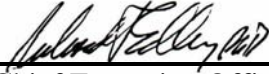

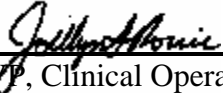

 An AmeriHealth Mercy Company		HealthChoices Policy and Procedure
<b>Name of Policy:</b>	Complaint and Grievance Policy	
<b>Policy Number:</b>	QI-CG-001	
<b>Applies to:</b>	<input checked="" type="checkbox"/> All counties <input type="checkbox"/> Bedford – Somerset <input type="checkbox"/> Blair <input type="checkbox"/> Capital Area <input type="checkbox"/> Franklin – Fulton <input type="checkbox"/> Lycoming – Clinton	
<b>Department Responsible:</b>	Quality Improvement	
<b>Purpose:</b>	To assure members have access to an organized system to address complaints and grievances.	
<b>Effective Date:</b>	10/01/01	
<b>Revised:</b>	06/17/02; 05/14/03; 08/13/03; 9/17/03; 11/15/03; 01/01/05; 09/21/05; 12/01/06; 07/01/07; 12/13/07	

<b>Required Signatures:</b>	
	 _____ Chief Executive Officer
	 _____ Medical Director
	 _____ VP, Clinical Operations
	 _____ Chief Operating Officer

**Definitions:** **Complaint:** A dispute or objection filed with CBHNP regarding a participating health care provider or the coverage, operations, or management policies of CBHNP, including, but not limited to 1) a denial because the requested service is not a covered benefit; 2) failure of the CBHNP to meet the required timeframes for providing a service; 3) failure of CBHNP to decide a complaint or grievance within the specified timeframes; 4) a denial of payment after a service has been delivered because the service(s) was

provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or; 5) a denial of payment after a service has been delivered because the services is not a covered benefit. The term does not include a grievance.

**Denial of Services:** A determination made by a CBHNP in response to a provider's or member's request for approval to provide a service of a specific amount, duration and scope which: disapproves the request completely, or approves provision of the requested service(s), but for a lesser amount, scope or duration than requested or disapproves provision of the requested service(s), but approves provision of an alternative service(s), or reduces, suspends, or terminates a previously authorized service.

**DPW Fair Hearing:** A Hearing conducted by the Department of Public Welfare, Bureau of Hearings and Appeals, in response to an appeal by a CBHNP Member.

**Grievance:** A request to have CBHNP or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. A grievance may be filed regarding a CBHNP decision to 1) deny, in whole or in part, of payment for a service if based on lack of medical necessity; 2) deny or issue a limited authorization of a requested service, including the type or level of service; 3) reduce, suspend, or terminate a previously authorized service; 4) deny the requested service but approve an alternative service. This term does not include a complaint.

**Policy:** Community Behavioral HealthCare Network of Pennsylvania (CBHNP) has established a fair and uniform process for Members to resolve complaint and grievances at the lowest administrative level consistent with the HealthChoices Requirements for Behavioral Health Managed Care Organizations.

- Procedure:**
1. General Guidelines
    - 1.1. Information about the Complaint and Grievance Policy and Procedure will be widely distributed through the following channels:
      - 1.1.1. Member Handbook
      - 1.1.2. Annual notification in CBHNP newsletter
      - 1.1.3. Upon member request, upon enrollment with CBHNP via Member Handbook, and at least 30 days prior to implementation of revisions.
      - 1.1.4. Provider Manual
      - 1.1.5. Postings within public view in provider offices

- 1.1.6. Newsletter or mailing when substantive changes are made
- 1.2. All CBHNP personnel will receive training on the Complaint and Grievance Policy and Procedure during orientation with an annual refresher.
- 1.3. A toll free telephone service will be available 24/7 for members to file or inquire about the status of a complaint or grievance. Any CHBNP staff person to whom a member expresses dissatisfaction is expected to log the contact, explain the process to the member, and provide notification to the Grievance and Appeals Coordinator.
- 1.4. CBHNP will accept a complaint or grievance in alternative formats which include TTD/TTY, Braille, tape, computer disk, and others. Language interpreters will be provided at no cost to the Member when necessary.
- 1.5. Members may not be charged a fee for filing a complaint or grievance at any level of the process. Members are verbally advised of this information by the CBHNP Complaint & Grievance Coordinator upon filing any level complaint or grievance.
- 1.6. The Director of Quality Improvement and the Assistant Director of Quality Improvement are responsible for the implementation and management of the Complaint and Grievance process. The Complaint and Grievance Coordinators and Complaint and Grievance Supervisor are responsible for the day-to-day operation and administration of the process, including the provision of information and instructions to Members.
- 1.7. A log will be maintained by the Complaint and Grievance Unit to capture data required for reporting and tracking the status to assure that the necessary steps are taken within the required timeframes through resolution of each Complaint and Grievance.
- 1.8. Members will be advised at each step of the Complaint and Grievance Process of their right to file a request for a Fair Hearing with the Department of Public Welfare in addition to or in lieu of CBHNP's Complaint and Grievance Process.
- 1.9. Members will have access to all relevant documentation pertaining to the subject of the complaint or grievance.
- 1.10. All complaint and grievance processes are reviewed at some level which creates a link between this activity, Utilization Management, and Quality Improvement.
- 1.11. Assistance with the complaint and grievance process will be provided by CBHNP at no cost to the Member.

