

<b>Beacon Comprehensive Behavioral Health Management Policy and Procedure Manual</b>	
<b>Policy Name:</b> Complaints and Grievances	<b>Patient Rights and Responsibilities</b>
<b>Date:</b> 2-94 <b>Reviewed by QI Committee:</b> 12-06, 07-07, 07-08, 11-08, 7-09, 02-10, 07-10, 07-11 <b>Revised by QI Committee:</b> 12-06, 07-07, 07-08, 11-08, 7-09, 02-10, 07-11	<b>Page:</b> 1 of 6 <b>Policy Number:</b> 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. Beacon Comprehensive Behavioral Health Management (Beacon CBHM) 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 Beacon CBHM *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 Health Plan Identification 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, Beacon CBHM 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 Executive 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 Executive Assistant for processing and resolution.
  - 2.1.2 QI Executive Assistant forwards copy of complaint to the Vice-President of Product Management and Compliance 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 Executive 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 Executive 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 Product Management and Compliance 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 Product Management and Compliance or Medical Director calls the provider directly.
- 2.1.9 In those situations in which Beacon CBHM 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 Executive 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 Executive 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 Executive Assistant and Vice-President of Product Management and Compliance or Director of Care Management who initiate an internal investigation.
  - 2.3.2 Within 5 calendar days of receipt of complaint the QI Executive 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 Product Management and Compliance or Director of Care Management 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

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- 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
- 3.1.4 In those situations in which Beacon CBHM is not delegated to resolve complaints, the QI Executive 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 Executive 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 Beacon CBHM 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 the Director of Care Management or Director of Intensive 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 Beacon CBHM 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 Product Management along with the Staff Supervisor will review staff performance and

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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
- 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.
- 4.2.1 4.2
- 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 Executive Assistant.

5.0 Documentation

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- 5.1 Patient Complaints
  - 5.1.1 All patient complaints are logged by the QI Executive Assistant when received.
  - 5.1.2 When resolved by payer, the written notification is sent from payer to patient and Beacon CBHM 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 Executive Assistant when received.
  - 5.2.2 When complaints are resolved, the written notification is sent from Beacon CBHM 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 Beacon CBHM 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.