PerformCARE®	Policy and Procedure
Name of Policy:	6-Criteria Complaint
Policy Number:	QI-042
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Quality Improvement
Related Stakeholder(s):	All departments
Applies to:	Associates
Original Effective Date:	08/22/18
Last Revision Date:	08/21/18
Last Review Date:	05/28/21
Next Review Date:	05/01/22

Policy: PerformCare has established a fair and uniform process for Members to resolve 6-criteria complaints 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 that Members have access to an organized process to address 6-Criteria complaints.

Definitions: **Complaint:** A dispute or objection regarding a participating healthcare provider or the coverage, operations, or management of PerformCare, which has not been resolved by PerformCare and has been filed with PerformCare or with Pennsylvania's Department of Health (DOH) or Insurance Department. PerformCare recognizes two types of complaints: 6-Criteria and Dissatisfaction Complaint.

6-Criteria Complaint: A complaint involving but not limited to, any of the following:

a. a denial because the requested service is not a covered service;
b. failure of PerformCare to meet the required timeframes for providing a service;
c. failure of PerformCare to decide a complaint or grievance within the specified timeframes;
d. a denial of 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;

e. a denial of payment after a service(s) has been delivered because the service(s) is not a covered benefit;
f. a denial of a request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities; or
g. a Member's dissatisfaction with PerformCare or a Provider (*As referenced in QI-043 Dissatisfaction Complaint Policy*).

Dissatisfaction Complaint: A complaint related to a Member's dissatisfaction with PerformCare or a Provider.

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 6-criteria complaint 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.

Denial of Services: A determination made by a PerformCare physician/psychologist advisor (PA) in response to a Provider's or Member's request for approval to provide a service of a specific amount, duration and scope which:

a. disapproves the request completely or
b. approves provision of the requested service(s) but for a lesser amount, scope, or duration than requested or
c. disapproves provision of the requested service(s) but approves provision of an alternative service(s) or
d. reduces, suspends, or terminates a previously authorized service.

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 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 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 6-criteria complaint review, an external 6-criteria complaint 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.

PSR: Commonwealth of Pennsylvania Department of Human Services Health Choices Behavioral Health Program – Program Standards and Requirements.

Acronyms: None

Procedure:

1. Internal Review Process for a 6-Criteria Complaint

1.1. A 6-criteria complaint must be filed within 60 calendar days from the date of the incident complained of or the date of the written notice of a decision.

1.2. Any PerformCare Associate can take the initial details of a Member and/or Member representative initiated complaint. A complaint and grievance (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 6-criteria complaint either orally or in writing. If filed orally, the request will be committed to writing and provided to the Member or the Member's representative for signature. The signature may be obtained at any point in the process. Failure to obtain a signed request for complaint will not delay the 6-criteria complaint process.

1.4. A Member may be afforded continuation rights through the 6-criteria complaint process, provided all conditions have been met as defined above.

1.5. Within 5 business days of receipt of the 6-criteria

complaint, PerformCare will send the Member and the Member's representative, if designated, an acknowledgment letter.

1.6. Each 6-criteria complaint will be investigated by the C&G Department.

1.7. Each 6-criteria complaint will be reviewed by a committee comprised of one 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 process. No committee member will be a subordinate of any previous decision-maker.

1.8. For 6-criteria complaints involving a clinical issue, 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 6-criteria complaint, after taking into consideration input from any other review committee members.

1.9. At least 2 calendar days prior to the review meeting, all committee members will receive a complaint information packet for review. Committee members are expected to review (but not discuss) the information in advance of the meeting. All complaint materials will be properly discarded upon conclusion of the meeting.

1.10. The Member will be afforded a reasonable opportunity to be present during the review. All attendees/participants of the review meeting will conduct themselves in a professional, respectful and impartial manner.

1.10.1. PerformCare will be flexible when scheduling the complaint 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.

1.10.2. 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.

1.10.3. The Member and/or anyone of the Member's choosing may present information related to the 6-criteria complaint. Providers may only attend with the Member's consent.

1.10.4. Individuals not directly involved with the 6-

criteria complaint review may attend the meeting for training purposes, with prior consent from the Member.

1.11. PerformCare's investigator must attend the review meeting to present the issues of the 6-criteria complaint. This investigator may not be involved in the decision made by the committee.