- 1.12. All Complaints and Grievances will have written documentation of the substance of the complaint or grievance; actions taken; the investigation of the substance of the complaint or grievance, including any aspects of clinical care involved; and proper notification to the Member of the disposition of the complaint or grievance, including further appeal rights.
- 1.13. All Complaints and Grievances will consider the clinical urgency of the situation when responding, including accommodations for Expedited Reviews. All Complaints and Grievances will follow the established timeframes for resolution as defined by the HealthChoices Program Standards and Requirements. Members will be advised when CBHNP, through its own inaction, fails to decide a Level I complaint or Level I grievance within the proper timeframes. A notice to the Member regarding this issue will be mailed on the date that CBHNP is aware of the failure to meet the timeframe, using the templates found in **Attachment 1**.
- 1.14. CBHNP will notify the Member when it denies payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania medical Assistance Program, using the template supplied by the Department as Attachment 14 of this policy. The notice must be mailed to the Member on the day that the decision is made to deny payment.
- 1.15. CBHNP will notify the Member when it denies payment after a service(s) has been delivered because the service provided is not a covered benefit, using the template supplied by the Department as Attachment 15 of this policy. The notice must be mailed to the Member on the day that the decision is made to deny payment.
- 1.16. CBHNP will notify the Member when it denies payment after a service(s) has been delivered because CBHNP determined that the service(s) was not medically necessary, using the template supplied by the Department as Attachment 13 of the policy. This notice must be sent to the Member on the day the decision was made to deny payment.
- 1.17. Pre and Post Service Appeals – This policy addresses pre-service appeals as *grievances*. Post service appeals as grievances are not applicable to HealthChoices as Medical Assistance providers are not permitted to bill Members for services. However, post-service appeals may fall under *Action Complaints* as defined in 2.2.5 and

2.2.6 below.

## 2. Complaint Requirements

### 2.1. First Level Complaint Process

2.1.1. A Member (or Authorized Representative) may file a complaint either orally or in writing. An oral complaint filed regarding the following will be committed to in writing by CBHNP and provided to the Member for signature. This signature request will be processed using Attachment 12 when:

- 2.1.1.1. a denial because the requested service is not a covered benefit, or
- 2.1.1.2. CBHNP failed to meet the required timeframes for providing a service, or
- 2.1.1.3. CBHNP failed to decide a complaint or a grievance within the specified timeframes, or
- 2.1.1.4. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
- 2.1.1.5. a denial of payment after a service has been delivered because the service is not a covered benefit.
- 2.1.1.6. The signature may be obtained at any point in the process, and failure to obtain a signed complaint will not delay the complaint process.

2.2. If the complaint is regarding the following, the Member may file a complaint within 45 days from the date the written notice from CBHNP was received:

- 2.2.1. a denial because the requested service is not a covered benefit, or
- 2.2.2. CBHNP failed to meet the required timeframes for providing a service, or
- 2.2.3. CBHNP failed to decide a complaint or a grievance within the specified timeframes, or
- 2.2.4. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
- 2.2.5. a denial of payment after a service has been delivered because the service is not a covered benefit.
- 2.2.6. For all other complaints, there is no time limit for filing a complaint from the time of the

incident related to the complaint.

- 2.3. If a Member files a complaint to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving on the basis that the service is not a covered benefit, the Member will continue to receive the disputed service at the previously authorized level pending resolution of the complaint. For these continuation rights to occur, the complaint must be hand delivered, done by phone, or post-marked within ten days from the date of the CBHNP written notice of decision.
- 2.4. Upon receipt of the complaint, CBHNP will send the Member and Member's representative, if designated by Member, an acknowledgment letter using the template in **Attachment 2a**.
- 2.5. If the complaint is regarding the following, CBHNP will send the Member and the Member's representative, if designated by Member, an acknowledgment letter using the template found in **Attachment 2b**:
  - 2.5.1. a denial because the requested service is not a covered benefit, or
  - 2.5.2. CBHNP failed to meet the required timeframes for providing a service, or
  - 2.5.3. CBHNP failed to decide a complaint or a grievance within the specified timeframes, or
  - 2.5.4. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
  - 2.5.5. a denial of payment after a service has been delivered because the service is not a covered benefit.
- 2.6. The first level complaint review for complaints **not involving** a clinical issue will be performed by a first level complaint review committee, which will include one or more employees of CBHNP who did not participate in the issue that is the subject of the complaint. No one with any previous involvement may become involved in the decision making of the complaint. The committee members and the physician or psychologist reviewer will not be a subordinate of any previous decision-maker involved in the Complaint.
- 2.7. The first level complaint review for complaints **involving** a clinical issue, will be performed by a first level complaint review committee, which will include one or more employees of CBHNP who did not participate in the issue that is the subject of the complaint. At least one

Member of the committee will meet the qualifications required of an individual who makes a medical necessity decision as described in DPW Program Standards and Requirements Appendix AA, section C.3. No one with any previous involvement may become involved in the decision making of the complaint. The complaint decision will be made by a licensed physician or by a licensed psychologist if the requested service is within the psychologist's scope of practice. A licensed psychologist may not make a complaint determination regarding inpatient services or prescribed medication. For complaints regarding substance abuse services, the determination will be made by a licensed physician. The physician or psychologist representative of CBHNP will also be appropriately experienced to render such a decision. The committee members and the physician or psychologist reviewer will not be a subordinate of any previous decision-maker involved in the Complaint.

- 2.8. If the complaint is regarding the following, Members will be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. CBHNP will be flexible when scheduling the review to facilitate the Member's attendance. If the Member cannot appear in person at the review, an opportunity to communicate with the first level complaint review committee by telephone will be provided:
  - 2.8.1. a denial because the requested service is not a covered benefit, or
  - 2.8.2. CBHNP failed to meet the required timeframes for providing a service, or
  - 2.8.3. CBHNP failed to decide a complaint or a grievance within the specified timeframes, or
  - 2.8.4. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
  - 2.8.5. a denial of payment after a service has been delivered because the service is not a covered benefit..
- 2.9. The first level complaint review committee will complete its review of the complaint as expeditiously as the Member's health condition requires, but no more than 30 days from receipt of the complaint, which may be extended by 14 days at the request of the Member.
- 2.10. The first level complaint review committee will prepare a summary of the issues presented and decisions made,

which will be maintained as part of the complaint record.

