

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, 11-08, 7-09, 02-10, 07-10 Revised by QI Committee: 12-06, 07-07, 07-08, 11-08, 7-09, 02-10	Page: 1 of 6 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 Patient Complaints

- 1.1.1 Whenever a patient 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.”
- 1.1.2 Staff is to gather the following information on all patient complaints. Information is entered on the CBHM/CHIPA *Complaint/Grievance Form*.
 - 1.1.2.1 Date of complaint
 - 1.1.2.2 Date of incident
 - 1.1.2.3 Full name of caller
 - 1.1.2.4 Phone number of caller
 - 1.1.2.5 Patient Name
 - 1.1.2.6 Patient Age
 - 1.1.2.7 Patient Address
 - 1.1.2.8 Subscriber Name and Social Security Number
 - 1.1.2.9 Provider Name
 - 1.1.2.10 Payer
 - 1.1.2.11 Nature of Complaint
- 1.1.3 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.
- 1.1.4 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.

1.2 Payer Complaints

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- 1.2.1 Whenever a payer representative expresses dissatisfaction with the services received, s/he is advised regarding the complaint policy and given the option of filing a complaint. Reference Appendix I “Grievance Script.”
- 1.2.2 The staff member forwards the payer representative to speak to a supervisor who gathers the details regarding the complaint. (Reference Section 1.1.2).
- 1.2.3 The supervisor notifies QI Assistant to log complaint.
- 1.3 Provider Complaints Regarding Utilization Management
 - 1.3.1 Whenever a provider expresses dissatisfaction with the utilization management services received, s/he is advised regarding the complaint policy and given the option of filing a complaint. Reference Appendix I “Grievance Script.”
 - 1.3.2 The staff member gathers the details regarding the complaint (Reference Section 1.1.2) and forwards the information to the Network Management Department.
 - 1.3.3 The Network Management Department logs the complaint.

2.0 Investigation

- 2.1 Patient Complaints
 - 2.1.1 All Complaint forms should be forwarded to QI Assistant for processing and resolution.
 - 2.1.2 QI Assistant forwards copy of complaint to the Vice-President of Clinical Services and Medical Director.
 - 2.1.3 A copy of the complaint will also be routed to other department managers as appropriate, i.e. claims or provider relations.
 - 2.1.4 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.
 - 2.1.5 Within five calendar days the QI Assistant will send written notification to the patient acknowledging receipt of complaint and anticipated resolution date.
 - 2.1.6 For high profile or urgent matters, the Vice-President of Clinical Services or Medical Director will contact the provider directly by telephone for a response.
 - 2.1.7 If provider fails to respond within ten working days, a second request is sent.

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- 2.1.8 After twenty working days with no response, the Vice-President of Clinical Services or Medical Director calls the provider directly.
- 2.1.9 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.
- 2.2 Payer Complaints
 - 2.2.1 After logging the complaint, the QI Assistant notifies the Vice-President of Product Management and Compliance who initiates an investigation.
 - 2.2.2 Within 5 calendar days of receipt of complaint the QI Assistant will send a written notification to the payer acknowledging receipt of complaint and the timeframe for resolution.
- 2.3 Provider Complaints Regarding Utilization Management
 - 2.3.1 After logging the complaint, the Network Management Department notifies the QI Assistant and Vice-President of Clinical Services who initiate an internal investigation.
 - 2.3.2 Within 5 calendar days of receipt of complaint the QI Assistant will send a written notification to the provider acknowledging receipt of complaint and the timeframe for resolution.

3.0 General Resolution Procedures

- 3.1 Patient Complaints
 - 3.1.1 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.
 - 3.1.2 For quality of care findings, the Vice-President 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.
 - 3.1.3 Resolution may include:
 - 3.1.3.1 Provider education to include review of policies and procedures
 - 3.1.3.2 Patient education
 - 3.1.3.3 Office staff education
 - 3.1.3.4 Network education through online provider updates
 - 3.1.3.5 Development or revision of policies and procedures
 - 3.1.3.6 Suspension or termination of provider

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- 3.1.4 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.
- 3.1.5 All complaints are to be resolved and notification given to patient within thirty days of receipt.
- 3.1.6 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.
- 3.2 Payer Complaints
 - 3.2.1 The payer complaint is reviewed together with statements from CBHM/CHIPA staff to determine if a non-quality of care (administrative) or quality of care (clinical) issue is present.
 - 3.2.2 For quality of care findings, the Vice-President of Product Management and Compliance along with Vice-President of Clinical Services will review staff performance and personnel file to determine if current policies and procedures were followed.
 - 3.2.3 Resolution may include:
 - 3.2.3.1 Staff education to include review of policies and procedures
 - 3.2.3.2 Network education through online provider updates
 - 3.2.3.3 Development or revision of policies and procedures
 - 3.2.3.4 Disciplinary actions for Employee
 - 3.2.4 All complaints are to be resolved and notification given to payer within thirty days of receipt.
- 3.3 Provider Complaints Regarding Utilization Management
 - 3.3.1 The provider complaint is reviewed together with statements from CBHM/CHIPA staff to determine if a non-quality of care (administrative) or quality of care (clinical) issue is present.
 - 3.3.2 For quality of care findings, the Vice-President of Clinical Services along with the Staff Supervisor will review staff performance and personnel file to determine if current policies and procedures were followed.
 - 3.3.3 Resolution may include:
 - 3.3.3.1 Staff education to include review of policies and procedures
 - 3.3.3.2 Network education through online provider updates
 - 3.3.3.3 Development or revision of policies and procedures
 - 3.3.3.4 Disciplinary actions for Employee

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3.3.4 All complaints are to be resolved and notification given to provider within thirty days of receipt.

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

5.0 Documentation

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- 5.1 Patient Complaints
 - 5.1.1 All patient complaints are logged by the QI Assistant when received.
 - 5.1.2 When resolved by payer, the written notification is sent from payer to patient and CBHM/CHIPA receives notification of resolution for inclusion in the QI Committee Minutes.
- 5.2 Payer Complaints
 - 5.2.1 All payer complaints are logged by the QI Assistant when received.
 - 5.2.2 When complaints are resolved, the written notification is sent from CBHM/CHIPA to the payer. A Payer Complaint report is forwarded to the QI Committee for tracking and trending.
- 5.3 Provider Complaints
 - 5.3.1 Provider complaints are logged in the Provider Complaint Database maintained by the Network Management Department.
 - 5.3.2 When complaints are resolved, the written notification is sent from CBHM/CHIPA to the provider. A Provider Complaint report is forwarded to the QI Committee for tracking and trending.
- 5.4 Additional Review Options
 - 5.4.1 If the health plan guidelines allow for a secondary complaint review after the initial resolution, these procedures will be included in the written notification.

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 bi-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.