

 WRAPAROUND MILWAUKEE Policy & Procedure	Date Issued: 9/1/98	Date Revised: 9/11/08	Section: ADMINISTRATION	Policy No: 008	Pages: 1 of 5 (9 Attachments)
	<input checked="" type="checkbox"/> Wraparound <input checked="" type="checkbox"/> Wraparound/REACH <input type="checkbox"/> FISS	Effective Date: 1/1/09	Subject: COMPLAINT / GRIEVANCE PROCESS		

I. POLICY

It is the policy of Wraparound Milwaukee/REACH that any party or enrollee or his/her representative who is dissatisfied with a policy, procedure, benefit, care or service has a right to seek resolution through the Wraparound Milwaukee complaint/grievance process. The policy follows guidelines established by the Department of Health & Family Services/HFS 94 – Patient Rights & Resolution of Patient Grievances (*see Attachment 1*).

The purpose of this Wraparound Milwaukee Complaint/Grievance Policy and Procedure is to provide a timely means to resolve complaints and grievances, to educate enrollees or representatives about appropriate use of the Wraparound Milwaukee/REACH program and to use enrollee / provider suggestions to improve Wraparound Milwaukee/REACH.

Note: An enrollee, family, advocate or staff person assisting an enrollee/family will not face any negative reproach if they initiate an informal or formal complaint/grievance.

II. PROCEDURE

Enrollees are provided with a Family Handbook and the Client Rights and Complaint/Grievance Procedure Handout that outlines Wraparound Milwaukee's/REACH's complaint/grievance process.

For the purpose of definition, the following applies:

Complaint: Any party's dissatisfaction with any aspect of service provision, lack of service provision, policy and procedure or benefit that is expressed verbally or in writing.

Grievance: Any enrollee's or enrollee's representative's (youth, family member, or advocate) written dissatisfaction with the outcome of a complaint. The Grievance process is a formal procedure with specific date, time and procedural requirements.

A. Procedure Regarding Informal/Formal Complaints.

Informal

1. All parties are encouraged to initially attempt to resolve conflicts or concerns in an "informal" manner. This means initiating a discussion with the individual(s) with whom the conflict or concern has arisen. A Child & Family Team meeting should be held if necessary and appropriate. Efforts should be taken to come to a resolution prior to the complaint/formal grievance process being initiated.

Note: The complainant has the right to file a complaint at any time if he/she believes resolution cannot be achieved through the "informal" process.

Formal

1. If resolution cannot be achieved at the informal level, then the complainants may call the Wraparound Milwaukee Quality Assurance Department at (414) 257-7608 to make an inquiry or file a complaint, or they may complete the COMPLAINT/SUGGESTION FORM (*see Attachment 2*) and submit it to the Wraparound Milwaukee Quality Assurance Department. Complaints should be filed within 45 days of the time one becomes aware of the concern. Extensions of this suggested time frame may be granted.
2. Upon receiving the complaint, the Wraparound Milwaukee Quality Assurance Director or her designee will review the information, speak with all/any necessary parties and complete the investigation, or forward the complaint to another identified investigator for follow up.

3. All attempts will be made to initially respond to the complainant within 10 working days with a final response or report determining substantiation or unsubstantiation to be completed within 30 days from the date the complaint was received. If the complaint is identified as “critical” in nature, then all efforts will be made to initially respond and resolve the issues within 2 working days or sooner, if possible.
4. When the Complaint outcome results in a decision adverse to an enrollee (youth or family), the enrollee will be advised of their right to submit a written Grievance to the Wraparound Milwaukee Quality Assurance Department. A written Grievance may be submitted in any form. However, it is suggested that the Wraparound Milwaukee GRIEVANCE INITIATION form be used and information relevant to the situation be submitted along with the Grievance (*see Attachment 3 - Form A*).

