SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY

NUMBER: BA040

NAME: GRIEVANCES, APPEALS AND SECOND OPINIONS

INITIAL APPROVAL DATE:	10/31/1995	BY: Sanilac CMH Board
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I. APPLICATION

Populations: **ALL**
Programs: **Direct - ALL**
Contracted – ALL

II. POLICY

It is the policy of Sanilac CMH that a grievance and appeal system will be established and maintained and that it will be in full compliance with Region 10, state and federal regulations, in order to ensure all individuals served have the right to a fair and efficient process for resolving disagreements regarding their services and supports. A recipient of, or applicant for, public mental health services may access several options to pursue the resolution of disagreements. It is the policy of Sanilac CMH to follow all Region 10, state and federal regulations regarding the resolution of complaints and disputes that individuals may have about their services and supports.

This policy and any corresponding policies in no way requires the enrollee to utilize the grievance or appeal processes prior to the filing of a Recipient Rights Complaint pursuant to Chapter 7 and 7a of the Michigan Mental Health Code and affiliate policies relative to the filing of Recipient Rights Complaints.

III. DEFINITIONS

1. Access: The initial point of contact for applicants to request mental health and substance use disorder services and supports.
2. Adverse Benefit Determination: A decision that adversely impacts an enrollee's claim for services due to:
    a. Denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
    b. Reduction, suspension, or termination of a previously authorized service.
    c. Denial, in whole or in part, of payment for a service.
    d. Failure to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service authorization.

DEFINITIONS cont.

e. Failure to make an expedited authorization decision within 72 hours from the date of receipt of a request for expedited service authorization.
f. Failure to provide service within 14 calendar days of the start date agreed upon during person-centered planning and as authorized by the PIHP.
g. Failure of the PIHP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal.
h. Failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal.
i. Failure of the PIHP/CMH to provide disposition and notice of a grievance/complaint within 90 calendar days of the date of the request.
j. For residents of a rural area with only one provider, the denial of an Enrollee's request to exercise his/her right to obtain services outside the network.
k. Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibilities.

3. Adequate Adverse Benefit Determination Notice: Written statement advising the Enrollee of a decision to deny or limit the authorization of CCBHC or Medicaid program services requested. Notice is provided to the Medicaid Enrollee **on the same date the action takes effect**.
4. Advance Adverse Benefit Determination Notice: Written statement advising the Enrollee of a decision to reduce, terminate, or suspend CCBHC or Medicaid program services currently provided. Notice is provided to the Enrollee **at least 10 calendar days prior to the proposed date the action is to take effect**.
5. Appeal: A review at the local/regional level by a PIHP/CMH of an Adverse Benefit Determination. This is handled by the PIHP for Medicaid enrollees and by Sanilac CMH for non-Medicaid individuals. An impartial local review of an individual's appeal of an Adverse Benefit Determination action presided over by Sanilac CMH staff who are not involved in the previous level of review.
6. Applicant: A person, or his/her legal representative, who makes a request for mental health or substance use disorder services.
7. Authorization of Services: The processing of requests for initial and continuing service delivery.
8. CCBHC: Certified Community Behavioral Health Clinic
9. Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP/CMH, including CCBHC and Medicaid Enrollees, and all other recipients of PIHP/CMH services.
10. Enrollee: An individual who has been determined eligible for CCBHC or a Medicaid program and who is receiving or may qualify to receive CCBHC or Medicaid program services through a PIHP/CMH.
11. Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by an Enrollee or the Enrollee's provider, when the time necessary for the normal appeal review process could seriously jeopardize the Enrollee's life or physical or mental health, or ability to attain, maintain, or regain maximum function. If the Enrollee requests the expedited review, the PIHP determines if the request is warranted.
12. Grievance: CCBHC or a Medicaid Enrollee's expression of dissatisfaction about PIHP/CMH service issues, other than an Adverse Benefit Determination, as defined above. Possible subjects for grievances include but are not limited to, quality of care or services

provided aspects of interpersonal relationships between a service provider and the Enrollee, failure to respect the Enrollee's rights regardless of whether remedial action is requested, or the right to dispute an extension of time proposed by the PIHP/CMH to make an authorized decision.

