

PerformCARE®		Policy and Procedure
Name of Policy:	Grievance	
Policy Number:	QI-044	
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton	
Primary Stakeholder:	Quality Improvement	
Related Stakeholder(s):	All departments	
Applies to:	Associates	
Original Effective Date:	10/01/01	
Last Revision Date:	04/26/22	
Last Review Date:	04/26/22	
Next Review Date:	04/01/23	

Policy: PerformCare has established a fair and uniform process for Members to resolve grievances at the lowest administrative level consistent with the *HealthChoices Requirements for Behavioral Health Managed Care Organizations (PSR Appendix H)*. Attachment 1 in this policy lists all General Requirements of Appendix H, with which PerformCare will remain in full compliance.

Purpose: To ensure all Members have access to an organized process to address grievances.

Definitions: **Consumer Representative:** An individual (or the parent/guardian of an individual) who has received or is currently receiving services with PerformCare. This person, who has previously received training related to the grievance process, will serve as a member of a review committee for deciding a grievance.

- a. If the grievance involves mental health services for an adult, the consumer representative must be an adult who has previously received or is currently receiving mental health services.
- b. If the grievance involves substance use services for an adult, the consumer representative must be an adult who has previously received or is currently receiving substance use services.
- c. If the grievance involves mental health services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has previously received or is currently receiving mental health services. The consumer representative may also be an individual who has

previously received or is currently receiving mental health services.

- d. If the grievance involves substance use services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has previously received or is currently receiving substance use services. The consumer representative may also be an individual who has received or is currently receiving substance use services.

Continuation Rights: When a request has been made to dispute PerformCare's decision to discontinue, reduce, or change a service that the Member had previously been authorized to receive, the Member must continue to receive the disputed service at the previously authorized level pending resolution, if the request is filed (orally, hand-delivered, faxed, or post-marked) within 1 calendar day from the mail date on the written notice of decision for acute inpatient services or within 10 calendar days from the mail date on the written notice of decision for any other services.

Department of Human Services (DHS) Fair Hearing: A hearing conducted by Pennsylvania's Department of Human Services, Bureau of Hearings and Appeals, in response to an appeal by a PerformCare Member.

Expedited Review: A review conducted in a condensed time frame should it be determined that a Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular timeframes. A Member's provider can submit a written certification explaining the need for such, or a clinical determination can be made by PerformCare. Should it be deemed necessary, expedited time frames may be put into effect when requesting an internal grievance review, an external grievance review, or a fair hearing.

External Review: A review conducted by an independent utilization review entity not directly affiliated with PerformCare and in response to an appeal by a PerformCare Member.

Grievance: A request to have PerformCare or a utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a covered service. A grievance may be filed regarding a PerformCare decision to:

- a. deny, in whole or in part, of payment for a service if based on lack of medical necessity;
- b. deny or issue a limited authorization of a requested service, including the type or level of service;
- c. reduce, suspend, or terminate a previously authorized service;
- d. deny the requested service but approve an alternative service.

Program Standards and Requirements (PSR): Commonwealth of Pennsylvania Department of Human Services Health Choices

Behavioral Health Program – Program Standards and Requirements.

Acronyms: **BMC:** Bureau of Managed Care
C&G: Complaints and Grievances
CRE: Certified utilization Review Entity
DHS: Department of Human Services
DOH: Department of Health
PSR: Program Standards and Requirements

Procedure: 1. Internal Review Process for Grievances

- 1.1. A grievance must be filed within 60 calendar days from the date the Member receives written notice of denial.
- 1.2. Any PerformCare Associate can take the initial details of a Member and/or Member representative initiated Grievance. A C&G Coordinator will conduct further outreach to the Member to provide notification of the Member's rights through the process and seek any clarification that may be necessary.
- 1.3. PerformCare Members (or an authorized representative) may file a grievance either orally or in writing.
- 1.4. The Member will be afforded continuation rights through the grievance process, provided all conditions have been met as defined above.
- 1.5. Within 3 business days of receipt of the grievance, PerformCare will send the Member and the Member's representative (if designated) an acknowledgment letter.
- 1.6. Each grievance will be reviewed by a grievance review committee made up of three or more individuals who have not participated in the matter under review. No one with previous involvement in the issue may become involved in the decision making process. No committee member will be a subordinate of any previous decision-maker.
- 1.7. At least one-third of the grievance review committee may not be an employee of PerformCare or a related subsidiary or affiliate.
- 1.8. At least 20% of PerformCare's grievance review committees used in a year must include a consumer representative.
- 1.9. At least one member of the committee will meet the qualifications required of an individual who makes medical necessity decisions, as described in Section C.3 of the *PSR Appendix AA*. This same individual will render the final decision for the grievance, after taking into consideration input from any other review

committee members. (*See Attachment 2 – Grievance Monitoring*)