2.11. CBHNP will send a written notice of the first level complaint decision to the Member or Member's representative, if designated by Member, service provider and the prescribing provider, if applicable, within five business days of the first level complaint review committee's decision, using the template found in **Attachment 3a**.

2.11.1. If the complaint is regarding the following, CBHNP will use the first level complaint decision template found in **Attachment 3b**, which indicates the Member may file a request for a DPW Fair Hearing within 30 days from the date on the written notice of CBHNP's first level complaint decision:

- 2.11.1.1. a denial because the requested service is not a covered benefit, or
- 2.11.1.2. CBHNP failed to meet the required timeframes for providing a service, or
- 2.11.1.3. CBHNP failed to decide a complaint or a grievance within the specified timeframes, or
- 2.11.1.4. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
- 2.11.1.5. a denial of payment after a service has been delivered because the service is not a covered benefit.

### 3. Second Level Complaint Process

- 3.1. The Member may file a request for a Second Level Complaint through CBHNP's complaint process, within 45 days from the date the Member receives written notice of the CBHNP First Level Complaint decision.
- 3.2. Upon receipt of the second level complaint, CBHNP will send the Member and Member's representative, if designated by Member, an acknowledgment letter using the template supplied by the Department as **Attachment 4**.
- 3.3. If a Member files a second level complaint to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving on the basis that the service is not a covered benefit, the Member will

continue to receive the disputed service at the previously authorized level pending resolution of the second level complaint. For these continuation rights to occur, the second level complaint must be hand delivered, done by phone, or post-marked within ten days from the date of the written notice of the CBHNP first level complaint decision.

- 3.4. The second level complaint review will be performed by a second level complaint review committee made up of three or more individuals who have not participated in the matter under review. No one with previous involvement in this issue may become involved in the decision making of the complaint. The committee members and the physician or psychologist reviewer will not be a subordinate of any previous decision-maker involved in the Complaint. The County Representative customarily will make up one of the three committee members. The County Representative may not have any previous involvement or oversight with the matter regarding the Member. In the event of a conflict of interest with the assigned County Representative, the County may assign another designee that may include a CBHNP staff person that did not have previous involvement in the issue.
- 3.5. At least one third of the committee members will be enrolled with CBHNP:
  - 3.5.1. If the complaint involves a service for an adult, the consumer Member(s) on the Second Level Complaint Committee will be adult who has received or is currently receiving Behavioral Health services (mental health services if the issue is a mental health complaint; substance abuse services if the issue is a substance abuse complaint) through CBHNP.
  - 3.5.2. If the complaint involves a service for a child or adolescent, the consumer Member(s) on the Second Level Complaint Committee will be a parent or guardian of a child or adolescent who has received or is currently receiving services (mental health services if the issue is a mental health complaint; substance abuse services if the issue is a substance abuse complaint) through CBHNP.
- 3.6. A committee member who does not personally attend the review meeting may not be part of the decision making process unless that person actively participates in the review by telephone and has the opportunity to review

any information introduced at the meeting.

- 3.7. In advance of the complaint meeting, CBHNP will provide panel Members with a complaint information packet for review prior to the meeting. Panel Members are encouraged to review the information in advance of the complaint meeting. Due to the confidential nature of this material, all complaint materials will be retrieved from those present and properly discarded by the facilitator immediately after each meeting.
- 3.8. The Member will be provided the opportunity to appear before the second level complaint review committee. CBHNP will be flexible when scheduling the second level complaint review to facilitate the Member's attendance. The Member will be given at least 15 days advance written notice of the review date. The committee meeting will be conducted at a time and place convenient to the Member. The Member may elect not to attend the second level complaint meeting but the meeting will be conducted with the same protocols as if the Member was present. If the Member cannot appear in person at the second level complaint review, an opportunity to communicate with the second level complaint review committee by telephone will be provided.
- 3.9. The Member and/or anyone the Member chooses may present the Member's position to the committee.
- 3.10. Testimony taken by the second level complaint review committee (including the Member's comments) will be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the complaint record.
- 3.11. The second level complaint review committee will complete the second level complaint review and render a decision within 30 days from CBHNP's receipt of the Member's second level complaint.
- 3.12. CBHNP will send a written notice of its decision, using the template supplied by the Department as **Attachment 5a**, to the Member, Member's representative, if designated by Member, service provider and the prescribing provider, if applicable, within five business days of the second level complaint review committee's decision.
- 3.13. If the complaint is regarding the following, CBHNP will use the second level complaint decision template found in **Attachment 5b**, which indicates the Member may file a request for a DPW Fair Hearing within 30 days from the date on the written notice of CBHNP's second level

complaint decision:

- 3.13.1. a denial because the requested service is not a covered benefit, or
  - 3.13.2. CBHNP failed to meet the required timeframes for providing a service, or
  - 3.13.3. CBHNP failed to decide a complaint or a grievance within the specified timeframes
  - 3.13.4. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
  - 3.13.5. a denial of payment after a service has been delivered because the service is not a covered benefit.
- 3.14. If the complaint is about the following, the Member may file a request for a fair hearing within 30 days from the date on the written notice of CBHNP's second level complaint decision.
- 3.14.1. a denial because the requested service is not a covered benefit, or
  - 3.14.2. the failure of CBHNP to meet the required timeframes for providing a service, or
  - 3.14.3. the failure of the CBHNP to decide a complaint or a grievance within the specified timeframes, or
  - 3.14.4. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
  - 3.14.5. a denial of payment after a service has been delivered because the service is not a covered benefit.
4. External Review of Second Level Complaint Review Decision
- 4.1. The Member may file a request for an external review of the second level decision with either the Department of Health or the Insurance Department within 15 days from the date the Member receives the written notice of CBHNP's second level complaint decision.
  - 4.2. If a Member files a request for an external review of a second level complaint decision to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving on the basis that the service is not a covered benefit, the Member will continue to receive the

disputed service at the previously authorized level pending resolution of the external review. For these continuation rights to occur, the request for external review must be hand delivered, done by phone, or post-marked within ten days from the date of the written notice in the CBHNP second level complaint decision.