1.12. The review committee must complete its review of the 6-criteria complaint and render a decision no later than 30 calendar days from the receipt of the 6-criteria complaint. The Member may request a one-time extension of 14 calendar days.

1.13. 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 calendar days from the receipt of the 6-criteria complaint, PerformCare will send a written notice of its decision to the Member, the Member's representative (if applicable), and the targeted provider, unless the timeframe has been extended by up to 14 calendar days at the Member's request. Both the summary and the letter will be maintained as part of the 6-criteria complaint record.

1.14. The review committee may also recommend provider follow-up. Referrals will be submitted to the appropriate PerformCare department(s) with the expectation for completion within 30 calendar days. PerformCare staff will document completion of the follow-up as part of the 6-criteria complaint record.

2. External Review Process for a 6-Criteria Complaint

2.1. A request for an external review of the 6-criteria complaint must be filed orally, hand delivered, or post-marked within 1 calendar day from the mail date on the written notice for acute inpatient services, or within 10 calendar days from the mail date on the written notice for any other services. This request may be filed with either Pennsylvania's DOH or Insurance Department.

2.2. A Member may be afforded continuation rights, provided all conditions have been met as previously defined.

2.3. Upon the request of either DOH or Pennsylvania's Insurance Department, PerformCare must submit all records from PerformCare's 6-criteria complaint review to the requesting department within 30 calendar days from the request and in the manner prescribed by that department. Additional materials related to the 6-

criteria complaint may be submitted by the Member, their healthcare provider, and/or PerformCare.

2.4. DOH and Pennsylvania's Insurance Department will determine the appropriate agency for the review.

3. DHS Fair Hearing Process for a 6-Criteria Complaint

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 6-criteria complaint.

3.2. A Member may 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, or a shorter time if requested by the Member. 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. 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.

4. Expedited Review Process for a 6-Criteria Complaint

4.1. PerformCare must conduct an expedited review of a 6-criteria complaint if a determination has been made by the BHMCO or from a written certification by Members 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 6-criteria complaint 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 complaint 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 a 6-criteria complaint may be filed either in writing or orally.

4.4. Upon receipt of a request for expedited review, PerformCare must inform the Member of their right to present information they deem relevant to the 6-criteria complaint, their right to do so in person or in writing, and the limited time they have available to do so.

4.5. The Member may be afforded continuation rights, provided all conditions have been met as defined above.

4.6. The expedited review for a 6-criteria complaint will be performed by a review committee comprised of one or more employees of PerformCare who did not participate in the issue that is subject of the 6-criteria complaint. No one with any previous involvement may become involved in the decision making of the 6-criteria complaint. No committee members will be a subordinate of any previous decision-maker involved in the 6-criteria complaint.

4.7. At least one member of the committee must 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 6-Criteria complaint, after taking into consideration input from any other review committee members.

4.8. The review committee must prepare a summary of the issues presented, the decision made, and the rationale for that decision. This summary must be maintained as part of the expedited 6-criteria complaint record.

4.9. PerformCare must give notice of the decision within either 48 hours of receiving the written certification or 72 hours of receiving the Member's request, whichever is shorter, unless the time frame for deciding the expedited complaint has been extended by up to 14 calendar days at the request of the Member. This notification must take place either in person or via phone to the Member, the Member's representative (if designated), the service Provider, and the prescribing Provider (if applicable).

4.10. PerformCare must also mail a written notice of the decision within 2 business days of the decision.

5. Expedited External Review Process for a 6-Criteria Complaint

5.1. A request for an expedited external review of a 6-criteria complaint may be filed within 2 business days

from the date the Member receives PerformCare's decision of the expedited 6-criteria complaint.

5.2. A Member may 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 6-criteria complaint review may be filed either in writing or orally.

5.4. PerformCare must follow DOH guidelines related to submission of requests for expedited external 6-criteria complaint reviews.

6. Expedited DHS Fair Hearing Process for a 6-Criteria Complaint

6.1. An expedited fair hearing may be filed within 120 calendar days from PerformCare's written decision of the expedited 6-criteria complaint review.

6.2. The Member must exhaust the 6-criteria complaint 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 6-Criteria complaint or supports a Member's request.