- 1.10. The grievance review committee will receive a copy of all documents for review at least 2 calendar days prior to the review meeting.
- 1.11. A committee member who does not personally attend the grievance 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 all information presented at the meeting.
- 1.12. The grievance review committee may not discuss the grievance prior to the review meeting.
- 1.13. The Member will be afforded a reasonable opportunity to be present and the right to comment and provide testimony on any document, record, and other information submitted or presented during the grievance review. All attendees/participants of the review meeting must conduct themselves in a professional, respectful and impartial manner.
 - 1.13.1. PerformCare will be flexible when scheduling the grievance review to facilitate the Member's attendance. The meeting will be conducted at a time and place that is convenient for the Member. Teleconference will also be presented as an option.
 - 1.13.2. The Member will be given at least 10 calendar days advance written notice of the review date, with an option to waive should the Member wish to have the meeting sooner.
 - 1.13.3. The Member may elect not to attend the review. If the Member does not attend, the meeting will be conducted with the same protocols as if the Member was present.
 - 1.13.4. The Member and/or anyone of the Member's choosing may present information related to the grievance. Providers may only attend with the Member's consent.
 - 1.13.5. Anyone not involved with the grievance process may attend the meeting for training purposes, only with the Member's consent.
- 1.14. A licensed clinician from PerformCare must attend the review meeting to present information related to PerformCare's decision about the medical necessity and appropriateness of the services. This presenter may not be present for the deliberation by the committee or

- involved in the decision made by the committee.
- 1.15. A Facilitator must attend the review meeting for coordination purposes and to ensure the meeting and deliberation follow *PSR Appendix H* standards. This facilitator will also be responsible for recording the meeting and deliberation.
 - 1.16. The decision of the grievance review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative (if designated) without regard to whether such information was submitted or considered in the initial determination of the issue. Upon completion of the meeting, the committee will deliberate and will base its decision solely upon the materials and testimony presented during the review.
 - 1.17. The review meeting and the deliberation of the committee's decision will be recorded. The meeting and deliberation will be transcribed. Both the recording and the transcription will be maintained in the grievance record.
 - 1.18. The review committee will render a decision no later than 30 calendar days from the receipt of the grievance. The Member may request a one-time extension of 14 calendar days.
 - 1.19. Upon a decision being rendered, the review committee will prepare a summary of the issues presented, the decisions made by the committee, and the rationale for those decisions. Within 30 days from receipt of the grievance, PerformCare will also send a written notice of its decision to the Member, the Member's representative (if designated), the service provider, and the prescribing provider (if applicable), unless the timeframe has been extended by up to 14 calendar days at the Member's request. Both the summary and letter will be documented in the grievance record.

2. External Review Process for Grievances

- 2.1. A request for an external review of the grievance may be made within 15 calendar days from the date the Member receives PerformCare's written notice of decision. This request may be filed with DOH.
- 2.2. The Member will be afforded continuation rights, provided all conditions have been met as previously defined.
- 2.3. Within 5 business days of receiving a request for an external grievance, PerformCare will notify the Member, the Member's representative (if designated), the Provider

- (if the provider filed the request), and BMC that the request for an external grievance review has been filed.
- 2.4. The external grievance review will be conducted by an independent utilization review entity not directly affiliated with PerformCare.
 - 2.5. Within 2 business days from receipt of the request for external grievance review, BMC will randomly assign a CRE to conduct the review. PerformCare and the assigned CRE will be notified of this decision.
 - 2.6. Within 2 business days of receiving notice of CRE assignment, PerformCare will send notification to Member with contact information of the CRE.
 - 2.7. PerformCare will forward all documentation regarding the grievance to the assigned CRE within 15 calendar days from the date the request for an external review was received.
 - 2.8. PerformCare will inform the Member (or representative) of the right to submit additional information to the CRE within 15 calendar days from the date the external review was filed. The Member will also provide copies of any additional information to PerformCare for consideration.
 - 2.9. The CRE will issue a written decision, within 60 calendar days from the filing of the external grievance, to PerformCare, the Member, the Member's representative (if designated), BMC, and Provider (if the Provider filed the grievance). The written decision will also include the rationale for the decision.
 - 2.10. The external grievance decision may be appealed by the Member, the Member's representative, or the Provider to a court of competent jurisdiction within 60 calendar days from the date the Member receives notice of the external grievance decision.