- 4.3. Upon the request of either the Department of Health or the Insurance Department, all records from the first level review and second level review will be transmitted to the appropriate department by CBHNP within 30 days from the request in the manner prescribed by that department. The Member, the health care provider or CBHNP may submit additional materials related to the complaint.
  - 4.4. If the complaint is about the following and the request is made by a health care provider, with the Member's written consent, the health care provider will sign Attachment 18, stating they understand the payment responsibilities for External Reviews. See Section 7.8 for procedure details.
    - 4.4.1. a denial because the requested service is not a covered benefit, or
    - 4.4.2. CBHNP failed to meet the required timeframes for providing a service, or
    - 4.4.3. CBHNP failed to decide a complaint or a grievance within the specified timeframes
    - 4.4.4. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
    - 4.4.5. a denial of payment after a service has been delivered because the service is not a covered benefit.
  - 4.5. The Department of Health and the Insurance Department will determine the appropriate agency for the review.
5. Expedited Complaint Process
- 5.1. CBHNP will provide the opportunity for a single expedited review of a complaint at any point prior to the first level complaint decision if a Member provides CBHNP with a written certification from his or her physician that the Member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular complaint process. This certification is necessary even when the Member's request for the expedited complaint is made orally. The certification will include the physician's

signature.

- 5.2. A request for an expedited review of a complaint may be filed either in writing or orally. Oral requests will be committed to writing by CBHNP. The Member's signature is not required.
- 5.3. Upon receipt of an oral or written request for expedited review, CBHNP will inform the Member of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.
- 5.4. If the provider certification is not included with the request for an expedited complaint, CBHNP will inform the Member that the provider must submit a provider certification as to the reason why the expedited review is needed. CBHNP will make a reasonable effort to obtain the certification from the provider. If the provider certification is not received within three business days from the Member's oral or written request for an expedited review, CBHNP will decide the complaint within the standard complaint timeframes as set forth in this policy. CBHNP will make a reasonable effort to give the Member prompt oral notice of this decision, and will send a written notice of the decision to decide the complaint within the standard timeframes within two days of the decision using the template found in **Attachments 5c (complaint) and 5d (grievance)**.
- 5.5. If a Member files a request for expedited review of a complaint to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving on the basis that the service is not a covered benefit, the Member will continue to receive the disputed service at the previously authorized level pending resolution of the complaint. For these continuation rights to occur, the request for expedited review must be hand delivered, done by phone, or post-marked within ten days from the date of the written notice of decision.
- 5.6. Complaints requiring expedited review will be performed by a second level complaint review committee made up of three or more individuals who did not previously participate in the decision to deny coverage or payment for the requested service(s). The review will be decided by an individual who meets the qualifications required of an individual who makes a medical necessity decision as described in DPW Program Standard and Requirements Appendix AA, Section C.3. No one with previous involvement in this issue may become involved in the

decision making of the complaint. The complaint decision will be made by a licensed physician or by a licensed psychologist if the requested service is within the psychologist's scope of practice. A licensed psychologist may not make a complaint determination regarding inpatient services or prescribed medication. For complaints regarding substance abuse services, the determination will be made by a licensed physician. The physician or psychologist representative of CBHNP will also be appropriately experienced to render such a decision.

- 5.7 At least one third of the committee members will be enrolled with CBHNP:
  - 5.7.1 If the complaint involves a service for an adult, the consumer Member(s) on the Second Level Complaint Committee will be an adult who has received or is currently receiving Behavioral Health services (mental health services if the issue is a mental health complaint; substance abuse services if the issue is a substance abuse complaint) through CBHNP.
  - 5.7.2 If the complaint involves a service for a child or adolescent, the consumer Member(s) on the Second Level Complaint Committee will be a parent or guardian of a child or adolescent who has received or is currently receiving services (mental health services if the issue is a mental health complaint; substance abuse services if the issue is a substance abuse complaint) through CBHNP.
- 5.8 CBHNP will issue the decision resulting from the expedited review in person or by phone to the Member, the Member's representative, if designated by Member, and the Member's provider within 48 hours of receipt of the provider's certification, but no more than three business days from the Member's oral or written request for an expedited review. In addition, CBHNP will send written notice of the decision to the Member, the Member's representative, if designated by Member, and the Member's provider within two days of the decision using the template found in **Attachment 6**.
- 5.9 A summary of the issues presented and decisions made will be maintained as part of the complaint record.
- 5.10 The Member or the Member's representative, with

proof of the member's written authorization for the representative to be involved and/or take action on the member's behalf, may file a request for an expedited external complaint review with CBHNP within two business days from the date the member receives the written notice of the expedited complaint decision.

- 5.11 CBHNP must follow Department of Health guidelines relating to submission of requests for expedited external reviews.
- 5.12 The Member may file a request for a DPW Fair Hearing within 30 days from the date the Member receives the written notice of CBHNP's expedited complaint resolution letter.
- 5.13 CBHNP will ensure that punitive action is not taken against a provider who either requests an expedited resolution of a complaint or supports a Member's request for an expedited review of a complaint.

## 6. Grievance Requirements

### 6.1. First Level Grievance Process

- 6.1.1. CBHNP will permit a Member or the Member's representative, which may include the Member's provider, with proof of the Member's written authorization for the representative to be involved and/or take action on the Member's behalf (see Attachment 17), to file a grievance either orally or in writing. Oral requests must be committed to writing by CBHNP and must be provided to the Member for signature. This signature request will be processed using Attachment 12. The Member's signature may not delay the grievance process. The Member will be given 45 days from the date the written denial notice was received to file a grievance.
- 6.1.2. A Member who files a grievance to dispute a decision to discontinue, reduce or change a service that the Member has been receiving will continue to receive the disputed service at the previously authorized level pending resolution of the grievance. For these continuation rights to occur, the grievance must be hand delivered, done by phone, or post-marked within ten days from the date of the written notice of decision.
- 6.1.3. Upon receipt of the grievance, CBHNP will send the Member and Member's representative, if designated by Member, an acknowledgment letter

using the template found in **Attachment 7**.

