers or designees will issue a report to NSMHA within 30 days of the decision if requested. Providers or designees will issue additional follow up reports upon request.
18. Provider or designee staff with the authority to assure implementation of agreements or decisions will provide follow up.
19. NSMHA may offer the consumer a follow up interview with the Grievance Committee to discuss any concerns about retaliation.
20. NSMHA will send a notice of action to the consumer that they can request a fair hearing if NSMHA fails to meet the timeline for normal disposition or extension of the grievance.

Level 2 – Expedited Grievances-Additional Requirements

If an expedited grievance is requested and NSMHA determines (or the provider of services or inpatient provider indicates (in making the request on the consumer's behalf or supporting the consumer's request), that taking the time for a standard resolution could seriously jeopardize the consumer's life, health, or ability to attain, maintain or regain maximum function, NSMHA will meet the additional requirements below:

1. Requests for expedited resolution may be initiated orally.
2. NSMHA will make a decision on consumer's request for expedited resolution and provide written notice of resolution as expeditiously as the consumer's mental health condition requires, within three (3) working days. They will also make reasonable efforts to provide oral notice.
3. NSMHA may extend the 3 working days timeframe by up to 14 calendar days if:

   a) Consumer, provider, or representative acting on behalf of the consumer requests the extension;

   OR

   b) NSMHA finds there is need for additional information and the delay is in the consumer's interest.

   For extensions requested by the enrollee, NSMHA will provide written notice of the request and related dates in writing. For extensions not requested by the enrollee, NSMHA will give the enrollee written notice of the reason for the delay.

4. NSMHA will provide the consumer a reasonable opportunity to provide information and inform the consumer of the limited time available for expedited resolutions.
5. NSMHA will ensure retaliation or punitive action is not taken against a consumer who requests an expedited resolution.
6. If NSMHA denies a request for expedited resolution of a grievance, it will transfer the grievance to the timeframe for standard resolution and make reasonable efforts to give the consumer prompt oral notice of the denial.
7. Previously authorized services and crisis services can continue during the grievance process to allow for time to process concerns in a non-expedited manner in most cases

If the consumer is dissatisfied with the results of the grievance process, they may request a fair hearing, with the Office of Administrative Hearings (OAH) within 90 calendar days from the grievance notice of resolution. The consumer may also request a fair hearing at any time if they believe there has been a violation of DSHS rules (See Policy 1004-Fair Hearing for additional information).

ATTACHMENTS

None

Effective Date: 2/5/2009; 12/8/2005
Revised Date: 7/21/2014
Review Date: 7/23/2014

North Sound Mental Health Administration

Section 1000 – Administrative: Appeal

Authorizing Source: See references Policy 1001
Cancels:
See Also:
Providers are required to adopt or have a policy "consistent with" this policy — Approved by: Board of Directors — Date: 6/29/2004
Responsible Staff: Operations Manager — Motion #04-027
Executive Director Signature: — Date: 8/29/2014

POLICY # 1003.00

SUBJECT: APPEAL

PURPOSE

To outline North Sound Mental Health Administration (NSMHA) appeal and expedited appeal processes and requirements for Medicaid enrollees (See Policy 1001 Complaint, Grievance, Appeal, Notice and Fair Hearing - General Policy Requirements, Policy 1002 Complaint and Grievance, and Policy 1004 Fair Hearing and Policy 1005 Notice Requirements for information about additional policy requirements).

NSMHA APPEAL POLICY

Medicaid enrollees or providers or representatives on behalf of the enrollee and with the enrollee's written consent may request an appeal of actions to NSMHA. They may also request an expedited appeal. For appeals of the denial of inpatient authorization or extension an inpatient provider may also request an appeal or expedited appeal on behalf of enrollee with written consent of the enrollee

A. Appeals Process

Medicaid enrollees will receive a written Notice of Action explaining the action NSMHA or its formal designee intends to take or has taken, the reasons for the action and the right to request an appeal or expedited appeal of these actions. The Notice of Action will also outline the process to appeal an action with NSMHA. Requesting providers or inpatient providers will also receive Notice (may be oral).

Appeals are requests to NSMHA for review of an action as outlined in the Notice of Action. Expedited appeals are requests to NSMHA for expedited review of an action.

Enrollees, providers, or representatives (with written consent) may initiate an appeal or expedited appeal orally or in writing to NSMHA. Requests for an appeal initiated orally must be followed up with a signed written request by the enrollee or representative. Requests for expedited appeal are not required to be followed with a written request.

Enrollees or their representatives may request an expedited appeal if the enrollee/representative believes the standard time for resolution would seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.

If an expedited appeal is requested and NSMHA determines or a provider or inpatient provider indicates taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function, NSMHA will meet the *additional* requirements for expedited appeal below:

Appeals must be initiated within 45 calendar days of the receipt of NSMHA's Notice of Action. Enrollees or their representatives may request previously authorized services continue or be reinstated during the Appeals process. For previously authorized services to continue the appeal must be initiated within 10 calendar days of the mailing of NSMHA's Notice of Action or by the intended effective date of NSMHA's proposed action (whichever is later). (See section B below for additional information about the continuation of services/benefits during the appeals process).

Enrollees, providers, or other representatives may contact Ombuds services for assistance or may initiate an appeal or expedited appeal verbally or in writing with NSMHA. Ombuds services are available to provide advocacy, assistance and investigation throughout NSMHA appeals process. Ombuds services work to assist the consumer or representative with appeals through NSMHA appeals and expedited appeals processes outlined below.

1. **Non expedited appeals**

    a. NSMHA staff will assist callers and provide follow up with the appeals process.
    b. If Medicaid enrollee or their representative is not receiving assistance from Ombuds services, Ombuds services will be offered for assistance.
    c. Medicaid enrollee may also have assistance from their provider or anyone of their choice throughout the process.
    d. NSMHA may also request records and participation form an enrollee's provider during the appeal process
    e. NSMHA staff will document the appeal, including the date of receipt, actions taken, resolution by NSMHA and date of notification to the consumer.
    f. If the appeal is done verbally, Medicaid enrollee or representative will follow up with a written signed request (written requests are not required for expedited appeals). Oral inquiries seeking to appeal are treated as appeals and therefore establish the earliest possible filing date for appeals.
    g. Written requests for appeal should include the enrollee's name, phone number, address, how NSMHA can best contact the enrollee, reasons for appeal and any evidence the enrollee or representatives wish to attach. The enrollee may send in supporting records, letters from their mental health provider, a list identifying qualified witnesses, or other information explaining services should be provided. Enrollees may request information from their mental health provider.
    h. NSMHA will provide verbal acknowledgement (may be by telephone) of the receipt of the appeal within one (1) business day from the oral or written appeal (whichever is first) and mail a written acknowledgement within five (5) business days of receipt of the oral or written appeal (whichever is first).
    i. Written acknowledgement will include notice to the Medicaid enrollee or representative that previously authorized benefits will continue or be reinstated during the appeals process at the enrollee or representative's request if the requirements outlined in Section B below are met.
    j. Written acknowledgement will also include notice for any circumstances in which the enrollee may be asked to pay for the services received during the appeals process if the decision is not in their favor.