13. Grievance Process: Impartial review of a CCBHC or a Medicaid Enrollee's grievance (expression of dissatisfaction) about PIHP/CMH service issues.
14. Grievance and Appeal System: The process the PIHP/CMH implements to handle appeals of Adverse Benefit Determinations and grievances, as well as the processes to collect and track information about them.
15. Hearing Officer: Staff person assigned to represent the PIHP/CMH at a State Fair Hearing.
16. Medicaid Services: Services provided to an Enrollee under the authority of the Medicaid State Plan, Habilitation Supports Waiver, and/or Section 1915(i) SPA.
17. Mental Health Professional: A person who is trained and experienced in the area of mental illness or intellectual/developmental disabilities, as identified per MDHHS staff qualification criteria.
18. Notice of Resolution: Written statement of the PIHP/CMH as to the resolution of a Grievance or Appeal, which must be provided to the Enrollee, as described in 42CFR 438.408.
19. Organizational Provider: Entities under contract with the PIHP/CMH that directly employ and/or contract with individuals to provide specialty services and supports. Examples of organizational providers include, but are not limited to other CMHs, hospitals, psychiatric hospitals, partial hospitalization programs, case management programs, specialized residential homes, assertive community treatment programs, and skill building programs.
20. PIHP (Prepaid Inpatient Health Plan): An organization that manages the CCBHC and Medicaid mental health, intellectual/developmental disabilities, and substance abuse services in their geographic area under contract with the State.
21. Recipient Rights Complaint: Written or verbal statement by a person receiving services, or anyone acting on behalf of the person receiving services alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through processes established in Chapter 7a.
22. Second Opinion: A request for another assessment by an applicant who has been denied mental health services or a recipient who is seeking and has been denied hospitalization.
23. Service Authorization: PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as requested under the applicable law.
24. State Fair Hearing: Impartial state level review for a CCBHC or a Medicaid Enrollee's appeal of an Adverse Benefit Determination, presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing".
25. Substantiated: The decision that there is sufficient evidence to support the enrollee's expression of dissatisfaction and merit for the grievance.
26. Supervisor: For the purpose of this policy and related policies, a supervisor can be at any level (e.g. the supervisor's supervisor).
27. Unsubstantiated: The decision that there is not sufficient evidence to support the enrollee's expression of dissatisfaction and merit for the grievance.

IV. STANDARDS

1. GENERAL

a. Recipients of publicly funded services may access several options to pursue the resolution of complaints. These options may include the right to file a local appeal, grievance, or a Recipient Rights Violation complaint. Options may also include the right to request a second opinion or a State Fair Hearing.
b. During the initial contact with Access and Sanilac CMH, the applicant will be provided information on the Grievance and Appeal System.
c. Individuals who wish to file a complaint may do so independently or with the assistance of Customer Services, other available staff, or a person of their choosing. A provider may not refuse to assist the individual who needs help filing a complaint and submitting that complaint for resolution.
d. Should an individual involved with this process have limited-English proficiency, the PIHP/CMH/organizational providers will take necessary and reasonable steps to make any accommodations.
e. PIHP/CMH must provide information about the grievance system to all providers and subcontractors at the time they enter into a contract.
f. Individuals denied entrance into Sanilac CMH services receive written notification of the right to request a Second Opinion.
g. The PIHP has delegated certain functions of the grievance and appeal process to both CMH and SUD providers, as defined in the PIHP/Provider contractual agreements. These functions are formally monitored by the PIHP on both an ongoing and annual basis.