B. Procedure for Formal Written Grievances.

1. When a written grievance is received at Wraparound Milwaukee, the letter will be date-stamped then logged onto the GRIEVANCE RECORD. (*See Attachment 4 - Form A-1.*) A written GRIEVANCE ACKNOWLEDGEMENT will be provided to the person submitting the grievance within five (5) calendar days of its receipt (*see Attachment 5 - Form B-1*).
2. All grievances will be investigated by the Wraparound Milwaukee Program Director (Program Level Review) or his or her designee.
3. Issues requiring clinical judgment and perceived quality of care grievances may be investigated by a Clinical Coordinator or Care Coordination Supervisor from a contract agency not directly involved in the complaint.
4. As necessary, additional medical or other pertinent information will be sought by Wraparound Milwaukee staff.
5. When the investigation is completed and information gathered, a Grievance Hearing will be held to review the grievance. The Grievance Hearing is to be scheduled within 10 days of receipt of the grievance. The Grievance Hearing will include the Program Director or his or her designee, the Care Coordinator and his or her Supervisor (as applicable), and the enrollee/parent(s)/legal guardian/caregiver who may invite an advocate or other representative(s). In addition, the Grievant may present evidence related to their Appeal and may have access to any records related to the issue being appealed (within the restrictions of the laws of Wisconsin).

The Wraparound Milwaukee Program Director can invite others (*specialty providers, legal counsel, etc.*), as appropriate.

6. A Grievance Hearing will be scheduled and the enrollee/parent(s)/legal guardian/caregiver will be notified in writing by a GRIEVANCE HEARING NOTIFICATION (*see Attachment 6 - Form B-2*) at least 7 calendar days in advance of the Hearing and will be informed of the date, time and location of the Hearing. The enrollee/parent(s)/legal guardian/caregiver or the enrollee’s representative may attend the Grievance Hearing and present oral and/or written information in support of the grievance.
7. Within 30 calendar days of receipt of the initial grievance, the Grievant will be notified of the decision or action, by a GRIEVANCE HEARING DECISION letter (*see Attachment 7 - Form B-3*), except as noted in section D below. A copy of the letter will also be sent to the Care Coordinator (as applicable).
8. The decision will be logged onto the Grievance Record.

C. Extensions to Resolve Grievances.

1. Normally, Wraparound Milwaukee will resolve a grievance within 30 calendar days of receipt of the

written grievance. The time period may be extended an additional 14 calendar days if the Investigator

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requires more time to complete the investigation. If additional time is required, the Grievant will be notified in writing by a GRIEVANCE REVIEW – 14 DAY EXTENSION (*see Attachment 8 - Form B-4*) that the grievance has not been resolved, when the resolution is expected and why the additional time is needed.

D. Urgent Care/Expedited Grievances.

1. Urgent Care/Expedited Grievances are defined as situations where the denial of services or referral for service could result in illness or injury or where delay in care or treatment would jeopardize the enrollee's health or may result in disability.
2. When this grievance is received, the letter will be date-stamped and logged onto the Grievance Record.
3. If necessary, immediate additional information to resolve the matter will be sought.
4. Within 2 working days of the Initial Grievance, the Wraparound Milwaukee Program Director will meet with Wraparound Milwaukee relevant staff to review the available information and render a decision. No extensions will be possible. The Grievant will be notified of the Grievance Hearing as soon as possible and may attend to present oral or written information.
5. This decision will be immediately communicated, first verbally, then in writing, to the Grievant.
6. If a request for an Urgent Care/Expedited resolution is denied by Wraparound Milwaukee, then the following will occur:
 - a. The request will be transferred to the standard time frame of no longer than 30 days from the date of receipt, with a possible 14 day extension.
 - b. Reasonable efforts must be made to orally inform the Grievant immediately of the denial and a written denial notice must occur within 2 calendar days.

E. Reduction or Denial of a Covered Service Grievances.

If the formal written grievance is regarding a reduction or denial of a covered service, and the recipient files it with either Wraparound Milwaukee, the County or the Department/State within 45 days of the decision to reduce or deny benefits, the following provisions apply:

1. If the recipient was not receiving the service prior to the reduction or denial, Wraparound Milwaukee does not have to provide the benefit while the decision is being appealed. If Wraparound Milwaukee's denial, limitation, reduction, termination or suspension of services is overturned or reversed by the County Department of Hearings & Appeals (DHA), Wraparound Milwaukee must authorize or provide the disputed services promptly and as expeditiously as the enrollees' mental health condition requires.
2. If Wraparound Milwaukee authorized and paid for this service prior to the decision, Wraparound Milwaukee must continue to provide the same level of service while the decision is in appeal. However, Wraparound Milwaukee may require the recipient to receive the service from within the Provider Network, if medically necessary and appropriate care can be provided within the network.

