

Comprehensive Behavioral Health Management/College Health IPA Policy and Procedure Manual	
Policy Name: Complaints and Grievances	Patient Rights and Responsibilities
Date: 2-94 Reviewed by QI Committee: 12-06, 07-07, 07-08 Revised by QI Committee: 12-06, 07-07, 07-08	Page: 1 of 4 Policy Number: RR-3

Purpose: To ensure patient satisfaction regarding all aspects of care and provide a formal mechanism to respond to patient, payer, or provider dissatisfaction. Comprehensive Behavioral Health Management/College Health IPA (CBHM/CHIPA) handles all complaints in a manner that is responsive to the clinical urgency of the situation.

Policy:

1.0 Information Gathering

- 1.1 Whenever a patient, payer, or provider expresses dissatisfaction with services received, s/he is advised regarding the complaint policy and given the option of filing a complaint. Reference Appendix I “Grievance Script.”
- 1.2 Staff is to gather the following information on all patient, payer, or provider complaints. Information is entered on the CBHM/CHIPA *Complaint/Grievance Form*.
 - 1.2.1 Date of complaint
 - 1.2.2 Date of incident
 - 1.2.3 Full name of caller
 - 1.2.4 Phone number of caller
 - 1.2.5 Patient Name
 - 1.2.6 Patient Age
 - 1.2.7 Patient Address
 - 1.2.8 Subscriber Name and Social Security Number
 - 1.2.9 Provider Name
 - 1.2.10 Payer
 - 1.2.11 Nature of Complaint
- 1.3 If complaint involves treatment of a minor, the caller will be referred to speak to a licensed clinician who will gather the information indicated in section 1.1.
- 1.4 If caller is not the patient and patient is over 18 years of age, the caller will be notified that prior to investigating a complaint regarding clinical quality of services, CBHM/CHIPA must obtain patient’s verbal or written consent. If consent cannot be obtained, the complaint will be forwarded to the Medical Director to determine if a Potential Quality Incident Report should be filed. Complaints related to administrative or financial matters can be investigated without consent from the adult patient.

2.0 Investigation

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- 2.1 All Complaint forms should be forwarded to QI Assistant for processing and resolution.
- 2.2 QI Assistant forwards copy of complaint to the Director of Clinical Services and Medical Director.
- 2.3 A copy of the complaint will also be routed to other department managers as appropriate, i.e. claims or provider relations.
- 2.4 QI Assistant will forward a copy of complaint via facsimile machine or U.S. mail to provider and ask for a written response within three working days.
- 2.5 Within five calendar days the QI Assistant will send written notification to the patient acknowledging receipt of complaint and anticipated resolution date.
- 2.6 For high profile or urgent matters, the Director of Clinical Services or Medical Director will contact the provider directly by telephone for a response.
- 2.7 If provider fails to respond within ten working days, a second request is sent.
- 2.8 After twenty working days with no response, the Director of Clinical Services or Medical Director calls the provider directly.
- 2.9 In those situations in which CBHM/CHIPA is not delegated for investigation of complaints the complaint and provider information is forwarded within one business day to appropriate party to complete investigation.

3.0 General Resolution Procedures

- 3.1 The patient complaint is reviewed together with the provider's response to determine if a non-quality of care (administrative) or quality of care (clinical) issue is present.
- 3.2 For quality of care findings, the Director of Clinical Services along with the Manager of Network Management will review provider's credentialing file and run utilization reports to determine if complaint was indicative of a provider not utilizing appropriate standards of practice.
- 3.3 Resolution may include:
 - 3.3.1 Provider education to include review of policies and procedures
 - 3.3.2 Patient education
 - 3.3.3 Office staff education
 - 3.3.4 Network education through online provider updates
 - 3.3.5 Development or revision of policies and procedures
 - 3.3.6 Suspension or termination of provider
- 3.4 In those situations in which CBHM/CHIPA is not delegated to resolve complaints, the QI Assistant forwards a copy of complaint and investigation information to the appropriate party who completes resolution of complaint.

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- 3.5 All complaints are to be resolved and notification given to patient within thirty days of receipt.
- 3.6 Prior to final complaint resolution, the QI Assistant will review to ensure that appropriate follow-up with the patient regarding treatment services is documented. This documentation should include information regarding current treatment plan or patient's refusal to accept treatment referrals.

4.0 Specific Resolution Procedures

- 4.1 Complaint regarding provider availability
 - 4.1.1 Provider belongs to a Primary Office Designation (POD)
 - 4.1.1.1 Manager of Network Management or Provider Relations Coordinator contacts POD office manager or owner to assess availability and assist in scheduling.
 - 4.1.1.2 If POD has no availability, a hold referral will be placed and patient will be assisted in obtaining an appointment with an individual provider.
 - 4.1.2 Individual provider office
 - 4.1.2.1 Manager of Network Management or Provider Relations Coordinator contacts provider to assess availability and assist in scheduling.
 - 4.1.2.2 If provider has no availability, a hold referral will be placed and based upon patient preference s/he will either be given additional provider referrals or assisted in obtaining an appointment with an individual provider.
- 4.2 Complaint about lack of authorization
 - 4.2.1 Patient's eligibility and benefit history is reviewed
 - 4.2.2 Current open authorizations are verified
 - 4.2.3 If date(s) of service in question are not authorized, provider will be contacted and asked to submit appropriate request for authorization.
 - 4.2.4 A CBHM/CHIPA licensed clinician will review the authorization request and notify provider regarding resolution.
 - 4.2.5 If sessions are denied, CBHM/CHIPA denial procedures will be followed and appeal instructions will be given to patient and to provider.
- 4.3 Complaint regarding provider payment
 - 4.3.1 Patient will be informed that provider will be contacted to determine dates of service not paid.

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- 4.3.2 Complaint will be forwarded to Supervisor of Claims for resolution with provider.
- 4.3.3 Supervisor of Claims to return resolved complaint to QI Coordinator.

5.0 Documentation

- 5.1 All complaints are logged when received.
- 5.2 When resolved by payer, the notification is sent from payer to patient and CBHM/CHIPA receives notification of resolution for inclusion in the QI Committee Minutes.

6.0 Quality Management Review

- 6.1 Provider access complaints and potential quality indicators are reviewed during the monthly Network Management Committee.
- 6.2 Complaints and potential quality indicators regarding utilization management are reviewed during the monthly Utilization Management Committee.
- 6.3 All complaint logs and potential quality indicators are reviewed and trended during the Quality Improvement Committee.
- 6.4 Corrective action plans and/or quality improvement programs are developed whenever a consistent trend in complaints is identified.

URAC Standards

- Core 22 – Consumer Communication Plan
- Core 27 – Complaint and Appeal System
- Core 29 – Complaint and Appeal Reporting