- 6.1.4. The first level grievance review will be performed by the first level grievance review committee, which will include one or more employees of CBHNP who did not participate in the decision that is the subject of the grievance. No one with previous involvement in this issue may become involved in the decision making of the grievance. At least one Member of the committee will meet the qualifications required of an individual who makes a medical necessity decision as described in DPW Program Standards and Requirements Appendix AA, Section C.3. No one with previous involvement in this issue may become involved in the decision making of the grievance. The grievance decision will be made by a licensed physician or by a licensed psychologist if the requested service is within the psychologist's scope of practice. A licensed psychologist may not make a grievance determination regarding inpatient services or prescribed medication. For grievances regarding substance abuse services, the determination will be made by a licensed physician. The physician or psychologist representative of CBHNP will also be appropriately experienced to render such a decision. The decision will be made by the physician or licensed psychologist. The committee members and the physician or psychologist reviewer will not be a subordinate of the previous decision-maker who denied the service.
- 6.1.5. The Member will be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. CBHNP must receive this request within 5 business days of the acknowledgement letter date. CBHNP will be flexible when scheduling the review to facilitate the Member's attendance. If the Member cannot appear in person at the review, an opportunity to communicate with the first level grievance review committee by telephone will be provided.
- 6.1.6. The first level grievance review committee will complete its review of the grievance and make a decision as expeditiously as the Member's health condition requires, but no more than 30 days from receipt of the grievance, which may be extended by

up to 14 days at the request of the Member.

6.1.7. The first level grievance review committee will prepare a summary of the issues presented and decisions made, which will be maintained as part of the grievance record.

6.1.8. CBHNP will send a written notice of the first level grievance decision using the template in **Attachment 8** to the Member, Member's representative (if designated by Member), service provider and the prescribing provider, if applicable, within five business days from the first level grievance review committee's decision. The Member may file a request for a DPW Fair Hearing within 30 days from the date on the written notice of CBHNP's first level grievance decision.

## 6.2. Second Level Grievance Process

6.2.1. The Member may file a request for a Second Level Grievance within 45 days from the date the letter is received containing CBHNP's First Level Grievance decision.

6.2.2. Upon receipt of the second level grievance, CBHNP will send the Member and the Member's representative, if designated by Member, an acknowledgment letter using the template found in **Attachment 9**.

6.2.3. A Member who files a second level grievance to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving will continue to receive the disputed service at the previously authorized level pending resolution of the second level grievance. For these continuation rights to occur, the second level grievance must be hand delivered, done by phone, or post-marked within ten days from the date the Member received the written notice of CBHNP's first level grievance decision.

6.2.4. The second level grievance review will be performed by a second level grievance review committee made up of three or more individuals who did not previously participate in the decision to deny coverage or payment for the requested service(s). No one with previous involvement in this issue may become involved in the decision making of the grievance. At least one Member of the committee will meet the qualifications required of an individual who makes a medical

necessity decision as described in DPW Program Standards and Requirements Appendix AA, Section C.3. A licensed psychologist may not make a grievance determination regarding inpatient services or prescribed medication. For grievances regarding substance abuse services, the determination will be made by a licensed physician. The physician or psychologist representative of CBHNP will also be appropriately experienced to render such a decision. In advance of the grievance meeting, CBHNP will provide panel Members with a grievance information packet for review prior to the meeting. Panel Members are encouraged to review the information in advance of the grievance meeting. Due to the confidential nature of this material, all grievance materials will be retrieved from those present and properly discarded by the facilitator immediately after each grievance. The second level grievance review committee will render a decision by consensus or a majority vote when required. The committee members and the physician or psychologist reviewer will not be a subordinate of the previous decision-maker who denied the service. The County Representative customarily will make up one of the three committee members. The County Representative may not have any previous involvement or oversight with the matter regarding the Member. In the event of a conflict of interest with the assigned County Representative, the County may assign another designee that may include a CBHNP staff that did not have previous involvement in the issue.

- 6.2.5. At least one third of the committee members will be enrolled with CBHNP:
  - 6.2.5.1. If the grievance involves a service for an adult, the consumer Member(s) on the Second Level Grievance Committee will be adult who has received or is currently receiving Behavioral Health services (mental health services if the issue is a mental health grievance; substance abuse services if the issue is a substance abuse grievance) through CBHNP.
  - 6.2.5.2. If the grievance involves a service for a

child or adolescent, the consumer Member(s) on the Second Level Grievance Committee will be a parent or guardian of a child or adolescent who has received or is currently receiving services (mental health services if the issue is a mental health grievance; substance abuse services if the issue is a substance abuse grievance) through CBHNP.

- 6.2.6. A committee member who does not personally attend the review meeting may not be part of the decision making process unless that person actively participates in the review by telephone and has the opportunity to review any information introduced at the meeting.
- 6.2.7. The Member will be provided the opportunity to appear before the second level grievance review committee. CBHNP will be flexible when scheduling the second level review to facilitate the Member's attendance. The Member will be given at least 15 days advance written notice of the review date. The committee meeting will be conducted at a time and place convenient to the Member. The Member may elect not to attend the second level grievance meeting but the meeting will be conducted with the same protocols as if the Member was present. If the Member cannot appear in person at the second level review, an opportunity to communicate with the second level grievance review committee by telephone will be provided.
- 6.2.8. The Member and/or anyone with the Member's written permission may present the Member's position to the committee. CBHNP will provide the Member with a listing of advocate organizations available to assist the Member.
- 6.2.9. The second level grievance review committee will complete the second level grievance review and reach a decision within 30 days from receipt of the Member's second level grievance.
- 6.2.10. The decision of the committee will be based solely on the information presented at the second level review committee meeting.
- 6.2.11. Testimony taken by the second level grievance review committee (including the Member's

comments) will be either tape recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the grievance record.