3. DHS Fair Hearing Process for a Grievance

- 3.1. A request for a Fair Hearing may be filed within 120 calendar days from the date of PerformCare's written notice of decision for the grievance.
- 3.2. A Member will be afforded continuation rights, provided all conditions have been met as previously defined.
- 3.3. Upon receipt of the request, the Bureau of Hearings and Appeals will schedule a hearing. Both the Member and PerformCare will receive notification of the hearing date by letter at least 10 calendar days before the hearing date. PerformCare must be present at the hearing to explain and defend the issue on appeal.
- 3.4. PerformCare must provide records, reports, and documents relevant to the subject of the fair hearing to

the Member at no cost.

- 3.5. The Bureau of Hearings and Appeals will issue an adjudication within 90 calendar days from receipt of the request. The adjudication is binding on PerformCare, unless reversed by the Secretary of Human Services. A request for reconsideration may be made within 15 calendar days from the date of the fair hearing decision and may be made by the Member or PerformCare.

4. Expedited Review Process for a Grievance

- 4.1. PerformCare must conduct an expedited review if a clinical determination has been made by PerformCare, or from a written certification by Member's provider, that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular grievance process.
- 4.2. If Provider's certification is not received within 72 hours of the Member's request for an expedited review, PerformCare must decide the grievance within the standard 30-calendar day time frame, unless a one-time 14-calendar day extension has been requested by the Member.
- 4.3. A request for an expedited review of grievance may be filed either in writing or orally.
- 4.4. Upon receipt of an oral or written request for expedited review, PerformCare must inform the Member of their right to present information they determine relevant to the grievance, their right to do so in person or in writing, as well as the limited time they have available to do so.
- 4.5. The Member will be afforded continuation rights, provided all conditions have been met as defined above.
- 4.6. Each grievance will be reviewed by a committee comprised 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 grievance. No committee member will be a subordinate of any previous decision-maker.
- 4.7. At least one-third of the grievance review committee may not be an employee of PerformCare or a related subsidiary or affiliate.
- 4.8. At least 20% of PerformCare's grievance review committees that are used to review grievances in a year must include a consumer representative.
- 4.9. At least one member of the committee will meet the qualifications required of an individual who makes

medical necessity decisions, as described in Section C.3 of the *PSR Appendix AA*. This same individual will render the final decision for the grievance, after taking into consideration input from any other members of the review committee. (See Attachment 2 – *Grievance Monitoring*)

- 4.10. A committee member who does not personally attend the Grievance 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 all information presented at the meeting.
 - 4.11. The review committee must prepare a summary of the issues presented, the decision made, and the rationale for that decision. This summary will be maintained as part of the grievance record.
 - 4.12. PerformCare must issue the decision resulting from the expedited review in person or by phone to the Member, the Member's representative (if designated), the service Provider, and the prescribing Provider (if applicable) within either 48 hours of receiving the Provider's certification or 72 hours of receiving the Member's request for an expedited review, whichever is shorter.
 - 4.13. PerformCare must mail written notice of the decision within 2 business days of the decision being rendered.
- 5. Expedited External Review Process for a Grievance**
- 5.1. A request for an expedited external review of a grievance may be filed within 2 business days from the date the Member receives PerformCare's decision of the expedited grievance.
 - 5.2. The Member will be afforded continuation rights through the expedited external review process if the request to file is made within 1 business day from the date of the written decision for acute inpatient services or within 2 business days for any other services.
 - 5.3. A request for an expedited external grievance review may be filed either in writing or orally.
 - 5.4. PerformCare must follow BMC guidelines related to submission of requests for expedited external grievance reviews.
- 6. Expedited DHS Fair Hearing Process for a Grievance**
- 6.1. An expedited fair hearing may be filed upon PerformCare's written decision of the internal grievance review.
 - 6.2. The Member must exhaust the grievance process prior to filing a request for an expedited fair hearing.