k. Qualified mental health care professionals who have appropriate clinical expertise will conduct appeals and make decisions. A psychiatrist will review all inpatient appeals prior to upholding the original denial.
l. NSMHA staff who make decisions about appeals will not be involved in previous level of decision-making on the same issue. NSMHA will provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person, as well as, in writing. If a meeting occurs, enrollees may also invite those of their choice to the meeting. Documentation will be provided five (5) days in advance of the meeting to allow for review and the enrollee, representative and others of the consumer's choice may present their information at the meeting.
m. NSMHA will request participation from providers as indicated in the appeal process and/or appeal meeting.
n. The parties to the appeal may include the enrollee and his/her representative, or the legal representative of a deceased enrollee's estate.
o. Enrollees and their representatives may examine their case file, including medical records and any other documents and records considered during the appeals process (before and during the appeals process). If the enrollee requests their representative review personal health information without the enrollee present, the enrollee must sign authorization forms in accordance with HIPPA rules and regulations.
p. NSMHA will mail a written notice of resolution as expeditiously as the enrollee's mental health condition requires, not exceeding 43 days of receipt of the oral or written notice of appeal. NSMHA may extend the prescribed timeframes for resolution of appeals by up to14 calendar days if:

    i. The enrollee (provider or representative acting on behalf of the enrollee) requests the extension

    OR

    ii. NSMHA shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.

For extensions requested by the enrollee, NSMHA will provide written notice of the request and related dates in writing. For extensions not requested by the enrollee, NSMHA will give the enrollee written notice of the reason for the delay.

q. Notices of resolution will include a written statement of the clinical rationale for the decision, including how the requesting provider or enrollee may obtain the utilization management clinical review or decision-making criteria, the results of the resolution process, the date it was completed, the process and available supports if the enrollee, provider, or inpatient provider has any concerns about retaliation and the right to request a fair hearing at any time if the enrollee believes there has been a violation of Washington State Department of Social and Health Services (DSHS) rules. For appeals regarding denial of service that are resolved in favor of the enrollee, the notice of resolution will include information about how the enrollee may obtain services, supports available to assist in obtaining service and information that enrollees must initiate services within 60 days.

r. For appeals not resolved wholly in favor of the enrollee, the notice will also include the right to request a State Fair Hearing, how to file a fair hearing, the right to continue to receive benefits pending a hearing, how to request the continuation of benefits and notice that the Enrollee may be asked to pay for the cost of continued services if the hearing decision upholds the original action.
s. When enrollees, providers, or inpatient providers have concerns about retaliation, they will be offered assistance by NSMHA.
t. NSMHA will send a Notice of Action to the enrollee about their right to request a fair hearing if NSMHA fails to meet the timeline for disposition or extension of the appeal.

2. Expedited Appeals Process-Additional Requirements

Enrollees or their representatives may request an expedited appeal if the enrollee /representative believe the standard time for resolution would jeopardize the enrollee's ability to maintain or regain maximum function.

If an expedited appeal is requested and NSMHA determines or NSMHA's provider of service or inpatient provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request), that taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function, NSMHA will meet the *additional* requirements below:

a. Requests for expedited resolution may be initiated orally and are not required to be followed by a written signed request by the enrollee or representative.
b. NSMHA will make a decision on expedited appeals and provide written notice within three (3) working days. NSMHA will also make reasonable efforts to provide oral notice.
c. NSMHA may extend the three (3) working days timeframe by up to 14 calendar days if:

    i. The enrollee, provider, or representative acting on behalf of the enrollee requests the extension

    OR

    ii. NSMHA shows to the satisfaction of the state agency upon its request, that there is need for additional information and how the delay is in the enrollee's interest.

    For extensions requested by the enrollee NSMHA will provide written notice of the request and related dates in writing. For extensions not requested by the enrollee NSMHA will give the enrollee written notice of the reason for the delay.

d. NSMHA will provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person, as well as, in writing and inform the enrollee of the limited time available for expedited resolutions.
e. NSMHA will ensure retaliation or punitive action is not taken against an enrollee or provider who requests an expedited resolution or supports an enrollee's appeal.

f. If NSMHA denies a request for expedited resolution of an appeal, it will transfer the appeal to the timeframe for standard resolution, and make reasonable efforts to give the enrollee prompt oral notice of the denial, follow up within two (2) calendar days with a written notice and inform the consumer of their right to file a grievance regarding the denial of expediency.

Enrollees or their representative may request a fair hearing, with the Office of Administrative Hearings (OAH) within 90 calendar days of the date of mailing of NSMHA's notice of disposition of the appeal if the enrollee does not agree with the resolution. The enrollee or representative may also request a fair hearing at any time if they believe there has been a violation of DSHS rules or timelines.

B. Continuation of Services/Benefits during the Appeals Process

NSMHA will continue the enrollee's benefits if all of the following apply:

1. The enrollee or the provider files the appeal on or before the later of the following:

    a. Within 10 calendar days of NSMHA, designee, or delegated provider mailing the notice of action; or
    b. Intended effective date of NSMHA's proposed action;

2. Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. Services were ordered by an authorized provider or inpatient provider;
4. Authorization period has not expired; and
5. Enrollee requests extension of benefits.

If, at the enrollee's request, NSMHA continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

1. Enrollee withdraws the appeal.
2. Ten days pass after NSMHA mails notice of disposition of an appeal and resolution is not in favor of the enrollee, unless the enrollee, within the 10-day timeline, has requested a State Fair Hearing (with continuation of benefits until DSHS's Fair Hearing decision is reached),
3. State Office of Administrative Hearings (OAH) issues a fair hearing decision adverse to the enrollee; or
4. Time period or service limits of a previously authorized service have been met.

Enrollees who request continuation of benefits will be notified if the final resolution of the appeal is adverse to the enrollee (upholds NSMHA or formal designee's action), NSMHA may request enrollee to reimburse the cost of the services furnished to enrollee while the appeal was pending.

C. Effect of Reversed Resolutions of Appeals

1. If NSMHA or OAH reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, NSMHA must authorize or provide the disputed services promptly and as expeditiously as the enrollee's mental health condition requires.

2. If NSMHA or OAH reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, NSMHA must pay for those services.
3. If the final resolution of the appeal upholds NSMHA's action, the regional support network may recover the amount paid for the services provided to enrollee while the appeal was pending, to the extent they were provided solely because of the requirement for continuation of services and in accordance with 42 CFR 431.230(b).

D. Notice of Action

NSMHA must issue written notices of actions for Medicaid enrollees explaining the action NSMHA intends to take, the reasons for the actions and the right to file an appeal or expedited appeal of these actions. The notice of action will also outline the process to appeal an action (see Policy 1005.00 Notice for additional requirements).

ATTACHMENTS

None

North Sound Mental Health Administration

Section 1000 – Administrative: Fair Hearing

Authorizing Sources: See references Policy 1001
Cancels:
See Also:
Providers are required to adopt or have a policy "consistent with" this policy | Approved by: Board of Directors | Date: 12/8/2005
Responsible Staff: Operations Manager | Motion #05-122
Executive Director Signature: | Date: 8/29/2014

POLICY #1004.00

SUBJECT: FAIR HEARING

PURPOSE

To outline the State Fair Hearing process and requirements (See Policy 1001-Complaint, Grievance, Appeal and Fair Hearing Policy General Requirements, Policy 1002-Complaint and Grievance, Policy 1003-Appeal and Policy 1005 Notice Requirements for information about additional policy requirements).

