

# Quality Management Department

DBHIDS/CBH defines, evaluates, and reviews all aspects of the delivery of behavioral health services to each individual covered under HealthChoices for Philadelphia County. The goal of DBHIDS/CBH is to ensure that appropriate treatment options are provided to individuals in a culturally sensitive, quality-driven, and supportive environment.

The Quality Management Department provides education to participating providers and people in recovery about quality of service standards. DBHIDS/CBH requires that a provider develop internal quality improvement processes that enhance and support the quality of care delivered. The Quality Management Department works closely with other DBHIDS/CBH departments to monitor the service delivery of providers. The Quality Management Department is responsible for monitoring the following:

- ◆ Complaint procedure (member driven)
- ◆ Complaint procedure (provider driven)
- ◆ Grievance process
- ◆ Provider teaming
- ◆ Quality concerns
- ◆ Clinical appeals
- ◆ Significant incident reports
- ◆ “Provider Preventable Conditions” reporting

## Complaint Procedure (Member Driven)

Providers should be aware that members have a right to complain and appeal. This process is detailed in the CBH Member Handbook that is issued to all members. A complaint is a dispute or objection filed with CBH regarding a participating healthcare provider or the coverage, operations, or management policies of CBH, including, but not limited to:

- ◆ A member’s dissatisfaction with CBH or a provider
- ◆ A denial because the requested service is not a covered benefit
- ◆ Failure of CBH to meet the required timeframes for providing a service, which includes CBH failure to deliver all services as authorized
- ◆ Failure of CBH to decide a complaint or grievance within the specified timeframes
- ◆ A denial of payment after a service(s) has been delivered because the service was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program
- ◆ A denial of payment after a service(s) has been delivered because the service is not a covered benefit
- ◆ When the term does not include a grievance (the term/process for a Complaint is not related to those service approval items that are included under the Grievance process.)

Anyone can file a complaint. The member may designate a member representative through written authorization. Should CBH not receive a representative form, the information will be shared with the member only. The member has the right to withdraw any filed complaint at any point in the process by contacting CBH at 1-888-545-2600.

CBH has established and maintains an internal complaint process with two levels of review. Complaints can also be expedited. In order for CBH to process an expedited request CBH must receive certification from the provider indicating that the member's life, health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy if the complaint is resolved in the standard time frame of 30 days.

Complaints can be called in to CBH Member Services (1-888-545-2600) or received via mail. Complaints can also be received from individuals with disabilities using alternative formats.

**First level review process includes:**

- ◆ A first level review committee consisting of
  1. one or more CBH employees who have not been involved in the original process, and
  2. a CBH physician or psychologist for clinically-related complaints.
- ◆ The allowance of a written or oral complaint
- ◆ The allowance of written data or other supporting information
- ◆ An investigation of the complaint, which will be completed within 30 days of the receipt of the complaint
- ◆ Written notification to the member regarding the decision of the initial review committee within five business days of the decision (includes the basis for the decision and the procedure to file a second level review of the decision of the initial review committee)

**Second level review process includes:**

- ◆ A review the first level decision by a second level committee consisting of
  1. three or more individuals who did not participate in the initial review,
  2. consumer representation (comprising one-third of the committee), and
  3. an alternate CBH physician or psychologist (if one participated in the first level review).
- ◆ The allowance of a written or oral complaint
- ◆ The allowance of written data or other supporting information

- ◆ An review of the first level review, which will be completed within 30 days of the receipt of the second level complaint
- ◆ Written notification to the member regarding the decision of the second level review committee within five business days of the decision (includes the basis for the decision)
- ◆ A term that the member has 15 days to appeal the decision of the second level review committee to the Department of Health or the Insurance Department, as appropriate

### **Expectations for providers during the first level process**

In compliance with Pennsylvania Act 68 of 1998, CBH is required to investigate and respond to all complaints brought to our attention by CBH members or, in the case of children, by parents/guardians. A CBH investigator will determine what is necessary to resolve the complaint, including citing policies/procedures, touring provider site, reviewing medical record, and/or speaking to member and/or provider staff. CBH may also request a written response from provider agencies in pursuit of resolution of complaints. The provider is expected to send all requested documentation to CBH within seven days of the request. If a member or legal guardian requests a copy of any correspondence received from the provider related to the complaint response, CBH is required to forward it to them. Provider cooperation is essential and is documented in every complaint.

### **Expectations for providers during the second level hearings**

CBH is compelled by Pennsylvania Act 68 of 1998 to hold hearings for all second level complaints upon request by CBH members; the scheduling and execution of these hearings often requires a great investment of time for CBH, the provider, and our members. CBH expects providers to participate in second level complaint hearings if the member requests provider participation; providers should be prepared to address the questions and concerns of both the hearing panel and the CBH member(s) involved.

## **Complaint Procedure (Provider Driven)**

A provider can file a complaint at 215-413-8581 regarding any CBH employee or CBH practice. The Director of Quality Management will contact the provider's Chief Executive Officer(CEO) to verify they want to proceed with the complaint. If the CEO wishes to proceed, the complaint will be resolved within 30 days and a decision letter issued within five business days of the decision.