- 6.3. PerformCare may not take punitive action against a provider who requests expedited resolution of a grievance or supports a Member's request.
- 6.4. The request may be filed orally or in writing.
- 6.5. The Member will be afforded continuation rights, provided all conditions have been met as previously defined.
- 6.6. Upon receipt of the request, the Bureau of Hearings and Appeals will schedule a hearing. PerformCare must be present at the hearing to explain and defend the issue on appeal.
- 6.7. PerformCare must provide records, reports, and documents relevant to the subject of the fair hearing to the Member at no cost.
- 6.8. The Bureau of Hearings and Appeals will issue an adjudication within 3 business days from receipt of the request. The adjudication is binding on PerformCare, unless reversed by the Secretary of Human Services. A request for reconsideration may be made within 15 calendar days from the date of the fair hearing decision and may be made by the Member or PerformCare. Only the Member may appeal to Commonwealth Court within 30 calendar days from the date of the adjudication or from the date of the Secretary's final order, if reconsideration was granted.

7. Provision of and Payment for Services following a Decision

- 7.1. If PerformCare, the Bureau of Hearings and Appeals, or the Secretary reverses a decision to deny, limit, or delay services that were not provided during the complaint, grievance, or fair hearing process, then PerformCare will authorize and/or provide these services no later than 72 hours from the date of notice of the reversed decision.
- 7.2. If PerformCare requests a reconsideration, PerformCare must authorize or provide the disputed service or item pending reconsideration unless PerformCare requests (and is granted) a stay of the Bureau of Hearings and Appeals' decision.
- 7.3. If PerformCare, the Bureau of Hearings and Appeals, or the Secretary reverses a decision to deny authorization of services, and the Member had received the disputed services during the complaint, grievance, or fair hearing process, PerformCare will pay for those services.

8. Healthcare Provider-Initiated Grievances

- 8.1. A healthcare provider may file a grievance.
- 8.2. The Member must authorize and give consent for a Provider to file the grievance.

- 8.3. Written consent will be obtained and maintained in the Member's record.
- 8.4. Providers may NOT require Members to sign a document giving authorization for the Provider to file a grievance as a condition of treatment.
- 8.5. A healthcare provider may not bill Members for services provided as part of a grievance once they assume the responsibility for filing the grievance.
- 8.6. A Member may choose to rescind their consent at any time during the grievance process.
- 8.7. A Member may not file a grievance for the same services denied, unless the healthcare provider fails to file the grievance or fails to continue the grievance process.
- 8.8. A Member's consent is automatically rescinded if the healthcare provider fails to file a grievance or fails to continue the grievance process.
- 8.9. A Member may continue with the grievance at the point the healthcare provider failed to continue with the process.
- 8.10. A Member may choose at any time during the grievance process to provide consent for the healthcare provider to continue with the grievance process.
- 8.11. A healthcare provider must provide the Member or the 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.
- 8.12. If the healthcare provider requests (and the Member consents) to file an external grievance, the healthcare provider will establish an escrow account in the amount of half the anticipated cost of the review. All necessary documentation associated with assuming financial responsibility will also be completed and on record.
- 8.13. The costs associated with an external review are processed as follows:
 - 8.13.1. If the decision of the external review is against the healthcare provider in full, the healthcare provider shall pay the fees and costs associated with the external review.
 - 8.13.2. If the decision is against PerformCare, in full or in part, PerformCare shall pay the fees and costs associated with the external review.
 - 8.13.3. At no time shall the Member be expected to pay for fees and costs associated with an external review.
 - 8.13.4. Fees and costs associated with this section of

- the policy do not include attorney's fees.
- 8.13.5. The CRE will bill the appropriate party upon completion of the review.

Related Policies: None

Related Reports: None

Source Documents

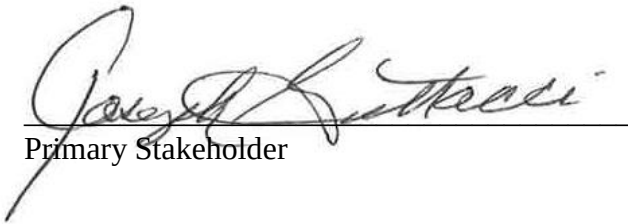
and References: *Commonwealth of Pennsylvania Department of Human Services HealthChoices Behavioral Health Program – Program Standards and Requirements (PSR)*