- 6.2.12. CBHNP will send a written notice of its decision, using the template in **Attachment 10a**, to the Member, Member's representative (if designated by Member), service provider and the prescribing provider, if applicable, within five business days of the second level grievance review committee's decision.
  - 6.2.13. The Member may file a request for a DPW Fair Hearing within 30 days from the date on the written notice of CBHNP's second level grievance decision.
  - 6.2.14. CABHC is responsible for facilitating the Level II grievance meetings for the Capital Area only (Cumberland, Dauphin, Lancaster, Lebanon, Perry Counties). When a Member has chosen a date for the meeting, CBHNP will notify CABHC of the meeting date. CABHC will assign a staff member to facilitate the meeting. Prior to the meeting CBHNP will provide CABHC a copy of the grievance information. CABHC is responsible for facilitation of the meeting, ensuring Member's rights are adhered to and assist in supporting the Level II committee panel.
- 6.3. External Review of the Second Level Grievance Decision:
- 6.3.1. The Member may file a request with CBHNP for an external review of the second level grievance decision (External Grievance Review) processed through the Department of Health who will assign a CRE. The request will be filed by phone or in writing within 15 days from the date the Member receives the written notice of the CBHNP second level grievance decision.
  - 6.3.2. All requests for external grievance reviews are processed through CBHNP. CBHNP will follow the protocols established by the Department of Health in meeting all timeframes and requirements necessary in coordinating the request and notification of the decision to the Member, Member's representative, if designated by Member, service provider and prescribing provider.

- 6.3.3. A Member who files a request for external grievance review to dispute a decision to discontinue, reduce or change a service that the Member has been receiving will continue to receive the disputed service at the previously authorized level pending resolution of the external grievance review. For these continuation rights to occur, the request for external grievance review must be hand delivered, done by phone, or post-marked within ten days from the date the Member received the written notice of CBHNP's second level grievance decision.
- 6.3.4. If the request is made by a health care provider, with the Member's written consent, the health care provider will sign Attachment 18, stating they understand the payment responsibilities for External Reviews. See Section 7.8 for procedure details.
- 6.3.5. Within five business days of receiving the request for an external grievance review, CBHNP will notify the Member, the Member's representative (if designated by Member), or the health care provider, and Department of Health that the request for an external grievance review has been filed.
- 6.3.6. The external grievance review will be conducted by an independent utilization review entity not directly affiliated with CBHNP.
- 6.3.7. Within two business days from receipt of the request for external grievance review, the Department of Health will randomly assign a certified utilization review entity (CRE) to conduct the review. CBHNP and assigned CRE will be notified of this decision.
- 6.3.8. If the Department of Health fails to select a CRE within two business days of receipt of a request for an external grievance review, CBHNP may designate a CRE to conduct a review from the list of CREs approved by the Department of Health. CBHNP may not select a CRE that has a current contract or is negotiating a contract with CBHNP or its affiliates or is otherwise affiliated with the CBHNP or its affiliates. No one with previous involvement in this issue may become involved in the decision making of the grievance.
- 6.3.9. CBHNP will forward all documentation regarding

the decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the decision, to the CRE conducting the external grievance review. This transmission of information will take place within 15 days from receipt of the request for an external grievance review.

- 6.3.10. CBHNP will inform the Member that within 15 days from receipt of the request for an external grievance review by CBHNP, the Member or the Member's representative, including the provider, with the Member's written permission, may supply additional information to the CRE conducting the external review for consideration. Copies will also be provided at the same time to CBHNP so that CBHNP has an opportunity to consider the additional information.
  - 6.3.11. Within 60 days from filing the request for the external grievance review, the CRE conducting the external grievance review will issue a written decision to CBHNP, the Member, the Member's representative and the provider (if the provider filed the grievance with the Member's consent), that includes the basis and clinical rationale for the decision. The standard of review will be whether the service was medically necessary and appropriate under the terms of the CBHNP contract.
  - 6.3.12. The external grievance decision shall be subject to appeal to a court of competent jurisdiction within 60 days of receipt of notice of the external grievance decision.
- 6.4. Expedited Grievance Process
- 6.4.1. CBHNP must conduct expedited review of a grievance at any point prior to the second level grievance decision, if a Member or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or take action on the Member's behalf, provides CBHNP with a certification from his or her provider that the Member's life, health or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular grievance process. This certification is necessary even when the Member's request for the expedited grievance is

made verbally. The certification must include the provider's signature.

- 6.4.2. A request for expedited review of a grievance may be filed either in writing or orally. Oral requests will be committed to writing by CBHNP. The Member's signature is not required.
- 6.4.3. Upon receipt of an oral or written request for expedited review, CBHNP will inform the Member of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.
- 6.4.4. If the provider certification is not included with the request for an expedited grievance, CBHNP will make a reasonable effort to inform the Member of the provider certification necessary to handle the grievance in an expedited manner. If the provider certification is not received within three business days from the Member's oral or written request for an expedited review, CBHNP will decide the grievance within the standard timeframes as set forth in this policy. CBHNP will make a reasonable effort to give the Member prompt oral notice of this decision, and will send a written notice of the decision to decide the grievance within the standard timeframes within two days of the decision using the template found in **Attachment 5d**.
- 6.4.5. A Member who files a request for expedited review of a grievance to dispute a decision to discontinue, reduce or change a service that the Member has been receiving will continue to receive the disputed service at the previously authorized level pending resolution of the grievance. For these continuation rights to occur, the request for expedited review must be hand delivered, done by phone, or post-marked within ten days from the date of the written notice of decision.
- 6.4.6. The expedited review process is bound by the same rules and procedures as the second level grievance review process with the exception of time frames, which are modified as specified in this section.
- 6.4.7. Grievances requiring expedited review will be performed by a second level grievance review committee made up of three or more individuals