Recipients must grieve to Wraparound Milwaukee, the County or the Department within 45 days of a reduction or denial of a service.

F. Procedure for County, State of Wisconsin Department of Health Services and State of Wisconsin Department of Hearings & Appeals State Fair Hearing Grievance Review.

If the decision achieved through the Program Level formal Grievance process is adverse to the Grievant, then he/she may appeal the decision, in writing, to the County (Behavioral Health Division Administrator), and/or may proceed to any other State Level of Grievance or Appeal that he or she desires. The County Appeal should be made within 14 days of the date that the program decision was received. County Level Appeals should be addressed to:

Milwaukee County Behavioral Health Division
9455 Watertown Plank Road
Milwaukee, WI 53226
Attn: BHD Administrator

If the County decision is adverse to the grievant, or if the grievant wishes to proceed directly to the State level, he or she may Appeal directly to the State of Wisconsin Department of Health Services (DHS).

For assistance with filing an Appeal to DHS, the enrollee can call the State of Wisconsin Medicaid Ombudsman at 1-800-760-0001.

The enrollee may also bypass all previous routes outlined and file a Grievance or Appeal directly with the State of Wisconsin Department of Hearings & Appeals (State Fair Hearing) by writing to:

State of Wisconsin
Department of Administration
Division of Hearings & Appeals
P.O. Box 7875
Madison, WI 53707-7875

G. Interpreter Services.

If needed, Interpreter services (for non-English speaking and hearing impaired persons) will be made available through Wraparound Milwaukee during the Complaint and Grievance process.

III. COMPLAINT/GRIEVANCE REVIEW GUIDELINES.

- A.** Any individual assigned to conduct a Complaint/Grievance investigation shall not have had any involvement in the conditions or activities forming the basis of the enrollee's or family's Complaint/Grievance, or have any other substantial interest in those matters arising from his or her relationship to the program or client, other than employment.
- B.** Members of any Grievance Review/Appeal Committee may not have been involved in any prior decision-making capacity regarding the basis of the Grievance.

IV. CONFIDENTIAL FILES.

A confidential file of each grievance, additional information, records of proceedings and decisions will be maintained for 5 years from the date of the last decision that was reached.

V. RECORD CLASSIFICATION/REPORTING.

- A.** Each grievance that is received will be logged onto the GRIEVANCE LOG (*see Attachment 9*), which will be maintained by the Program Director or his or her designee.
- B.** A report on current or past grievance history will be prepared on 15 days notice.

VI. COMPLAINTS AND GRIEVANCES MADE TO PROVIDERS AND ADMINISTRATIVE SERVICES.

- A.** Any complaint that is made or grievance that is sent to a Wraparound Milwaukee Provider or Administrative Service will be forwarded immediately to the Wraparound Milwaukee Quality Assurance Director. This provision will be included in any contract or agreement entered into with Wraparound Milwaukee.
- B.** When a Complaint or Grievance is forwarded by a Provider or Administrative Service to Wraparound Milwaukee, the complaint/grievance processes described in II. A. 2. through F. will be followed.

VII. SUMMARY OF TIME FRAMES FOR COMPLAINTS AND GRIEVANCES.

- A.** Complaint or Grievance Filed.

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- B. Notification of Receipt of Complaint or Grievance will be sent to Complainant/Grievant within 10 or 5 days, respectively, of Wraparound Milwaukee's receipt of Complaint or Grievance.
- C. If Complaint, the final decision will be made and sent to Complainant within 30 days of Wraparound Milwaukee's receipt of Complaint.
- D. If Grievance, a Grievance Hearing will be scheduled within 10 days of receipt of the Grievance.
- E. Grievant (*other than Urgent Care/Expedited*) must get 7 days advance notice of the scheduling of the Grievance Hearing.
- F. If Urgent Care/Expedited Grievance, a Grievance Hearing will be held and a decision made within 2 days of Wraparound Milwaukee's receipt of Grievance.
- G. Grievant is notified of the decision within 30 days of the receipt of the Grievance unless Wraparound Milwaukee notifies the Grievant of the need for a 14 day extension.
- H. All Grievances will be resolved within 45 days of Wraparound Milwaukee's receipt of the Grievance.