6.4. The request may be filed orally or in writing.

6.5. A Member may be afforded continuation rights, provided all conditions are met as previously defined.

6.6. Upon receipt, 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. 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 6-Criteria Complaint

8.1. A healthcare provider may file a 6-criteria complaint.

8.2. The Member must authorize and give consent for Provider to file a 6-criteria complaint.

8.3. Written consent will be obtained and maintained in the Member's record.

8.4. Providers may NOT require the Members to sign a document giving authorization for Provider to file a 6-criteria complaint as a condition of treatment.

8.5. A healthcare provider may not bill the Members for services provided as part of a 6-criteria complaint once they assume the responsibility for filing the 6-criteria complaint.

8.6. A Member may choose to rescind their consent at any time during the 6-criteria complaint process.

8.7. A Member may not file a 6-criteria complaint for the same services denied, unless the healthcare provider fails to file the 6-criteria complaint or fails to continue the 6-criteria complaint process.

8.8. A Member's consent is automatically rescinded if the healthcare provider fails to file a 6-criteria complaint or fails to continue the 6-criteria process.

8.9. A Member may continue with the 6-criteria complaint at the point the healthcare provider failed to continue with the process.

8.10. A Member may choose at any time during the 6-criteria complaint process to provide consent for the healthcare provider to continue with the 6-criteria complaint process.

8.11. A healthcare provider must provide the Member or the Member's representative notification of their intent not to pursue the 6-criteria complaint 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 (with the Member's consent) to file an external review of a 6-criteria complaint, 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. The Member will at no time be expected to pay for any 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: *QI-043 Dissatisfaction Complaint Policy*
QI-044 Grievance Policy

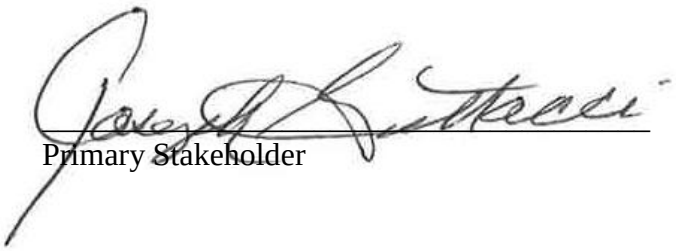
Related Reports: None

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-001 Complaint Policy*
QI-CG-001 Complaint and Grievance Policy

Attachments: *Attachment 1 General Requirements for Complaint, Grievance, and Fair Hearing Processes*

Approved by:



Primary Stakeholder

PerformCARE®

QI-042 Attachment 1

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 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. PerformCare must designate and train sufficient staff to be responsible for receiving, processing, and responding to Member Complaints and Grievances in accordance with the requirements in Appendix H.
10. Anyone involved in the complaint and grievance processes must receive training in the areas related to their responsibility at least annually or more frequently, if needed. This includes all PerformCare staff as well as County and Consumer Representatives who participate in review committees.
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, implementation, and management 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 representative

    PerformCare 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 obtain and document all consents and authorizations from Member or Representative through the Complaint or Grievance process.

18. PerformCare must ensure that there is a link between the Complaint and Grievance processes and the Quality Management and Utilization Management programs.

19. 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.

20. PerformCare must accept complaints and grievances from Members who have disabilities and which may be given in alternative formats including: TTD/TTY; 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 so they treat these Members with patience, understanding, and respect.

21. 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.

22. PerformCare must provide language interpreter services when requested by a Member at no cost.

23. PerformCare must offer Members the assistance of a PerformCare staff throughout the complaint and grievance processes at no cost. 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.

24. 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.

25. 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.

26. If the outcome 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.

27. 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.

28. PerformCare must provide written notification to Member when PerformCare:
    a. fails to decide a first level complaint or a grievance within the time frames specified in Appendix H- this notice must be mailed to the Member 1 calendar day following the date the decision was to be made
    b. 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- this notice must be mailed to the Member on the day that the decision is made to deny payment
    c. denies payment after a service(s) has been delivered because the service(s) provided is not a covered service(s) for the Member- this notice must be mailed to the Member on the day that the decision is made to deny payment
    d. denies payment after a service(s) has been delivered because PerformCare determined that the emergency room service(s) was not medically necessary- this notice must be mailed to the Member on the day the decision is made to deny payment
    e. denies the Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities- this notice must be mailed to the Member on the day the decision is made to deny payment

29. PerformCare must include **Attachments 10a and 10b** of *Appendix H* when sending a letter or notice to a Member and a 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.