FAIR HEARING POLICY

A fair hearing is conducted through the auspices of the state Office of Administrative Hearings (OAH). The term "fair hearing" is synonymous with administrative hearing.

A. Rights to Request a Fair Hearing

Consumers and their representatives have the right to request pre-hearing and administrative hearing processes described in Washington Administrative Code (WAC) Chapter 388-02. Consumers may call the Office of Administrative Hearings (OAH) at 1-800-583-8271 to inquire about qualifying for a State fair hearing. Situations when a consumer may request a fair hearing include the following:

1. Consumer believes there has been a violation of the Washington State Department of Health and Social Services (DSHS) rules;
2. NSMHA violates timeframes for a grievance or appeal;
3. Medicaid enrollee does not receive a favorable disposition of an appeal by NSMHA;
4. Consumer does not receive a favorable disposition of a grievance from NSMHA;
5. State-funded consumer following receipt of a written Notice of Adverse Determination by NSMHA or formal designee (grievance may also be pursued with NSMHA); and/or
6. Consumer is dissatisfied with their services.

B. Assistance with Fair Hearings

NSMHA will provide assistance to consumers in pursuing fair hearings. NSMHA will provide information about how to request a fair hearing and access to Ombuds services. Ombuds services are available to investigate, advocate and assist consumers throughout the fair hearing process at no cost.

There will be no retaliation against a consumer who requests a fair hearing. Consumers may contact NSMHA or Ombuds services if they have concerns about retaliation.

C. **Timelines to File a Fair Hearing**

If consumers receive a written Notice of Adverse Determination or do not receive favorable disposition of a grievance or appeal (Medicaid enrollees) by NSMHA, they may request a fair hearing. In the case of appeals, the request for fair hearing should be filed within 90 days from the date of receipt of the Notice of Adverse Determination.

If consumers are dissatisfied with services or believe there has been a violation of DSHS rules or NSMHA or providers have violated certain timelines, they may request a fair hearing at any time. Consumers may call OAH at 1-800-583-8271 to inquire about qualifying for a State fair hearing prior to utilizing NSMHA grievance or appeals process. Ombuds services are available to assist consumers with this process.

D. **Where to Request a Fair Hearing**

Consumers may request a fair hearing with OAH by calling 1-800-583-8271. Consumers may also contact the Ombuds Services toll free at 1-888-336-6164 or NSMHA for assistance in requesting a fair hearing.

E. **Continuation of Benefits/Services during the Grievance, Appeal and Fair Hearing Process**

Consumers may request their previously authorized services or benefits continue or are reinstated during NSMHA and provider or grievance process, NSMHA appeal process (enrollees) and State fair hearing process.

NSMHA encourages resolution of appeals and grievances at the lowest possible level. NSMHA also encourages a second opinion process to assist with resolution. However, a consumer may request a fair hearing without first utilizing the provider or NSMHA's grievance process. They may also request a state fair hearing prior to utilizing NSMHA's appeal process (Medicaid Enrollees) if they believe DSHS rules or timelines have been broken.

If a consumer requests a fair hearing prior to utilizing NSMHA's appeal or grievance process, NSMHA will continue or reinstate previously authorized services (if the original period covered by the original authorization has not expired) pending fair hearing at the consumer's request.

Consumers will be notified in writing for any circumstances in which consumer may be asked to pay for the cost of those services if the hearing decision upholds the original decision.

APPEAL PROCESS

During NSMHA's Appeals process, NSMHA will continue or reinstate the enrollee's benefits if all of the following apply (see also Policy #1003-Appeal for additional information and requirements):

1. Enrollee or provider files the appeal on or before the later of the following:

    a. Within 10 calendar days of receipt of NSMHA's Notice of Action or
    b. Intended effective date of NSMHA's proposed action.

2. Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

3. Services were ordered by an authorized provider or inpatient provider;
4. Enrollee requests a continuation of services/benefits; and
5. Original authorization period has not expired at the time of the request for continuation of benefits.

If, at enrollee's request, NSMHA continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

1. Enrollee withdraws the appeal;
2. Ten days pass after NSMHA mails notice of disposition of an appeal and resolution is not in favor of enrollee, unless enrollee, within the 10-day timeline, has requested a State Fair Hearing (with continuation of benefits until the fair hearing decision is reached);
3. OAH issues a fair hearing decision adverse to the enrollee; or
4. Time period or service limits of a previously authorized service have been met.

Enrollees will receive information regarding their right to request previously authorized services continue or be reinstated during the appeals and fair hearing process and they may be asked to pay for services provided during the appeal and fair hearings process if the decision is adverse to the consumer.

Following appeals that are not resolved wholly in favor of the enrollees, NSMHA's notice of adverse ruling will also include: right to request a State Fair Hearing, process for requesting a Fair Hearing, right to request to continue to receive benefits while the hearing is pending, how to make the request and notice for any circumstances in which the enrollee may be asked to pay for the cost of those benefits if hearing decision upholds the original action.

GRIEVANCE PROCESS

During NSMHA or provider grievance process, NSMHA and providers will continue or reinstate consumer's previously authorized services at consumer's or their representative's request. NSMHA will also continue or reinstate previously authorized services pending fair hearing (Previously authorized services will continue if the original period covered by the original authorization has not expired).

Consumers will receive information regarding their right to request services continue or be reinstated during the grievance and fair hearing process and notice for any circumstances in which they may be asked to pay for disputed services provided during grievance and fair hearings process if the decision is adverse to consumer.

Following provider grievances are not resolved wholly in favor of consumer, NSMHA providers' grievance notice of resolution will include: right and process to pursue a grievance with NSMHA and right for previously authorized services to continue or be reinstated during NSMHA's grievance process at the consumer or consumer representative's request and notice for any circumstances in which consumer may be asked to pay for the cost of those services if the grievance upholds the original decision.

Following NSMHA grievances are not resolved wholly in favor of the consumer, NSMHA's grievance notice of resolution will include: right to request a State Fair Hearing, process for requesting a Fair Hearing, right to request continuation of previously authorized services while hearing is pending, how to make request and notice for any circumstances in which consumer may be asked to pay for the cost of those services if hearing decision upholds the original decision.

A. Reversed Resolutions of Appeals

If State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while an appeal was pending, NSMHA/formal designee and providers must authorize or provide the disputed services promptly and as expeditiously as the enrollee's mental health condition requires.

If State fair hearing officer reverses a decision to deny authorization of services and enrollee received the disputed services while appeal was pending, NSMHA must pay for those services.

If final resolution of the appeal upholds NSMHA's action, NSMHA may recover amount paid for services provided to enrollee while appeal was pending to the extent they were provided solely because of requirement for continuation of services and in accordance with Code of Federal Regulations (CFR) 42.431.230 (b).

B. Additional Requirements for Fair Hearings

NSMHA, community mental health agencies, designees, and other contracted individuals and providers will cooperate with and abide promptly by all administrative hearing procedures and decisions. NSMHA will require this in contracts and will monitor this requirement.