2. NOTICE

a. The CMH, PIHP and organizational providers will utilize the Notice of Adverse Benefit Determination as approved by the PIHP, for any determinations that adversely impact enrollees' services or supports. Notices must meet the language format needs of the Enrollee, as specified in 42CFR 438.10. Enrollee notice must be in writing and must include:
    i. The Adverse Benefit Determination description that has been taken or is proposed;
    ii. The reason for the Adverse Benefit Determination, including the policy/authority relied upon for the decision;
    iii. The effective date of the action;
    iv. The right to file an Internal Review/Local Level Appeal through the PIHP Grievance and Appeal Office and instructions for doing so;
    v. The circumstances under which an expedited appeal can be requested and instructions for doing so;
    vi. A description of the procedures that the Enrollee is required to follow to exercise any of these rights (42CFR 438.404(b)(4));
    vii. An explanation of how the Enrollee may represent him/herself or use legal counsel, a relative, a friend, or other spokesman;
    viii. The right for the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination (including medical necessity criteria, and processes, strategies, or evidentiary standards used in setting coverage limits);
    ix. The Enrollee's right to have benefits continued pending resolution of the Appeal; instructions on how to request benefit continuation, and a

description of the circumstances under which the Enrollee may be required to pay the costs of the continued services. (Advance Notice only).

x. That 42CFR440.230 (d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

3. **GRIEVANCE**
    a. Grievances must be resolved within 90 calendar days of the date of the request.
    b. A grievance may be filed at any time.
    c. A grievance may be filed by the Enrollee, guardian, parent of minor child or legal representative, or provider with written permission from the consumer indicating the wish to file a grievance.
    d. A grievance may be filed orally or in writing and then logged into the system.
    a. Acknowledgment of the grievance will be provided within 5 business days. (42 CFR 438.406(b)(1).
    b. All grievances must be documented in the "Grievance Module" of the Electronic Medical Record, e.g. Enrollee's access to the State Fair Hearing process respecting grievances is only available when the PIHP fails to resolve the grievance and provide resolution within 90 calendar days of the date of request.
    c. The PIHP has delegated the processing (acknowledgement, investigation, and resolution) of mental health service-related grievances to the CMH as defined in contract language.
    d. The CMH and PIHP shall designate at least one staff person to be responsible for facilitating the resolution of grievances.
    e. A Resolution of Notice containing the results of the grievance process shall be provided.
    f. Grievance records shall be maintained in the CMH EMR or PIHP MIX module for review.

4. **APPEAL**
    a. Enrollees may pursue the option to dispute any Adverse Benefit Determination.
    b. The CMH/PIHP Appeal is the first step of an appeal and must be completed prior to the State Fair Hearing.
    c. Enrollees are given **60 calendar days** from the date of the Notice of Adverse Benefit Determination to request the Appeal.
    d. The Enrollee may request an Appeal either orally or in writing. The CMH/PIHP must provide that oral inquiries seeking to appeal an Adverse Benefit Determination are treated as requests for filing to establish the earliest possible filing date for the appeal.
    e. An organizational provider may file an appeal on behalf of the Enrollee, as long as it has written permission from the Enrollee. The CMH/PIHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an Enrollee's appeal. The provider may not request service continuation on behalf of the Enrollee.
    f. Upon request, Enrollees will be given assistance from staff in the filing process, including explanation of process and/or completing forms. This also includes, but is not limited to interpreter services, auxiliary aids and services upon request, and toll-free numbers with interpreter capabilities.