VIII. FORMS

- HFS 94 PATIENT RIGHTS & RESOLUTION OF PATIENT GRIEVANCES (*see Attachment 1*)
- COMPLAINT / SUGGESTION FORM (*see Attachment 2*)
- GRIEVANCE INITIATION (*see Attachment 3*) FORM A
- GRIEVANCE RECORD (*see Attachment 4*) FORM A-1
- GRIEVANCE ACKNOWLEDGEMENT (*see Attachment 5*) FORM B-1
- GRIEVANCE HEARING NOTIFICATION (*see Attachment 6*) FORM B-2
- GRIEVANCE HEARING DECISION (*see Attachment 7*) FORM B-3
- GRIEVANCE REVIEW - 14 DAY EXTENSION (*see Attachment 8*) FORM B-4
- GRIEVANCE LOG (*see Attachment 9*)

Reviewed & Approved by: _____



Bruce Kamradt, Director

COMPLAINT / SUGGESTION FORM

To be completed by any individual who would like to report a complaint or make a suggestion about any aspect Of the Wraparound Milwaukee program (*i.e., Families, Care Coordinators, Providers, etc.*)

Name of Person/Agency Filing Complaint or Suggestion _____			
Date _____			
Address _____	City _____	State _____	Zip _____
Phone Number _____		Fax Number _____	
What is your association with Wraparound? <input type="checkbox"/> Parent/Caregiver <input type="checkbox"/> Youth <input type="checkbox"/> Provider			

Name of Care Coordinator (<i>if applicable</i>) _____
Name of Care Coordinator's _____

Name of associated Wraparound Enrollee/Youth _____ (<i>If relevant to this complaint / suggestion</i>)
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If a Complaint, Name of Person/Agency Complaint is Against _____

Details of Complaint or Your Suggestion: (*Please be specific including names, dates, etc., when applicable.*)

(Please use back of form or attach an additional sheet of paper if more space is needed)

If this is a Complaint, what have you done in an attempt to resolve your concern? (*Please include who you've spoken to and the result of the conversation. Did the Child & Family Team discuss the concern?*)

What would you like to occur as a result of your complaint/suggestion?

Signature of Person Completing Form _____

Signature of Care Coordination Agency Supervisor, if it is a Care Coordinator that is filling out the Complaint _____

Send To: WRAPAROUND MILWAUKEE
9201 Watertown Plank Road
Milwaukee, WI 53226
Attn: Pamela Erdman - Quality Assurance Director

Or Fax To: Pamela Erdman
Quality Assurance Department
at (414) 257-7575

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(For Wraparound Use Only)

To be Completed by Quality Assurance Department / Investigator

Person Assigned to Investigate _____ **Date Assigned** _____

Date Received by Investigator _____

Please complete Investigation and Return to Pam Erdman by _____
(5 working days)

Results of Investigation: *(Be specific and include dates, times, names of individuals spoken to, etc.)*

Investigator's Signature _____ **Date** _____

***NOTE:** Please call Pam Erdman at (414) 257-7608, if unable to complete the investigation by the date indicated above.

.....

Name of Child/Family _____

Care Coordinator/Provider _____

Grievance Description *(include dates of relevant events, names, addresses & phone numbers of all parties):*

Desired Resolution:

Please Check One of the Following:

- I request a meeting/hearing to discuss and try to resolve above grievance with all interested parties and representatives. Wraparound Milwaukee will notify parties listed.
- I do not request a meeting/hearing at this time. I request a written response to my grievance.
- I request that the grievance be filed and do not desire any further action.

Submitted By:

Signature _____

Date _____

Print Name _____

Phone _____

Address _____

**Send To: WRAPAROUND MILWAUKEE
9201 Watertown Plank Road
Milwaukee, WI 53226
Attn: Pamela Erdman, Quality Assurance Director
Fax: (414) 257-7575**