ATTACHMENTS

None

North Sound Mental Health Administration

Section 1000 – Administrative: Notice Requirements

Authorizing Sources: See references in NSMHA Policy 1001
Cancels:
See Also:
Providers must "comply with" this policy
Responsible Staff: Deputy Director
Executive Director Signature:

Approved by: Board of Directors
Motion #04-027

Date: 6/29/2004

Date: 8/29/2014

POLICY# 1005.00

SUBJECT: NOTICE REQUIREMENTS

PURPOSE

To ensure notices regarding individuals' services are provided in a manner that gives timely, clear and easily understood information to individuals' seeking and receiving mental health services.

DEFINITIONS

See North Sound Mental Health Administration (NSMHA) Policy 1001 for definitions.

POLICY

NSMHA ensures Notices are sent to individuals to inform them of authorization of services or when NSMHA, or its formal designee, takes an Action per NSMHA Policy 1001, related to their requested or previously authorized services.

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be determined by a Mental Health Professional (MHP) with the appropriate clinical expertise to make that decision. A decision to deny inpatient care can only be made by a psychiatrist or doctoral-level clinical psychologist.

Notices outlined in this policy are sent or provided to:

1) The individual and/or legal representative;
2) A legal guardian or parent who is the legal custodian of a person under the age of 18 years as allowed by state and federal privacy regulations; or
3) A representative of a state or governmental agency that has legal custody or control of a person under the age of 18 years as allowed by state and federal privacy regulations. If the individual is in the legal custody of the State of Washington, such as, in state foster care or group home placement, NSMHA or its designee must provide a copy of any Notice of Action to the regional Children's Administration office when either an intake is denied or services beyond the intake have not been authorized.
4) The requesting inpatient or outpatient provider will also be notified by NSMHA.

<u>Language and Format of Notices</u>

Only Notice templates developed or issued by NSMHA may be used. Notices will be provided in languages and format as outlined in NSMHA Policy 1515 Interpreter and Translation Services. Written Notices shall:

1) Use easily understood language and format.
2) Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

Notices of Determination will include:

1) A description of authorized services and timeframes.
2) Information about the availability of other services under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for individuals under 21 and their legal representative for individuals with Washington Apple Health coverage.

Notices of Adverse Determination will include a statement of:

1) The determination NSMHA or its formal designee intends to make;
2) The reasons for the determination;
3) A description of alternative services, if available;
4) Explanation of the individual's right to a second opinion, expedited grievance, or grievance.

    a) The timeframes and processes to request a second opinion, expedited grievance, or grievance;
    b) The rights and processes to have benefits continue pending resolution of the grievance;
    c) The circumstances under which the individual may be required to pay the costs of these services;
    d) The circumstances when an individual can request a fair hearing.

Notices of Action shall include a statement of:

1) The action NSMHA or its formal designee intends to take (see NSMHA Policy 1001 for a complete list of actions and definitions);
2) The reasons for the action;
3) A description of alternative services, if available;
4) An explanation of the individual's right to request a second opinion, appeal, or expedited appeal;

    a) The timeframes and processes to request a second opinion, expedited appeal, or appeal;
    b) The rights and processes to have benefits continue pending resolution of the appeal;
    c) The circumstances under which the individual may be required to pay the costs of these services;
    d) The circumstances when an individual can request a fair hearing;
    e) The definitions of reduction, termination, suspension and denial.

PROCEDURE

<u>Notice Types and When to Issue Them</u>

Notice of Determination

Notices of Determination (NODs) shall be provided to all individuals covered by Washington Apple Health and NSMHA state-funds when they are authorized for services by NSMHA or its formal designee. Notices of Determination shall be issued by:

1) NSMHA for outpatient services.
2) NSMHA's formal designee for Inpatient Utilization Management (UM).

Notice of Adverse Determination

Notices of Adverse Determination (NOADs) shall be provided to individuals covered by ***state funds*** when:

1) NSMHA or its designee determines services beyond an intake or previously authorized benefit are not medically necessary and no services are authorized by NSMHA.

    a) This is considered a denial when a Behavioral Health Agency (BHA) submits a request for re/authorization or denial and no services are authorized by NSMHA (NSMHA issues an NOAD).
    b) This is considered a disagreement over treatment plan when the individual wants continued services and the MHCP/BHA determines they are not medically necessary and plans to discharge the individual (BHA issues an NOAD).

Or

2) NSMHA or its formal designee, does not authorize or provide a mental health service (outpatient or inpatient) that has been requested ***and*** is within available resources for individuals covered by state funds (see NSMHA Policy 1574). This is considered a denial when:

    a) The determination is about inpatient (NSMHA's formal designee for Inpatient UM issues NOAD); or
    b) The determination is made by NSMHA (NSMHA issues NOAD); or
    c) A Residential, Wraparound/WISe (Wraparound with Intensive Services), Intensive Outpatient Services (IOP), Integrated Dual Disorder Treatment (IDDT), or Program for Assertive Community Treatment (PACT) provider denies a request for admission to the program due to the individual not meeting clinical criteria (respective intensive program issues NOAD). It is not a denial (i.e., a Notice is not issued) if there is not current capacity in the program.

    This is considered a disagreement over treatment plan when:

    The individual has requested a service from the MHCP/BHA and the service is not provided (BHA issues NOAD).

Or

3) NSMHA or its formal designee provides outpatient mental health services at a lower intensity than has been requested.

    a) This is considered a denial when NSMHA authorizes services at a lower intensity than has been requested by the BHA (NSMHA issues NOAD).
    b) This is considered a disagreement over treatment plan when the MHCP/BHA provides services at a lower intensity than has been requested by the individual (BHA issues NOAD).

Or

4) NSMHA reduces, suspends, or terminates previously authorized outpatient services (NSMHA issues NOAD). NSMHA or its designee, will not reduce, suspend, or terminate previously authorized inpatient services.

Notice of Action

Notices of Action shall be provided to individuals covered by ***Washington Apple Health*** when:

1) NSMHA or its formal designee, denies access to an intake assessment appointment requested by an individual (NSMHA issues NOA).

Or

2) NSMHA determines services beyond an intake or previously authorized benefit are not medically necessary and no services are authorized by NSMHA.

    a) This is considered a denial when a BHA submits a request for re/authorization or denial and no services are authorized by NSMHA (NSMHA issues NOA).
    b) This is considered a disagreement over treatment plan when the individual wants continued services and the MHCP/BHA determines they are not medically necessary and plans to discharge the individual (BHA issues NOA).

Or

3) NSMHA or its formal designee does not authorize or provide a mental health service (outpatient or inpatient) that has been requested. This is considered a denial when:

    a) The determination is about inpatient (NSMHA's formal designee for Inpatient UM issues NOA); or
    b) The determination is made by NSMHA (NSMHA issues NOA); or
    c) A Residential, Wraparound/WISe, IOP, IDDT, or PACT provider denies a request for admission to the program due to not meeting admission criteria (respective intensive program issues NOA). It is not a denial (i.e., a Notice is not issued) if there is not current capacity in the program.

    This is considered a disagreement over treatment plan when:

    The individual has requested a service from the MHCP/BHA and the service is not provided (BHA issues NOA).

