COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY AND PROCEDURES MANUAL				
Chapter **Program Quality**	**Section** **Provider Network Management**	**Chapter** **05**	**Section** **05**	**Subject** **13**
Subject **Network Provider Grievance and Dispute Resolution Process-Non-Compliance, Competence, or Conduct**	**Authorization**		**Approved: 01/30/18** **Replaces: None**	

Reviewed/No Updates: December 2020; Updated March 2022

I. PURPOSE: To outline a mechanism for participating provider grievances (complaints) and requests for reconsideration of decisions (appeal) relating to provider network management issues, including their status within the provider network and actions related to provider's non-compliance, professional competency, or conduct. These actions may include decisions made when CMHA has chosen to discontinue a provider's participating status with CMHA based on issues of quality of care/service, performance or non-compliance, or deny a provider's application as a paneled provider. It also includes action taken as a result of any other breaches highlighted in the contract as a "material breach" and a potential cause for termination such as discrimination, non-compliance with applicable laws, non-compliance with consumers' recipient rights and consumer grievance procedures, etc.

II. APPLICATION: All providers employed, contracted, or subcontracted by CMHA.

III. DEFINITIONS:

A. Grievance/Complaint: A formal complaint made on the basis of something that somebody feels is unfair.

B. Individually Licensed Provider: An individual employed or contracted by CMHA to provide behavioral health care, support, or services who has met the qualifications evidenced by education, training, certification, registration, or experience.

C. Organizational Providers (Facilities): Providers with whom CMHA contracts that directly employ and/or contract with individual practitioners to provide behavioral health care services. Examples of organizational providers include, but are not limited to: other Community Mental Health Services Programs; psychiatric hospitals; and specialized residential providers.

D. Specialized Residential Providers: Licensed foster care homes operating with a specialized certification from the Department of Consumer and Industry.

E. Sub-Contractor: A secondary contract in which the provider originally contracted with in turn contracts with another individual or entity to provide all or part of the work or service.

IV. POLICY: CMHA implements a process to address provider grievances and offers a dispute resolution process. CMHA reserves the right to limit the number of providers of any particular service.

V. PROCEDURE: *Please Note: The dispute resolution process does not apply to medical necessity appeals (which are covered under a separate policy) or conditions dictated in the provider contract that result in immediate termination or suspension, such as:*

a) *Revocation, restriction, suspension, discontinuation or loss of required certification, accreditation, authorization or license required by any federal or State local law, ordinance, rule or regulation to operate and/or provide services in this Network or the exclusion, debarment or suspension from participation in any federal or State health care programs*

b) *An appeal of contract termination shall have no effect on the immediate termination of the contract and services under contract. The termination will remain in effect until the appeal process is completed and will be rescinded only if the termination is not upheld on the appeal.*

c) *The right to appeal will be included in each provider contract and reference by policy.*

See the provider contract for a full listing of conditions for immediate termination.

A. A provider wanting to file a formal administrative grievance/complaint may do so by e-mailing CMHA's Contract Manager at contractmgr@gccmh.org.

B. If an organizational provider, group, or individually licensed provider disagrees with a determination by CMHA in the application process or during a review of a provider's status, and wishes to initiate the grievance and appeal process, the provider may do so by submitting a written request to the Chief Executive Officer within thirty (30) days of disposition. The request must include the following (see Provider Appeal/Dispute Resolution Request form):

a) Reason for dispute;

b) Documentation to support the dispute.

C. All provider appeals must be received, in writing, within 30 days of notification of the action that is being appealed. Supporting documents, written statements, and other documentation that support the appeal may accompany the appeal request. The request for appeal may be mailed, faxed or emailed to:

Gogebic Community Mental Health Authority
Attn: Chief Executive Officer
103 West US2
Wakefield, MI 49968
Fax: (906) 229-6190Email:
mhall@gccmh.org

D. A first-level review will be conducted within twenty (20) calendar days of receipt of the provider request by a panel of at least three (3) qualified individuals not involved in previous decisions relating to this grievance. At least one (1) member will be a participating provider not involved in the day-to-day operations of CMHA network

management and who is a peer of the participating provider that filed the dispute. Members of CMHA's Credentialing Committee may be used for this level review.

E. If the first-level review is not satisfactory and there is additional information to be considered from the provider, a second-level review may be requested by submitting written request for a second-level review to CMHA's CEO within 14 days of disposition from first level review.

F. Consideration by a second-level review will be conducted within 14 calendar days of the request by provider by a panel of at least three (3) qualified individuals not involved in previous decisions relating to this grievance. At least one (1) member will be a participating provider not involved in the day-to-day operations of CMHA network management and who is a peer of the participating provider that filed the grievance. Members of CMHA's Quality Improvement/Utilization Management Committee may be used for this level review.

G. After formal review of the grievance, a written summary of CMHA's examination and outcome will be given to the provider, within 14 calendar days of completion.

H. The decision of the review panel (second-level review) shall be the final CMHA position regarding the grievance.

I. Any corrective action plan issued by CMHA regarding action being appealed shall be on hold pending the final CMHA decision regarding the grievance.

J. An emergent request shall be processed within five (5) business days.

K. If a contract provider has been issued a dismissal notice from the CMHA network, then the contract provider is considered participating up through the last day of participation as indicated on the notice unless the notice is received on or after the last participation day, in which case the provider must be given reasonable time to initiate the appeal mechanism.

VI. REFERENCES AND LEGAL AUTHORITY: CARF Behavioral Health Standards; Balanced Budget Act of 1997, 438.214(b)(2); URAC Health Plan Standards, as applicable; Medicaid Provider Manual; NorthCare/CMHSP Delegation Agreement; MDHHS/PIHP Master Contract (Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program), Section 7.1, Medicaid Sub-Contracting Agreement (PIHP/CMHSP Contract) Section XII

VII. EXHIBITS: Provider Appeal/Dispute Resolution Request