GRIEVANCE RECORD

Medicaid Client
 Non-Medicaid Client

Client Name _____ Client DOB _____

Grievance Submitted by _____

Phone _____ Care

Coordinator _____

Description of Grievance (*verbal dissatisfaction - specify*): _____

Date Initiated _____ Desired Resolution _____

Was Grievant Contacted? Yes No If Yes, Date _____

Was Grievant Informed of Grievance Procedure? Yes No

GRIEVANCE

I. Program Director Review Date Received: _____

A. Nature of Grievance

_____ 1. Dissatisfaction with Care Coordinator's implementation of Plan of Care (*Describe*):

_____ 2. Benefit Denials (*claims or benefits; refusal to refer or provide a requested service*)
Describe:

_____ 3. Dissatisfaction with Service quality, provider, etc.:

Date of: _____

_____ 4. Other (*Specify*): _____

B. Grievance Hearing Date (*10 calendar days*): _____

_____ 1. Members Present:

_____ 2. Decision (*check one*): Approved Modified Denied

_____ 3. Was additional 14 days needed? (*check one*): Yes No

Signature of Person Completing this Form _____ Date _____

Title _____

GRIEVANCE ACKNOWLEDGMENT

(Within 5 Days of Receipt)

[Date]

[Grievant]

[Address]

Re: [Client Name]
[Client DOB]

Dear [Grievant]:

Wraparound Milwaukee received your letter on [date] that expressed a Grievance concerning [description of grievance].

Your Grievance is important and will be evaluated by the appropriate Wraparound Milwaukee staff member. In order for us to resolve your Grievance, we will need to review all important and available information related to your Grievance. We will schedule a Grievance Hearing with you within 10 days of Wraparound Milwaukee's receipt of your Grievance.

At your Grievance Hearing, you have the right to present evidence related to your Appeal and to have access to any records (within the restrictions of the law) related to the issue being appealed.

You may contact the Wraparound Milwaukee Quality Assurance Department at (414) 257-7608 with any questions you may have regarding the Grievance process.

Sincerely,

Quality Assurance Department
Wraparound Milwaukee

cc: Care Coordinator
Client File

GRIEVANCE HEARING NOTIFICATION

(Within 10 Days of Receipt)

[Date]
[Grievant]
[Address]

Re: [Client Name]
[Client DOB]

Dear [Grievant]:

Your Grievance will be presented to Wraparound Milwaukee on [date].

You have the right to be present at the Grievance Hearing to present additional written or verbal information that is important to your case. The Hearing will take place at [time, date, place of Hearing].

You may contact the Wraparound Milwaukee Quality Assurance Department at (414) 257-7608 with any questions you may have regarding the Grievance Hearing.

Sincerely,

Quality Assurance Department
Wraparound Milwaukee

cc: Care Coordinator
Client File

[Date]
[Grievant]
[Address]

Re: [Client Name]
[Client DOB]

Dear [Grievant]:

Wraparound Milwaukee's Program Level Grievance Committee met on [date] to hear your Grievance. [You were at the Hearing to present {verbal or written} additional information OR You were not at the Hearing to present verbal or written information].

After evaluating the available information, the decision was to [describe]. The Wraparound Milwaukee Program Level Grievance Committee Hearing is the final Grievance process available to you through Wraparound Milwaukee. You may appeal the Committee's decision to the Administrator of the Milwaukee County Behavioral Health Division by writing to:

Milwaukee County Behavioral Health Division
9455 Watertown Plank Road
Milwaukee, WI 53226
Attn: BHD Administrator

Or to the State of Wisconsin by writing to:

State of Wisconsin
Department of Administration
Division of Hearings & Appeals
P.O. Box 7875
Madison, WI 53707-7875

If Wraparound Milwaukee can be of assistance to you in this or other matters, please feel free to call our Quality Assurance Department at (414) 257-7608.

Sincerely,

Quality Assurance Department
Wraparound Milwaukee

cc: Care Coordinator
Client File

GRIEVANCE REVIEW – 14 DAY EXTENSION

(Within 45 Days of Receipt)

[Date]

[Grievant]

[Address]

Re: [Client Name]

[Client DOB]

Dear [Grievant]:

In order for the Wraparound Milwaukee Program Level Grievance Committee to resolve your Grievance, which we received on [date], we will require an additional 14 calendar days. This additional time is needed to [example: to acquire additional medical information from your primary care physician, etc.]

Following receipt of the additional information, your Grievance will be evaluated in a timely manner. It is expected that a resolution to your Grievance will be reached no later than [date - 14 calendar days from date of this letter]. You will be notified of this decision.

You may contact the Wraparound Milwaukee Quality Assurance Department at (414) 257-7608 with any questions you may have.

Sincerely,

Quality Assurance Department
Wraparound Milwaukee

cc: Care Coordinator
Client File