g. Enrollees may request an expedited appeal. Documentation must show that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum functioning.
    i. If there is a denial of a request for the expedited appeal the CMH/PIHP shall:
        1. Transfer the appeal to the timeframe for standard resolution.
        2. Make reasonable efforts to give the Enrollee prompt oral notice of the denial and follow up **within two (2) calendar days** with a written notification.
        3. Provide the Enrollee the option to file a Grievance about the denial of the expedited appeal request.
    ii. If the request is granted, the CMH/PIHP shall resolve the Appeal and provide Notice of Resolution **within 72 hours after the CMH/PIHP receives the request**.
h. The CMH/PIHP may extend the timeframe of resolution of appeal if evidence can prove the need for additional information will benefit the Enrollee. All of the following must be met:
    i. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;
    ii. **Within 2 calendar days**, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision;
    iii. Resolve the Appeal as expeditiously as the Enrollee's health condition requires **but not to exceed 30 calendar days**.
i. Enrollees must be provided a reasonable opportunity to present evidence, testimony and allegations of fact or law, in person as well as in writing. In the case of an expedited request, the Enrollee must be notified of the limited time available.
j. Enrollees and/or Representative must be allowed the opportunity, before and during the appeal process, to examine the Enrollee's case file, including medical records and any other documents and records during the appeal process.
k. The CMH/PIHP will ensure the individual making the decision on appeals are individuals:
    i. Who were not involved in the previous level of review or decision-making, nor a subordinate of that individual;
    ii. Who, if deciding either of the following, are healthcare professionals who have the appropriate clinical expertise, as determined by MDHHS, in treating the Enrollee's condition or disease.
        1. An appeal of denial that is based on lack of medical necessity, or
        2. An appeal that involved clinical issues.
    iii. Must take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
l. A Notice of Resolution, in writing from the CMH/PIHP upon completion of the CMH/PIHP Appeal, will be given to the Enrollee **no later than 30 calendar days** from the date of receipt of request for a standard appeal, **72 hours for expedited appeal**.

5. **STATE FAIR HEARING**
    a. Enrollees have the right to an impartial review by a state level administrative law judge (State Fair Hearing), after notice of resolution of the CMH/PIHP Appeal upholding an Adverse Benefit Determination.
    b. A State Fair Hearing is allowed if the CMH/PIHP fails to adhere to the notice and timing requirements for the resolution of grievances and appeals.
    c. The CMH/PIHP may not limit or interfere with an Enrollee's freedom to make a request for a State Fair Hearing.
    d. Enrollees are given **120 calendar days** from the date of the Notice of Resolution from the CMH/PIHP Appeal process to file a State Fair Hearing.
    e. Enrollee's may request service continuation if:
        i. All previous conditions are met; and
        ii. The request was made **within 10 calendar days** of the date of the Notice of Resolution from the CMH/PIHP Appeal.
    f. If the Enrollee's services were reduced, terminated, or suspended without advance notice, the CMH/PIHP must reinstate services to the level before the Adverse Benefit Determination.
    g. The parties to the State Fair Hearing include the PIHP, the Enrollee and his/her representative. The Recipient Rights Officer (Mental Health) shall not be appointed as the Hearings Officer because of the inherent conflict of roles and responsibilities.
    h. Expedited hearings are available.
    i. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if the following conditions are met:
        i. The review must be at the enrollee's option and must be required before or used as a deterrent to the State Fair Hearing;
        ii. The review must be independent of both the State and the PIHP;
        iii. The review must be offered without any cost to the enrollee;
        iv. The review must not extend any of the timeframes specified above and must not disrupt the continuation of benefits.

6. **CONTINUATION OF BENEFITS PENDING APPEAL**
    a. Enrollees may request services to continue while waiting for appeal if all the following are true:
        i. The Enrollee files the request for appeal timely **within 60 calendar days** from the date on the Adverse Benefit Determination Notice.
        ii. The Enrollee files the appeal in a timely manner, **within 10 calendar days** of the date of the notice, before or on the effective date indicated on the notice;
        iii. The appeal involves an Adverse Benefit Determination of termination, reduction, or suspension of a previously authorized service;
        iv. The services were ordered by an authorized provider;
        v. The original period covered by the original authorization has not expired;
        vi. The Enrollee must ask for it.
    b. Benefits must continue (if all conditions above are met) until one of the following occurs:
        i. The Enrollee withdraws the appeal;

ii. The Enrollee fails to request a State Fair Hearing and continuation of benefits **within 10 days** after the CMH/PIHP sends the Enrollee the Notice of Resolution, upon completion of the appeal;
iii. The State Fair Hearing office issues a hearing decision adverse to the Enrollee;
iv. The duration of the previously authorized service has ended

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

7. **RECORD KEEPING**
   a. The CMH/PIHP is required to maintain records of Enrollee Grievances and Appeals.
   b. The CMH, as part of the delegation, is required to keep records of the Medicaid mental health grievances that are processed. The PIHP will review the CMH grievances to ensure compliance with requirements, and as part of state quality strategy.
   c. Records must contain the minimum:
      i. A general description of the reason for the Grievance or Appeal;
      ii. The date received;
      iii. The date of review;
      iv. The resolution at each level of the Appeal or Grievance, if applicable;
      v. The date of the resolution at each level, if applicable;
      vi. Name of the covered person for whom the Grievance or Appeal was filed.
   d. The CMH/PIHP must maintain such records accurately and in a manner accessible to the State and available upon request to CMS.