Or

4) NSMHA or its formal designee provides mental health services at a lower intensity than has been requested.

    a) This is considered a denial when NSMHA authorizes services at a lower intensity than has been requested by the BHA (NSMHA issues NOA).
    b) This is considered a disagreement over treatment plan when the MHCP/BHA provides services at a lower intensity than has been requested by the individual (BHA issues NOA).

Or

5) NSMHA reduces, suspends, or terminates previously authorized outpatient services (NSMHA issues NOA). NSMHA or its designee will not reduce, suspend, or terminate previously authorized inpatient services.

Or

6) Other actions are taken (NSMHA issues NOA).

Timelines for Issuing Notices

Notices issued for inpatient determinations

1) See NSMHA Policy 1571 Inpatient Certification and Authorization

Notices issued by BHAs for outpatient services

1) See NSMHA Policy 1551 for timelines related to Disagreement with the Treatment Plan actions.
2) See corresponding NSMHA Policies for timelines related to specific, specialized programs including Residential, Wraparound/WISe, IOP, IDDT and PACT.

Notices issued by NSMHA for outpatient services

When the responsibility for issuing the Notice resides with NSMHA, BHAs will submit any necessary documentation to NSMHA so that the determination and corresponding Notice may be issued per the following timelines:

1) *All Notices (Notice of Determination, Notice of Action and Notice of Adverse Determination)*

   a) For standard service authorization decisions, as expeditiously as the individual's mental health condition requires, not exceeding 14 calendar days following receipt of the request for service. An extension of up to 14 calendar days is possible if the individual or the provider requests it, or NSMHA justifies, to the DSHS upon request, a need for additional information and how the extension is in the individual's interest.

      If NSMHA extends the timeframes for standard authorization decisions it must 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 he or she disagrees with that decision. NSMHA must issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

   b) For expedited service authorization decisions, as expeditiously as the individual's mental health condition requires, no later than 3 working days after receipt of the request for service. An extension of up to 14 calendar days is possible if the individual requests an extension or NSMHA justifies, to the DSHS upon request, a need for additional information and how the extension is in the individual's interest.

      For expedited decisions, an extension is warranted:

      i. When the individual's presenting mental health condition affects their ability to maintain or regain maximum functioning; or
      ii. If the individual presents a potential risk of harm to self or others.

2) *Notice of Action and Notice of Adverse Determination Only*
   a) For denial of payment, on the date of the action or adverse determination affecting the claim/payment.
   b) For termination, suspension, or reduction of previously authorized services, at least 10 calendar days before the effective date of the action or, as applicable, adverse determination except if the criteria noted in 42 CFR 431.213 or 431.214 are met:

i. NSMHA or designee has factual information confirming the death of a recipient.
ii. NSMHA or designee receives a clear written statement signed by a recipient that they no longer wish services or gives information that requires termination or reduction of services and indicates that they understand that this must be the result of supplying that information.
iii. The recipient has been admitted to an institution where he or she is ineligible under the plan for further services.
iv. The recipient's whereabouts are unknown and the post office returns NSMHA or designee's mail directed to the recipient indicating no forwarding address.
v. NSMHA establishes the fact that the recipient has been accepted for Washington Apple Health services by another local jurisdiction, state, territory, or commonwealth.
vi. The recipient's physician prescribes a change in the level of medical care.
vii. The notice involves an adverse determination made with regard to the pre-admission screening requirements (for Nursing Facilities admissions) from section 1919(e) (7) of the Act.
viii. The date of action will occur in less than ten (10) calendar days, in accordance with Code of Federal Regulations (CFR) 42 Section 483.12 (a) (5) (ii), which provides exceptions to the 30-day notice requirements of Section 483.12 (a) (5) (i), (Long Term Care Requirements), or
ix. NSMHA has facts indicating that the action should be taken because of probable fraud by the recipient and the facts have been verified, if possible, through secondary services.

For exceptions (i) through (viii) above NSMHA may mail the Notice of Action or Adverse Determination no later than the date of action or adverse determination. In the case of fraud (ix), NSMHA may mail the Notice of Action five (5) calendar days in advance of the action.

ATTACHMENTS

None

North Sound Mental Health Administration

Section 1500 – Clinical: Authorization and Re/Authorization for Ongoing Outpatient Services

Authorizing Source: CFR 438.210; MHD Contract 2007-09; Provider Contract 2007-09
Cancels:
See Also: Approved by: Executive Director Date: 8/29/2014
Responsible Staff: Quality Manager Signature:

POLICY #1505.00

SUBJECT: AUTHORIZATION AND RE/AUTHORIZATION FOR ONGOING OUTPATIENT SERVICES

PURPOSE

To outline how individuals in need of outpatient mental health services from North Sound Mental Health Administration (NSMHA) contracted Behavioral Health Agencies (BHAs) are authorized or reauthorized (re/authorization shall mean both processes throughout the remainder of the policy) to receive medically necessary services in order to ensure consistent application of NSMHA's re/authorization processes.

POLICY

Individuals requesting NSMHA re/authorization for mental health services must first meet financial eligibility criteria. Individuals who have Washington Apple Health with a Regional Support Network benefit identified, per ProviderOne, are considered financially eligible. For individuals who do not have this benefit, see NSMHA Policy 1574 State Only Funding Plan – Mental Health Services regarding financial eligibility for services.

For individuals who have made an initial request for service and have had an intake with a NSMHA-contracted BHA for which NSMHA is the payer, NSMHA shall review an authorization request when the BHA substantiates the individual meets financial eligibility, Washington State Access to Care Standards (per DSHS contract) and medical necessity criteria. Per DSHS contract, medical necessity means:

1. The requested service is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in the recipient that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.
2. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the individual requesting service. "Course of treatment" may include mere observation or, where appropriate, no treatment at all.
3. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness covered by Washington State for public mental health services.
4. The intervention is deemed to be reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a covered mental illness.
5. The individual is expected to benefit from the intervention.
6. The individual's unmet need cannot be more appropriately met by any other formal or informal system or support.

For individuals who are currently in an open outpatient episode and current authorization period for which NSMHA is the payer, NSMHA shall review a re/authorization request when the BHA substantiates the individual meets financial eligibility and NSMHA Continued Stay Criteria as follows:

1. Continues to meet the Washington State Access to Care Standards (ACS) diagnosis and Global Assessment of Functioning (GAF)/Children's Global Assessment Scale (CGAS) criteria (B qualifiers not applicable) **and all** components of medical necessity:

   a. The individual's impairment(s) and corresponding need(s) must be the result of the mental illness.
   b. The intervention is deemed reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness.
   c. The individual is expected to benefit from the intervention.
   d. The individual's unmet need(s) would not be more appropriately met by any other formal or informal system or support.

And/or one or more of the following:

1. Individual is engaged in a transition to discharge plan. If the transition plan is successful, the individual will be discharged from the episode of care within 90 days of the initiation of the transition to discharge plan. If the individual's condition changes during the course of the transition, such that continued treatment is determined to be medically necessary, a review of the Recovery/Resiliency Plan will occur and a revised plan will reflect the purpose of ongoing care.
2. Although the individual's functioning has improved and exceeds the GAF/CGAS standard, continued treatment is deemed medically necessary to prevent deterioration as evidenced by previous documented unsuccessful efforts at discharge.
3. Although the individual's functioning has improved, they have needs, which cannot be met by any other system or resource other than NSMHA-funded mental health and, if unmet, would result in deterioration of functioning and likely re-admission.
4. Individual has a current Less Restrictive (LR) Court Order or Conditional Release (CR) in place.