Superseded Policies

and/or Procedures: *CC-CG-004 Grievance Policy*
QI-CG-001 Complaint and Grievance Policy

Attachments: *Attachment 1 General Requirements for Complaint, Grievance, and Fair Hearing Processes*
Attachment 2 Grievance Monitoring Process and Checklist

Approved by:



Primary Stakeholder

General Requirements for Complaint, Grievance, and Fair Hearing Processes

1. PerformCare must have written policies and procedures for registering, responding to, and resolving complaints and grievances (at all levels) as they relate to the MA population.
2. All complaint, grievance, and fair hearing policies and procedures developed by PerformCare must be approved in writing by the Department prior to their implementation.
3. Complaint and grievance processes must be fair, easy to understand, easy to follow, easily accessible and respectful of the Member's rights.
4. PerformCare policies and procedures regarding Member complaints and grievances must be provided to Members in written form:
 - a. Upon enrollment into the BH-MCO,
 - b. Upon Member request, and
 - c. At least 30 calendar days before a Department-approved change becomes effective.
5. PerformCare must require Network Providers to display information about how to file a complaint or a grievance and the complaint and grievance process at all Network Provider offices.
6. PerformCare may not charge Members a fee for filing a complaint or grievance.
7. PerformCare must require Network Providers to display a notification that Members will not incur a fee for filing complaints or grievances at any level of the process at all Network Provider offices.
8. PerformCare must operate a toll-free telephone service for Members to use to file complaints and grievances and to follow up on complaints and grievances filed by Members. The phone service must be operated 24 hours a day, 7 days a week by appropriately trained staff. Voice mail or recorded messages are not allowed. PerformCare must provide Members with the number of the toll-free telephone service.
9. All PerformCare staff that interact with Members must receive training on complaints and grievances that includes how to record a complaint or grievance and how to provide the information staff receive to designated complaint and grievance staff for processing.
10. All county and PerformCare staff involved in the complaint and grievance processes and all review committee members must receive training in the areas related to their responsibility at least annually or more frequently, if needed.
11. All county and PerformCare staff involved in the complaint and grievance processes and all review committee members must have the necessary orientation, knowledge, and experience to make a determination about assigned issues and must analyze information and resolve disputed issues in a fair and nondiscriminatory manner.

12. All review committee proceedings shall be conducted in a manner that is informal and impartial to avoid intimidating the Member or the Member's representative.
13. PerformCare's Director of Quality Improvement and Supervisor of Complaints and Grievances are responsible for the overall coordination of the complaint and grievance processes. Complaint and Grievance Coordinators and Supervisor are responsible for the day-to-day operation and administration of the process, including the provision of information and instructions to Members.
14. PerformCare must maintain an accurate log of all complaints and grievances, which includes, at a minimum:
 - a. Identifying information about the Member
 - b. A description of the reason for the complaint or grievance
 - c. The date the complaint or grievance was received
 - d. The date of the review or review meeting (if applicable)
 - e. The decision
 - f. The date of the decision
 - g. If the second level complaint review committee or the grievance review committee included a consumer representativePerformCare must provide the log to the Department or CMS upon request.
15. PerformCare must retain all complaint and grievance records, which must include a copy of any document reviewed by the review committees and the complaint or grievance log, for 10 years from the date the complaint or grievance was filed.
16. PerformCare must allow the Member or Member's representative (if the Member has provided PerformCare with written authorization that indicates that the representative may be involved and/or act on the Member's behalf) access to all relevant documents pertaining to the subject of the Member's complaint or grievance, including any new or additional evidence considered, relied upon, or generated for the complaint or grievance review and, if an investigator was assigned, any information obtained as part of the investigation. PerformCare may not charge Members or their representatives for copies of the documentation.
17. PerformCare must ensure that there is a link between the complaint and grievance processes and the Quality Management and Utilization Management programs.
18. PerformCare may not use the time frames or procedures of the complaint or grievance process to avoid the medical decision process or to discourage or prevent a Member from receiving medically necessary care in a timely manner.
19. PerformCare must accept complaints and grievances from Members who have disabilities which are in alternative formats including: TTD/TTY for telephone inquiries and complaints and grievances from Members who are deaf or hearing impaired; Braille; recording; or computer disk; and other commonly accepted alternative forms of communication. PerformCare staff who receive telephone complaints and grievances must be aware of the speech limitation of some Members who have disabilities and treat these Members with patience, understanding, and respect.