V. PROCEDURES

1. **GENERAL**
   a. Staff will assist Enrollee with filing a customer service complaint, filing grievances, filing appeals, filing state fair hearings, or making contact with the appropriate office of jurisdictions.
2. **GRIEVANCE**
   a. An Enrollee shall file a grievance orally or in writing to Sanilac CMH for mental health related complaints.
   b. Customer Service staff shall determine if the compliant is a Corporate Compliance complaint, Recipient Rights complaint, or an appeal, and refer to the appropriate office of jurisdiction for processing.
   c. The designated staff will acknowledge the grievance; complete an investigation by taking the steps necessary to gather information to create the best resolution; then provide a written Notice of Resolution of the grievance to the Enrollee/representative.
      i. Designated staff shall:
         1. Not be involved with the original complaint
         2. Possess the appropriate authority to require corrective action if needed;
         3. Additionally, a health care professional, with appropriate clinical expertise, will be required if the grievance involves clinical issues or involved the denial of an expedited appeal.
      ii. The Designee shall:

1. Acknowledge and log each grievance received;
2. Ensure the individual(s) who makes decisions on grievances are individuals:
    a. Who were not involved in any previous level of review or decision making
    b. Are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease;
        i. A grievance regarding the denial of expedited resolution of an appeal
        ii. A grievance that involves clinical issues.
    c. Have the authority to require corrective action if necessary.
    d. Shall take into account all comments, documents, records and other information submitted by the Enrollee/Representative without regard to whether such information was submitted or considered in the initial complaint.

d. The Notice of Resolution shall contain the date completed, the resolution and steps taken to resolution..
    i. Resolution of Notice shall contain:
        1. The results of Grievance process;
        2. The date the Grievance process was concluded;
e. The CMH staff will log all grievances and information into the EMR.
f. The PIHP will review grievances on a quarterly basis for requirement compliance.

3. **NOTICE OF ADVERSE BENEFIT DETERMINATION**
    a. At the time of an adverse decision regarding services, the CMH/PIHP and organizational providers shall complete the appropriate Notice of Adverse Benefit Determination and give/mail to the Enrollee/Guardian.
    b. Timing of notices
        i. Adequate Notice given/mailed to Enrollee/Guardian on the effective date. Adequate notices are used for the following determinations:
            1. Denial of payment for service, in part or whole, given at the time of the action affecting the claim.
            2. Denial of access into mental health service programs.
            3. Denial of access into Substance Use Disorder programs.
            4. Denial or limited denial of requested services, amount, or duration of services.
        ii. Advance Notice is given/mailed to the Enrollee/Guardian a minimum of 10 calendar days prior to the effective date of the action. Advance notices are used for the following determinations:
            1. Termination of services prior to the end of the current authorization.
            2. Reduction of services prior to the end of the current authorization.
            3. Suspension of services prior to the end of the current authorization
    c. Exceptions to Advance Notice:
        i. A notice may be mailed/given no later than the date of action of previously authorized services if:
            1. There is factual information confirming the death of the Enrollee.
            2. The CMH/PIHP receives a clear written statement signed by an Enrollee that he no longer wishes to receive services, or that gives information that requires the termination or reduction of services and

indicates that the Enrollee understands that this must be the result of supplying that information.