Role of Provider (each NSMHA contracted provider will):

1. Comply with NSMHA mechanisms to ensure consistent application of review criteria for re/authorization decisions, including consultation with NSMHA when appropriate.
2. Identify, define and specify the amount, duration and scope of each service the individual will receive in collaboration with the individual.
3. Provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
4. Ensure services are provided in accordance with NSMHA's level of care guidelines as medically necessary and are not arbitrarily denied or reduced, (for example, the amount, duration, or scope of a required service) based solely upon diagnosis, type of mental illness, or the individual's mental health condition.
5. Submit requests and supporting documentation in a timely manner so NSMHA may comply with specified timeframes for decisions as required by federal and state standards.

Role of NSMHA:

1. Ensure consistent application of review criteria for authorization decisions and not arbitrarily deny a service authorization request.
2. Ensure services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
3. Not deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or mental health condition of the individual.
4. Ensure authorization of a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the individual's condition or disease.

5. NSMHA will comply with specified timeframes for decisions as required by federal and state standards.
6. NSMHA will provide for standard and expedited re/authorization decisions and notices per required timeframes.
7. NSMHA may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity; or for the purpose of utilization management, provided the services furnished can reasonably be expected to achieve their purpose, as required by federal and state standards. NSMHA and its contractors will consider what constitutes "medically necessary services" in a manner that is no more restrictive than that used in the Washington Apple Health program as indicated in State statutes and regulations, the State Plan and other State policy and procedures. NSMHA, in accordance with these regulations, is responsible for covering services related to the following:

   a. The prevention, diagnosis and treatment of health impairments.
   b. The ability to achieve age-appropriate growth and development.
   c. The ability to attain, maintain, or regain functional capacity.

8. NSMHA will ensure compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any individual.

PROCEDURE

Authorization

Based upon information from the completed intake assessment, the provider requests from NSMHA either authorization or adverse determination.

Request for Authorization

1. If, upon completion of the intake assessment, the BHA clinician believes ACS and medical necessity are met, the BHA shall transmit a completed electronic request for authorization per NSMHA data dictionary including, but not limited to: diagnoses, eligibility criteria, and identified Level of Care to NSMHA. If necessary, NSMHA staff will request additional clinical information to justify the authorization.

   a. Standard authorization requests shall be sent to NSMHA within 14 calendar days of the individual's request for service. If the assessing clinician cannot complete the initial assessment within the first 14 calendar days, the individual or the assessment clinician may request an extension of up to an additional 14 calendar days.
   b. For expedited authorizations, phone notification shall be made to NSMHA (360-416-7013) to alert them to the need for immediate review. Phone notification shall be followed by faxing the authorization request and assessment to NSMHA (360-416-7017) for review within 3 working days of the individual's request for service. Expedited authorization requests (electronic) must be sent to NSMHA in addition to the phone and fax process. This timeframe may be extended by an additional 14 calendar days if requested by the individual consumer.
   c. If a diagnosis is Provisional, per Diagnostic and Statistical Manual (DSM) standards, this identification must be included in the electronic authorization request. This information should be included in the "Additional Information to Consider" field of the Additional Authorization Information transaction and should identify the specific diagnosis and diagnosis code that is provisional.
   d. State funded individuals need the following additional information to accompany the request:

   i. Identification of priority population category per NSMHA Policy 1574.
   ii. Explanation for any requested authorization period longer than three (3) months.

2. All persons who meet the financial criteria, ACS and medical necessity criteria are authorized by NSMHA within 1 business day of the receipt of the authorization request whenever possible or, at the most, within 14 calendar days of receipt of the request. NSMHA will notify the individual and provider of all authorizations and their benefits.

   a. If authorized, the person is accepted into services and appropriate appointments are made as expeditiously as the individual's health condition requires with the first ongoing appointment to occur no later than 28 calendar days from the request for service.
   b. There are some services that require additional criteria be met and/or may not be available immediately due to capacity limitations (e.g., Residential, Program for Assertive Community Treatment (PACT), Intensive Outpatient Program for Adults (IOP), WISe (Wraparound with Intensive Services)).
   c. Authorization periods do not exceed one year. The following groups of individuals will be authorized for the period specified:

      i. State funded individuals – see NSMHA Policy 1574.
      ii. Individuals with Washington Apple Health who are identified as needing services at a Level of Care (LOC) 1 or 2 at the initial authorization are authorized for a period up to 6 months.

   d. The requested authorization start date may not precede the first day of the month prior to the month the authorization request is received. Any requests received with an earlier start date shall be modified by NSMHA.

3. If NSMHA reviewers deny a service authorization request or authorize a service in an amount, duration, or scope that is less than requested, they will notify the requesting provider and give the individual written notice in sufficient time to ensure state-established timeframes are met.

   These decisions will be made by a NSMHA staff who meets the requirements of a Mental Health Care Professional (MHCP) and who has appropriate clinical expertise to make the decision.

Request for Adverse Determination

1. If, upon completion of the intake assessment, the provider believes ACS and medical necessity are not met, they will send the intake assessment form, Access call sheet and any other available documentation or medical records reviewed in the assessment process to NSMHA staff with the completed NSMHA Denial Review Request form within 14 calendar days (standard) or within 3 working days (expedited) from the initial request for service.
2. NSMHA staff will review the documentation and determine whether or not to authorize services.

   a. If services are authorized, NSMHA staff will notify the individual and provider of the decision to authorize services. The individual will be notified of their benefit package.
   b. If no services are authorized, NSMHA will notify the requesting provider and give the individual written notice in sufficient time to ensure state-established timeframes are met.

<u>Reauthorization</u>

While the MHCP and individual review progress toward the individual's Recovery/Resiliency Plan (RPP) goals routinely throughout the course of treatment, for individuals whose current authorization is about to expire, the MHCP must ensure the RRP review is conducted within 45 days of the current authorization's

expiration. Based upon this review, the MHCP shall determine re/authorization of services is warranted or determine transition to discharge should begin if it hasn't already.

Request for Reauthorization

1. If, upon completion of the RRP review, the provider believes Continued Stay Criteria are met, they will transmit a completed electronic request for re/authorization per NSMHA's data dictionary including, but not limited to: diagnoses, eligibility criteria and identified Level of Care to NSMHA within the two (2) week period prior to the expiration of the current authorization. If necessary, NSMHA staff will request additional clinical information to justify the reauthorization.

    a. If a diagnosis is Provisional, per DSM standards, this identification must be included in the electronic authorization request as noted in the request for authorization above. However, it should be noted provisional diagnoses are generally expected to be clarified by the re/authorization request.
    b. State funded individuals need the following additional information to accompany the request

        i. Identification of priority population category per NSMHA Policy 1574.
        ii. Explanation for any requested re/authorization period longer than three (3) months.