20. PerformCare must provide Members who have disabilities assistance with preparing and presenting their case at complaint or grievance reviews at no cost to Member. This includes, but is not limited to:
 - a. Providing qualified sign language interpreters for Members who are deaf or hearing impaired;
 - b. Providing information submitted on behalf of PerformCare at the complaint or grievance review in an alternative format accessible to the Member filing the complaint or grievance. The alternative format version must be supplied to the Member before the review and at the review, so the Member can discuss and/or refute the content during the review; and
 - c. Providing personal assistance to Members with other physical limitations with copying and presenting documents and other evidence.
21. PerformCare must provide language interpreter services when requested by a Member at no cost to the Member.
22. PerformCare must offer Members the assistance of a PerformCare staff throughout the complaint and grievance processes at no cost. The PerformCare staff cannot have been involved in and cannot be a subordinate of anyone who was involved in any previous level of review or decision-making on the issue that is the subject of the complaint or grievance.
23. PerformCare must require that anyone who participates in making the decision on a complaint or grievance was not involved in and is not a subordinate of anyone who was involved in any previous level of review or decision-making on the issue that is the subject of the complaint or grievance.
24. Upon receipt of a complaint or grievance, PerformCare must offer to provide Members with names and contact information of advocacy organizations available to assist Members.
25. If the decision of a Member's complaint or grievance indicates that a corrective plan of action and/or follow-up is needed to address quality of care concerns, PerformCare must implement the corrective plan of action and/or follow-up and document the actions taken in the complaint or grievance record or include in the record where documentation of the action or follow-up can be found.
26. If a Member continued to receive services at the previously authorized level because the Member filed a Complaint, Grievance, or Fair Hearing to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving within one calendar day from the mail date on the written notice of decision if acute inpatient services were being discontinued, reduced, or changed or within 10 calendar days from the mail date on the written notice of decision if any other services were being discontinued, reduced, or changed, PerformCare must pay for the services pending resolution of the Complaint, Grievance, or Fair Hearing.
27. PerformCare must notify the Member when PerformCare fails to decision a first level complaint or grievance within the timeframes specified in Appendix H.

PerformCare must mail this notice to the Member 1 day following the date the decision was made.

28. PerformCare must 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. PerformCare must mail this notice to the Member on the day that the decision is made to deny payment.
29. PerformCare must notify the Member when it denies payment after a service(s) has been delivered because the service(s) provided is not a covered service(s) for the Member. PerformCare must mail this notice to the Member on the day that the decision is made to deny payment.
30. PerformCare must notify the Member when it denies payment after a service(s) has been delivered because PerformCare determined that the emergency room service(s) was not medically necessary. PerformCare must mail this notice to the Member on the day the decision is made to deny payment.
31. PerformCare must notify the Member when it denies the Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities. PerformCare must mail the notice to the Member on the day the decision was made to deny the request to dispute a financial liability.
32. PerformCare must include the Non-Discrimination Notice and Language Assistance Services templates when sending a letter or notice to a Member and Member's representative if the Member has provided PerformCare with written authorization that indicates that the representative may be involved and/or take action on the Member's behalf.
33. PerformCare must use the templates supplied by the Department. PerformCare may not modify the templates, and must follow the instruction in the templates for including detailed, specific information related to the complaint or grievance.

Grievance Monitoring

1. Grievances are reviewed for Medical Necessity by a psychiatrist or psychologist, from PerformCare or from Prest
2. The psychologist or psychiatrist participating in the review will be responsible for:
 - ✓ Leading the deliberation
 - ✓ Listening to the input of the other panel members
 - ✓ Weighing all information provided during the meeting and deliberation
 - ✓ Rendering the final decision
 - ✓ Completing and submitting the Grievance Review Committee Report to the C&G Department
3. This same psychologist/psychiatrist will be documented in all aspects of the case as the person who participated in the review and rendered the decision. Such locations include:
 - ✓ The meeting sign-in sheet
 - ✓ The Internal Grievance Assessment
 - ✓ The Grievance Review Committee Report
 - ✓ Any other applicable documentation that would reference the review of a specific grievance review.

Checklist for Grievance Monitoring

Grievance Episode		
C&G Coordinator		
Reviewer's Name		
Is the reviewer's name in the following locations?	<u>Yes</u>	<u>No</u>
Sign-in sheet	☐	☐
Report	☐	☐
Assessment	☐	☐