3. The Enrollee has been admitted to an institution where he/she is ineligible under CCBHC or Medicaid for further services.
4. There is established fact that the Enrollee has been accepted for CCBHC or Medicaid services by another local jurisdiction, state, territory, or commonwealth.
5. The Enrollee's whereabouts are unknown and the United States Post office returns agency mail directed to him/her indicating no forwarding address.
6. A change in the level of medical care is prescribed by the Enrollee's physician.
7. The CMH/PIHP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the Enrollee (CMH/PIHP has 5 days in this case).

4. **APPEAL**
   a. Enrollee may file an appeal by calling or writing to the CMH/PIHP Grievance and Appeal Office, **within 60 calendar days** of the date of the Adverse Benefit Determination Notice.
   b. Enrollees are to be directed to the PIHP Grievance and Appeal Office for filing appeals. This is not a delegated function to CMH.
      i. Providers filing appeals on behalf of the Enrollee must present the written permission from the Enrollee to the PIHP Grievance and Appeal Office upon filing.
      ii. Enrollee may request for service continuation, only if all conditions are met as listed above.
      iii. Acknowledgement Letter is mailed to enrollee **within 5 business days**.
      iv. Staff will investigate the dispute, reviewing all documentation presented, and will seek out a healthcare professional that was not involved with the original decision.
      v. Once a decision is made, the enrollee will be sent the Notice of Resolution, and if appropriate, instructions on how to request a Medicaid State Fair Hearing.
         1. Notice of Resolution shall contain:
            a. A general description of the reason for appeal;
            b. The date received;
            c. The date of the review process;
            d. The results of the appeal process;
            e. The date of resolution;
         2. If the resolution is not resolved wholly in favor of the Enrollee, the notice must also include:
            a. The right to a State Fair Hearing with instructions on how to file;
            b. Timeframe of **120 calendar days** to request a State Fair Hearing;
            c. The right to have services continue, if all conditions are met in section F. of this policy, and instructions on how to request service continuation

d. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination.

vi. Designated staff will log all relevant information into the appropriate EMR.

5. **STATE FAIR HEARING**
   a. Upon receiving the Notice of Resolution, the Enrollee, if not satisfied with the resolution, may request a State Fair Hearing **within 120 calendar days** from the date of the Notice of Resolution.
   b. Upon receipt of the Hearing Request, designated PIHP staff will process and prepare for the hearing.

6. SECOND OPINION
   a. Individuals or their representatives may request a Second Opinion if they disagree with a service denial (as outlined below):
      i. If the preadmission screening completed by Sanilac CMH denies hospitalization, the individual or the person making the application may request a second opinion from the Chief Executive Officer (CEO), Chief Operating Officer (COO) or his/her designee.
         1. The CEO, COO, or designee, shall arrange for an additional evaluation by a psychiatrist, other physician, psych nurse practitioner, or psychologist to be performed **within 3 business days**.
         2. If the conclusion of the second opinion is different from the conclusion of the prescreening, the CEO, COO, or designee, shall make a decision based on all clinical information available. Written notice of the decision will be part of the disposition of the reassessment.
         3. If the conclusion of the second opinion concurs with the initial assessment, the individual or representative will be provided information on alternative services and the availability of those services. Appropriate referral(s) will be made.
      ii. If the biopsychosocial/clinical/autism assessment completed by Sanilac CMH denies services, the individual or his/her representative may request a second opinion from the Chief Executive Officer (CEO), Chief Operating Officer (COO) or his/her designee.
         1. The CEO, COO, or designee, shall arrange for an additional evaluation by a licensed master level mental health professional to be performed **within 3 business days**.
         2. If the conclusion of the second opinion is different from the conclusion of the prescreening, the CEO, COO, or designee, in conjunction with the Medical Director, shall make a decision based on all clinical information available. Written notice of decision will be part of the recommendations in the reassessment.
         3. If the conclusion of the second opinion concurs with the initial assessment, the individual or representative will be provided information on alternative services and the availability of those services. Appropriate referral(s) will be made.

7. **RECORD KEEPING**
   a. All Grievance and Appeal records shall be kept in a manner appropriate for review upon request.

VI. **EXHIBITS** - None
VII. **REFERENCES** - None