2. All persons who meet the financial criteria and Continued Stay Criteria are authorized by NSMHA within 1 business day of the receipt of the authorization request whenever possible or, at the most, within 14 calendar days of receipt of the request. NSMHA will notify the individual and provider of all authorizations and their benefits within 14 calendar days of the decision.

    a. There are some services that require additional criteria be met and/or may not be available immediately due to capacity limitations as noted previously in the request for authorization above.
    b. Authorization periods do not exceed one (1) year. The following groups of individuals will be authorized for the period specified:

        i. State funded individuals – see NSMHA Policy 1574.
        ii. Individuals with Washington Apple Health identified as needing services at a LOC 1 or 2 who meet the following criteria shall be authorized utilizing an alternate reauthorization review process.

            1.) Current LOC 1 or current LOC 2 and was LOC 2 in previous authorization period; and,
            2.) Meet criteria from Category 1 and/or Category 2

                a.) Category 1 – No inpatient, crisis, or jail services since the last authorization period AND current treatment episode is less than two (2) years.
                b.) Category 2 – Individuals who do not have an "A" diagnosis per ACS.

            3.) Alternate re/authorization review process

                a.) On a monthly basis, NSMHA shall generate a report of individuals by BHA who meet the above criteria.

b.) The report shall be generated and sent by the 10th of each month to each BHA for those individuals whose authorization is due to expire the following month.

c.) BHA staff shall review each chart on the report and, for those individuals who meet reauthorization criteria, the BHA reviewer shall sign and date the report certifying the individual meets criteria for reauthorization for up to six months of ongoing services or up to 90 days to transition out of services. This signed and dated certification must be returned to NSMHA prior to submission of the reauthorization request in order for a determination to be made by NSMHA. Any request for reauthorization for which certification has not been received will be considered as a request sent in error and shall be decertified.

c. The requested start date of an authorization may not precede the first day of the month prior to the month the authorization request is received. Any requests received with an earlier start date shall be modified by NSMHA.

3. If NSMHA reviewers deny a service reauthorization request or reauthorize a service in an amount, duration, or scope that is less than requested, they will notify the requesting provider and give the individual written notice in sufficient time to ensure that state-established timeframes are met.

   These decisions will be made by a NSMHA staff who meets the requirements of a Mental Health Professional (MHP) and who has appropriate clinical expertise to make the decision.

Discharge from Treatment

If, upon completion of the RRP review, the MHCP believes Continued Stay Criteria are not met, the MHCP shall transition the individual toward planned discharge per NSMHA Policy 1540 Discharge from Treatment.

If the individual doesn't agree with planned discharge, see NSMHA Policies 1551 Recovery/Resiliency Plans and 1005 Notice Requirements for additional information.

Timelines for Standard and Expedited Re/authorization Decisions

Standard re/authorization decisions

For standard re/authorization decisions, provide notice as expeditiously as the individual's health condition requires and within state-established timeframes that may not exceed 14 calendar days following receipt of request for service (for re/authorizations this is 14 calendar days following receipt of the reauthorization request), with a possible extension of up to 14 additional calendar days*, if the individual or the provider requests extension. NSMHA will automatically approve without advance notice any extension request by an individual or provider. An extension may also be obtained if NSMHA justifies (to the Department of Social and Health Services (DSHS) upon request) a need for additional information and how the extension is in the individual's interest.

Expedited re/authorization decisions

For cases in which a provider indicates, or NSMHA or its designee determines that following the standard timeframe could seriously jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function, NSMHA must make an expedited re/authorization decision and provide notice as expeditiously as the individual's health condition requires and no later than 3 working days following receipt of the request for service (for re/authorization this is 3 working days following receipt of the reauthorization request). NSMHA may extend the 3 working days' time period by up to 14 calendar days

if the individual requests an extension*. NSMHA will automatically approve, without advance notice, any extension request by an individual or provider. An extension may also be obtained if NSMHA justifies (to DSHS upon request) a need for additional information and how the extension is in the individual's interest.

*When calculating the number of days from the request for service, the first day is the day after the request for service. For example, the request for service is received on January 14th a standard decision must occur by or on January 28th. For a request that comes in on a Thursday and is identified as expedited, the assessment and authorization decision must be completed by the end of the following Tuesday.

Extensions

Extensions are expected to be utilized only in rare circumstances and must be of benefit to the individual. When an extension is utilized, the BHA must document a rationale for the extension in its authorization (in the Additional Authorization Information transaction) or adverse determination request (on the Denial Review Request form) to NSMHA. NSMHA will monitor the use and pattern of extensions and apply corrective action where necessary.

Change in Mental Health Coverage

Attainment of Coverage

For individuals who become NSMHA-eligible while already in treatment with a provider agency, a current diagnostic justification must be present in the clinical record. The current assessment and RRP must meet or be updated to meet DSHS and NSMHA standards. Authorization for services will be submitted to NSMHA within 14 days of the time the provider becomes aware of the change in payer/NSMHA eligibility. Providers are responsible for ensuring the appropriate funding source is charged for services depending upon the individual's financial eligibility.

Loss of Coverage or Change in Payer

For individuals for whom NSMHA is no longer the payer*, the BHA must request termination of NSMHA authorization by the 10th of the month following the discontinuation of NSMHA as payer. In addition, the BHA shall not submit encounters' to NSMHA from the date the BHA determines NSMHA is no longer the payer.

*NSMHA is the payer as identified in ProviderOne or when the individual is eligible for use of NSMHA state funds (see NSMHA Policy #1574).

To request a termination of a current NSMHA authorization, the BHA sends a 278 Authorization Request transaction. Upon receipt of this request, NSMHA shall terminate the authorization and send a Notice to the individual.

ATTACHMENTS

None

North Sound Mental Health Administration

Section 1500 – Clinical: Resiliency/Recovery Plans (Individual Service Plans)

Authorizing Source: WAC 388-865-0425, WAC 388-865-0405(5); U.S. Code Title 20, Chapter 33, Subchapter III, Section 1436
Cancels:
See Also:
Providers must comply with this policy and individualized implementation guidelines may be developed by CMHAs
Responsible Staff: Deputy Director

Approved by: Executive Director
Signature:

Date: 8/29/2014

POLICY# 1551.00

SUBJECT: RESILIENCY/RECOVERY PLANS (INDIVIDUAL SERVICE PLANS)

PURPOSE

To ensure development of the Resiliency/Recovery Plan (also referred to as an Individual Service Plan) is a collaborative effort between the individual, or individual's parent or legal representative if applicable, and Mental Health Care Provider (MHCP) that results in a person-centered, strength-based plan that meets the individual's unique mental health needs.

POLICY

The term Individual Service Plan (ISP) is terminology utilized in Washington Administrative Code (WAC). While it is acceptable to use this terminology, NSMHA strongly encourages providers to use the term Resiliency or Recovery Plan or similar terminology (e.g., Individual Recovery Plan or Wraparound Plan). These terms better reflect the region's focus on integrating the fundamentals of recovery as found in the National Consensus Statement on Mental Health Recovery. Further, plans shall reflect the principles and fundamentals found in the NSMHA *Guidelines to Person-Centered Recovery and Resiliency* (contained within the NSMHA Clinical guidelines http://www.nsmha.org/PDFs/Clinical_Guidelines/Clinical_Guidelines_Manual.pdf).