who did not previously participate in the decision to deny coverage or payment for the requested service(s). The expedited review will be decided by an individual who meets the qualifications required of an individual who makes a medical necessity decision as described in DPW Program Standards and Requirements Appendix AA, Section C.3. No one with previous involvement in this issue may become involved in the decision making of the grievance. The grievance decision will be made by a licensed physician or by a licensed psychologist if the requested service is within the psychologist's scope of practice. A licensed psychologist may not make a grievance determination regarding inpatient services or prescribed medication. For grievances regarding substance abuse services, the determination will be made by a licensed physician. The physician or psychologist representative of CBHNP will also be appropriately experienced to render such a decision. The decision will be made by the physician or licensed psychologist. The physician or psychologist reviewer will not be a subordinate of the previous decision-maker who denied the service.

- 6.4.8. At least one third of the committee members will be enrolled with CBHNP:
  - 6.4.8.1 If the grievance involves a service for an adult, the consumer Member(s) on the Second Level Grievance Committee will be an adult who has received or is currently receiving Behavioral Health services (mental health services if the issue is a mental health grievance; substance abuse services if the issue is a substance abuse grievance) through CBHNP.
  - 6.4.8.2 If the grievance involves a service for a child or adolescent, the consumer Member(s) on the Second Level Grievance Committee will be a parent or guardian of a child or adolescent who has received or is currently receiving services (mental health services if the issue is a mental health grievance; substance abuse services if the issue is a substance abuse grievance)

through CBHNP.

- 6.4.9. CBHNP will issue the decision resulting from the expedited review in person or by phone to the Member, the Member's representative, if designated by the Member, and the Member's provider within 48 hours from receipt of the provider certification, but no more than three business days from the Member's oral or written request for an expedited review. In addition, CBHNP will send written notice of the decision to the Member, the Member's representative, if designated by Member, and the Member's provider within two days of the decision using the template found in **Attachment 11**.
- 6.4.10 The Member may file a request for an expedited external grievance review with CBHNP within two business days from the date the Member receives the written notice of the CBHNP's expedited grievance decision.
- 6.4.11. CBHNP will follow Department of Health guidelines relating to submission of requests for expedited external reviews.
- 6.4.12. The Member may file a request for a fair hearing within 30 days from the date on the written notice of CBHNP's expedited grievance decision.
- 6.4.13 CBHNP will ensure that punitive action is not taken against a provider who either requests an expedited resolution of a grievance or supports a Member's request for expedited review of a grievance.
- 6.4.14 If the request is made by a health care provider, with the Member's written consent, the health care provider will sign Attachment 18, stating they understand the payment responsibilities for External Reviews. See Section 7.8 for procedure details.
- 6.4.15 When a Member or provider is in disagreement with a denial regarding an inpatient admission request and is after normal business hours or on weekends, CBHNP CCM's will offer a peer-to-peer physician review of the request for admission. (See also CM-007 related to inpatient denials). This voluntary reconsideration is not required, nor does it take the place of an expedited grievance review, but is an additional option

offered by CBHNP.

6.5. DPW Fair Hearing Process

- 6.5.1. A Member does not have to exhaust the complaint or grievance process prior to filing a request for a fair hearing.
- 6.5.2. A Member or the Member's representative may request a fair hearing within 30 days of the date on the initial written notice of decision and within 30 days from the date on a complaint or grievance notice of decision at any level, of any of the following:
- 6.5.3. the denial, in whole or in part, of payment for a requested service if based on lack of medical necessity;
- 6.5.4. the denial of a requested service on the basis that the service is not a covered benefit;
- 6.5.5. the denial or issuance of a limited authorization of a requested service, including the type or level of service;
- 6.5.6. the reduction, suspension, or termination or a previously authorized service;
- 6.5.7. the denial of a requested service but approval of an alternative service;
- 6.5.8. the failure to provide services in a timely manner, as defined by DPW;
- 6.5.9. the failure of CBHNP to decide a complaint or grievance within the timeframes specified in this policy; or
- 6.5.10. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
- 6.5.11. a denial of payment after a service has been delivered because the service is not a covered benefit.
- 6.5.12. The request for a fair hearing will include a copy of the written notice of decision that is the subject of the request. Requests should be sent to:

*Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievance and Appeals  
Beechmont Building # 32  
P.O. Box 2675  
Harrisburg, PA 17105-2675*

- 6.5.13. A Member who files a request for a fair hearing to dispute a decision to discontinue, reduce or change a service that the Member has been receiving will continue to receive the disputed service at the previously authorized level pending resolution of the fair hearing. For these continuation rights to occur, the request for a fair hearing must be hand delivered, done by phone, or post-marked within ten days of the date of the written notice of decision.
- 6.5.14. Upon the receipt of the request for a fair hearing, the Department's Bureau of Hearings and Appeals or a designee will schedule a hearing. The Member and CBHNP will receive notification of the hearing date by letter at least ten days in advance, or a shorter time if requested by the Member. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.
- 6.5.15. CBHNP is a party to the hearing and will be present. CBHNP, which may be represented by an attorney, will be prepared to explain and defend the issue on appeal. The Department's decision is based solely on the evidence presented at the hearing.
- 6.5.16. CBHNP will provide Members, at no cost, with records, reports, and documents, relevant to the subject of the fair hearing.
- 6.5.17. The Bureau of Hearings and Appeals has up to 90 days from the receipt of a request for a fair hearing to process final administrative action. If the Bureau of Hearings and Appeals has not taken final administrative action within 90 days of the receipt of the request, CBHNP will follow the requirements at 55 Pa. Code 275.4 regarding the provision of interim assistance upon the request for such by the Member. When the Member is responsible for delaying the hearing process the time limit for final administrative action will be extended by the length of the delay attributed to the Member (55 Pa. Code 275.4).
- 6.5.18. The Bureau of Hearings and Appeals' adjudication is binding on CBHNP unless

reversed by the Secretary of Public Welfare. Either party may request reconsideration from the Secretary within 15 days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within 30 days from the date of adjudication (or from the Secretary's final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on CBHNP.