Individual recovery planning is an ongoing, dynamic process that begins at the intake assessment. A clearly articulated plan provides the following benefits to the individual and the treatment team:

1. Serves as a roadmap for the individual and the treatment team, providing direction and allowing the team and individual or family to evaluate progress toward the resiliency/recovery goals and desired outcomes (i.e., objectives that once met indicate discharge criteria) and the effectiveness of interventions;
2. Supports the individual as he/she works through his/her personal resiliency/recovery process;
3. Documents both individual and provider responsibilities towards resiliency/recovery.

Resiliency/Recovery Plans (RRPs) reflect:

1. Goals that address individual needs identified at intake and throughout the treatment episode. This may include, but is not limited to:
    a. Mental health needs (i.e., related to diagnosis) necessitating current treatment episode;
    b. Non-mental health needs requiring referral and support;
    c. Risk factors;
    d. Rationale for deferring treatment/referral of a need.
2. Individual's stated resiliency/recovery goals and desired outcomes (discharge criteria).
3. Interventions and services that are resiliency/recovery-oriented and can reasonably be expected to assist the individual in achieving his/her goals.

PROCEDURE

The Behavioral Health Agency (BHA) must have a person-centered, strengths-based RRP that meets the individual's unique mental health needs and promotes the individual's resiliency and recovery. The plan must be developed in collaboration with the individual, or the individual's parent or other legal representative if applicable and a copy provided to the individual. The plan must:

1. Be developed within thirty days from the first session following the intake evaluation.
2. Document that the MHCP collaborating on the plan is a Mental Health Professional (MHP) or that the plan has been reviewed by a MHP (i.e., signature of MHP on the plan).
3. Address the individual's unique needs including, but not limited to:
   a. Identified mental health needs including information and education about the individual's mental illness.
   b. Age, gender, cultural and/or disability strengths or issues identified by the individual, or their parent or other legal representative if applicable, as relevant to treatment.
   c. Identified needs beyond mental health needs such as physical health care, substance use, daily activity needs such as employment and education.
4. Identify and incorporate specific strengths and resources in a way that actively supports the individual in recovery/resiliency.
5. Include resiliency/recovery objectives that are measurable and that allow the MHCP and individual to evaluate progress.
6. Identify medically necessary service modalities, mutually agreed upon by the individual and MHCP, for this treatment episode.
7. Demonstrate the individual's participation in the development of the plan.*
   a. The plan includes at least one goal/objective identified by the individual or parent/legal representative if applicable.
   b. The plan includes the individual's signature and/or quotes documented in the plan.
   c. Be in language and terminology that is understandable to the individual and his/her family.
   d. Participation must include family or significant others as requested by the individual or as applicable for individuals under 13 or who have a legal representative.

      For individuals 13-17 for whom the parent/legal representative has consented to treatment when the individual has not (see statutes on Parent-Initiated Treatment), there is evidence that the RRP was developed collaboratively with the parent/other legal representative even if the individual has refused.
8. Include coordination goals/objectives with any other systems or organizations when required or that the individual identifies as being relevant to his or her treatment with the individual's consent or their parent or other legal representative, if applicable. This includes, but is not limited to:
   a. Coordination with any Individualized Family Service Plan (IFSP) when serving children less than three years of age.
   b. Education and/or employment system
   c. Children's Administration
   d. PCP and other health care providers
   e. Department of Corrections
   f. Substance use treatment provider

9. Contain crisis planning for all individuals Level 4 and up (as identified by Child and Adolescent/Level of Care Utilization System – CA/LOCUS) and all other individuals as clinically indicated including but not limited to individuals who:

   a. Experience an episode of decompensation,
   b. Use the emergency department frequently and/or inappropriately,
   c. Have multiple contacts with the crisis system (excluding the crisis line),
   d. Experience psychiatric hospitalization,
   e. Experience incarceration.

   The crisis plan may be a separate document from the RRP. Elements of a thorough crisis plan include:

   a. Individual and family voice.
   b. Focus on health and safety of individual, family and others (e.g., natural supports, professionals). May include, but not be limited to, information about:

      i. Self harm
      ii. Harm to others (e.g., assaultiveness, sexual aggression, criminal behavior)
      iii. Previous psychiatric hospitalizations
      iv. Emergency department usage
      v. Ability and willingness to take medication, list of current medications as applicable
      vi. Substance use - current and historical
      vii. Medical conditions
      viii. Developmental issues

   c. Roles, directives and responsibilities of individual and family and others.
   d. Early warning signs of decompensation.
   e. How to contact both formal and natural supports (contact phone number for MHCP and Crisis Line at minimum).
   f. Proactive and progressive measures, by the individual as well as informal and formal supports, to prevent a crisis.
   g. Proactive and progressive measures, by the individual as well as informal and formal supports, for intervening in a crisis.

10. Include documentation that the individual's plan was reviewed at least every 180 days and as necessary updated sooner to reflect any changes in the individual's treatment needs or as requested by the individual or their parent or other legal representative, if applicable.
11. Progress notes shall clearly reflect provision of treatment consistent with the RRP.
12. The treatment proposed and provided is consistent with NSMHA clinical guidelines. In the absence of a NSMHA clinical guideline, treatment follows generally accepted clinical practice for the individual's diagnosis.

<u>*Disagreement with Resiliency/Recovery Plan</u>

As the plan is developed collaboratively, disagreements over various aspects of the plan may arise. Some of these disagreements are considered expression of dissatisfaction with NSMHA-related services and would follow the grievance process when applicable. However, disagreements regarding service type and intensity that cannot be resolved result in an Action (Disagreement with the Treatment Plan) and require a Notice be sent. Issuance of Notices, resulting from Disagreement with the Treatment Plan actions, is delegated by NSMHA to BHAs.

A disagreement about the RRP occurs when the individual refuses to sign the plan *because* of disagreement with the plan or when the individual verbally states disagreement with the plan. Please note there are limitations of an individual on a Less Restrictive Court Order (LRO) or Conditional Release (CR) to disagree with aspects of the RRP that are directed in the court order (refer to the individual's court order to determine how this issue may apply to a specific individual). When disagreements regarding service type and intensity occur, attempts to resolve the disagreement prior to issuing a Notice are expected to be offered by the BHA.

1. The MHCP and/or supervisor shall offer to discuss and attempt resolution of the disagreement within 30 days of disagreement.
2. If the individual refuses to discuss with the MHCP and/or supervisor or resolution does not occur, the BHA shall offer a second opinion or Level 1 (provider level) grievance to the individual. These processes should follow their required timelines as noted in policy (see NSMHA Policies 1002 Grievances and 1520 Second Opinion).
3. If the individual refuses a second opinion or Level 1 (provider level) grievance or these processes do not resolve the disagreement, the BHA designee shall review the disagreement and issue a Notice if he/she determines the issue cannot be resolved at the BHA level within 14 calendar days of refusal or completion of the previous step.

    a. Any issuance of a Notice by a BHA must be completed by the BHA's designee.
    b. Individuals covered by Medicaid receive a Notice of Action; individuals covered by state funds receive a Notice of Adverse Determination.
    c. The Notice shall identify specifically what the individual is disagreeing with and what his/her desired outcome is.
    d. A copy of any Notice issued is sent to NSMHA within one business day.

ATTACHMENTS

None