6.6. Expedited Fair Hearing Process

- 6.6.1. A request for an expedited fair hearing may be filed with DPW either in writing or orally.
- 6.6.2. A Member does not have to exhaust the complaint or grievance process prior to filing a request for an expedited fair hearing.
- 6.6.3. An expedited fair hearing will be conducted if a Member or a Member's representative provides the DPW with written certification from the Member's provider that the Member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular fair hearing process. This certification is necessary even when the Member's request for the expedited fair hearing is made orally. The certification will include the provider's signature.
- 6.6.4. A Member who files a request for an expedited fair hearing to dispute a decision to discontinue, reduce or change a service that the Member has been receiving will continue to receive the disputed service at the previously authorized level pending resolution of the fair hearing. For these continuation rights to occur, the request for an expedited fair hearing must be hand delivered, done by phone, or post-marked within ten days of the date from the written notice of decision.
- 6.6.5. Upon the receipt of the request for an expedited fair hearing, the DPW Bureau of Hearings and Appeals or a designee will schedule a hearing.
- 6.6.6. CBHNP is a party to the hearing and will participate in the hearing. CBHNP, which may be represented by an attorney, will be prepared to explain and defend the issue on appeal. The failure of CBHNP to participate in the hearing will not be reason to postpone the hearing.

- 6.6.7. CBHNP will provide Members, at no cost, with records, reports, and documents, relevant to the subject of the fair hearing.
  - 6.6.8. The Bureau of Hearings and Appeals has 3 business days from the receipt of the Member's oral or written request for an expedited review to process final administrative action. The Bureau of Hearings and Appeals' adjudication is binding on CBHNP.
  - 6.6.9. The Bureau of Hearings and Appeals' adjudication is binding on CBHNP unless reversed by the Secretary of Public Welfare. Either party may request reconsideration from the Secretary within 15 days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within 30 days from the date of adjudication (or from the Secretary's final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on CBHNP.
- 6.7. Provision of and Payment for Services Following Decision
- 6.7.1. If CBHNP, the Department of Public Welfare - Bureau of Hearings and Appeals, Department of Health, Department of Insurance, or the assigned CRE reverses a decision to deny, limit, or delay services that were not furnished during the complaint, grievance or fair hearing process, CBHNP will authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires.
  - 6.7.2. If CBHNP or the DPW Bureau of Hearings and Appeals reverses a decision to deny authorization of services, and the Member received the disputed services during the complaint, grievance or fair hearing process, CBHNP will pay for those services.

7. Health care Provider initiated grievances

- 7.1. A health care provider may, with written consent of the Member, file a written grievance. In order for the provider to represent the Member in the filing of a grievance, the provider will obtain the written consent of the Member (see Attachment 17). A provider may obtain the Member's written permission at the time of treatment. A provider may NOT require a Member to sign a

document authorizing the provider to file a grievance as a condition of treatment. The written consent will include:

- 7.1.1. The name and address of the Member, the Member's date of birth and identification number,
  - 7.1.2 If the Member is a minor, or is legally incompetent, the name, address and relationship to the Member of the person who signed the consent,
  - 7.1.3 The name, address and plan identification number of the provider to whom the Member is providing consent,
  - 7.1.4 The name and address of the plan to which the grievance will be submitted,
  - 7.1.5 An explanation of the specific service for which coverage was provided or denied to the enrollee to which the consent will apply, and
  - 7.1.6 The following statement: "The Member or the Member's representative may not submit a grievance concerning the services listed in this consent form unless the Member or the Member's representative rescinds consent in writing. The Member or Member's representative has the right to rescind consent at any time during the grievance process."
- 7.2. The healthcare provider may not bill the Member for services provided as part of the grievance, once they assume the responsibility for filing the grievance.
  - 7.3. The Member may choose to rescind their consent at any time during the grievance process.
  - 7.4. The Member may not file a grievance for the services listed in the consent form, unless the Health care provider fails to file the grievance or fails to continue the grievance process.
  - 7.5. The Members consent is automatically rescinded if the Health care provider fails to file a grievance or fails to continue the grievance process.
    - 7.5.1. The Member may file the grievance for the services in dispute, if the Health care provider fails to file the grievance.
    - 7.5.2. The Member may continue with the grievance at the point the Health care provider failed to continue with the process.
    - 7.5.3. The Member may choose at any time during the grievance process to provide consent for the Healthcare provider to continue with the

grievance process.

7.6 The healthcare provider must provide to the Member or Member's representative notification of their intent not to pursue the grievance within 10 days of the date of the service denial or within 10 days of the date of the decision of a review.

7.7 Provision of and Payment for Services Following External Review Decisions

7.7.1 If the external grievance is requested by the healthcare provider, the healthcare provider and CBHNP will have established an escrow account in the amount of half the anticipated cost of the review.

7.7.2 The costs associated with the External Review will be processed as follows:

7.7.2.1. If the CRE's External Review decision filed by the health care provider is against the health care provider in full, the health care provider shall pay the fees and costs associated with the external review.

7.7.2.2.If the CRE's External Review decision is against CBHNP, in full or in part, CBHNP shall pay the fees and costs associated with the external review.

7.7.2.3.At no time shall the Member be expected to pay for fees and costs associated with an external review.

7.7.2.4.Fees and costs associated with this section of the policy do not include attorney's fees.

7.7.2.5.The CRE will bill the appropriate party upon completion of the review.

**Related Policies:** CM-013; CM-007; QI-003; QI-CG-003; QI-CG-005; CM-011; CM-025; HR-003; QI-018

**Related Reports or Attachments:** Attachments 1 through 18