# Grievance Procedure

A grievance is a request for CBH to reconsider a decision solely concerning the Medical Necessity Criteria (MNC) and appropriateness of a health care service. A grievance may be filed regarding a CBH decision to:

- ◆ Deny, in whole or in part, payment for a service if based on lack of Medical Necessity
- ◆ Deny or issue a limited authorization of a requested service, including the type of level of service
- ◆ Reduce, suspend or terminate a previously authorized service
- ◆ Deny the requested service but approve an alternative service

CBH has established and maintains an internal grievance process with two levels of review and an expedited grievance process. In order for CBH to process an expedited request CBH must receive certification from the provider indicating the member's life, health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy if the grievance is resolved in the standard time frame of 30 days. The member may designate a member representative through written authorization. Should CBH not receive representative form, the information will be shared with the member only.

## **First level grievance process includes:**

- ◆ A psychologist/ physician review of the medical record and additional information submitted (if applicable)
- ◆ A psychologist/ physician decision to uphold, partially overturn, or overturn the initial decision
- ◆ Completion of the review within 30 days of the receipt of the grievance
- ◆ Written notification to the member regarding the decision of the initial review committee within five business days of the decision (includes the basis for the decision and the procedure to file a second level review of the decision of the initial review committee)

## **Second level grievance process includes:**

- ◆ A review of the first level decision by a second level review committee consisting of
  1. three or more persons who did not previously participate in any decision to deny payment for the health care service and,
  2. consumer representation (comprising one-third of the committee)
- ◆ Notification to the member or the healthcare provider of the right to appear before the second level review committee 15 days prior to the scheduled date

- ◆ The completion of the second level review within 30 days of the receipt of the request for review
- ◆ A written notification to the member and healthcare provider regarding the decision of the second level review committee within five business days of the decision, including the basis and clinical rationale for the decision and the procedure for appealing the decision

CBH has established and maintains an external grievance process by which a member, personal representative with the written consent of the member, or a healthcare provider with the written consent of the member, can appeal the denial of a grievance following the completion of the internal grievance process. The external grievance process will be conducted by a certified review entity not directly affiliated with CBH. In order to file an external grievance CBH Member Services must be contacted. Additionally, a Fair Hearing can be filed by a member, personal representative with written consent of the member, or health care provider with the written consent of the member when a denial is issued. A Fair Hearing can be filed at anytime following the issuance of a denial letter.

## Provider Teamings

An interdepartmental provider teaming is convened when CBH becomes aware of a significant provider-related issue. This may include quality concerns, significant member incidents, a Provisional Licensing status by the Office of Mental Health and Substance Abuse Services (OMHSAS) or the Department of Drug and Alcohol Program (DDAP), or a request initiated by the CBH Board of Directors. Any CBH Officer or staff person in consultation with the Director of Quality Management can convene a Provider Teaming. Depending on the nature of the concern, staff representing Quality Management, Compliance, Medical Affairs, Network Development, Clinical Management, Provider Relations, Network Improvement and Accountability Collaborative (NIAC), Member Services, Performance Evaluation, Analytics and Research (PEAR), Consumer Satisfaction Team (CST), Behavioral Health Special Initiative (BHSI), and/or other DBHIDS staff may be included in the provider teaming. During the teaming, a review of all issues occurs and a plan of action is determined. Plan of action may include but not be limited to: a request for a Quality Improvement Plan or action plan, chart reviews, or site visit.

## Quality Concerns

Quality of care issues are typically generated by Clinical Management and/or Medical Affairs as a result of clinical and service request reviews, NIAC post site visit, or by Member Services regarding incidents and member concerns when members do not wish to file a formal complaint.

# Clinical Appeals Procedure

Providers may submit a clinical appeal in writing to request retrospective reimbursement for days of service not authorized. Appeals can occur at two levels:

## First level appeals:

- ◆ All first level appeal requests must be submitted no more than 90 days after the last day of the episode of care in question.
- ◆ The appeal packet must include:
  - ✓ Cover letter addressed to:

Community Behavioral Health  
Clinical Appeals Specialist  
801 Market Street  
Seventh Floor  
Philadelphia, PA 19107
  - ✓ Level of care being requested
  - ✓ Exact dates of service being requested
  - ✓ Member CBH identification number or social security number
  - ✓ Contact information (phone number and address) to whom an appeal response letter should be addressed
  - ✓ Brief reason for the appeal
  - ✓ Copies of documentation supporting the days in question
  - ✓ All evaluation/assessments required by the clinical care management department to determine medical necessity (i.e. psychiatric evaluations, CBE's, CBR, ASAM's, PCPC's)
  - ✓ All progress notes
  - ✓ All treatment plans
  - ✓ All discharge plans
- ◆ The Appeals Specialist will review the case. The Appeals Specialist will determine if the case warrants an:
  - **Administrative Review** - meaning the provider did not adhere to CBH protocols or the case involves a clerical error or

- **Physician Review** - meaning the dates in question were denied by a CBH physician and the case needs to be reviewed by another CBH physician.
- ◆ CBH will notify providers of the result of their first level appeal in writing within 30 days of the receipt of the appeal request. If the results indicate physician review, the provider may submit a second level appeal. Instructions on how to submit this second level appeal will be provided within the response letter. Please keep in mind a provider cannot seek a second level appeal if the first level appeal was denied due to an administrative review.

### **Second level appeals:**

- ◆ All second level appeals must be submitted no more than 30 days from the date of the first level appeal response letter. Resubmission of the clinical information is not necessary.
- ◆ All second level appeals should be addressed to:

Community Behavioral Health  
Clinical Appeals Specialist  
801 Market Street  
Seventh Floor  
Philadelphia, PA 19107

- ◆ A CBH physician (that has never reviewed the days in question for medical necessity) will review the clinical information. CBH will notify providers of the result of their second level appeal in writing within 30 days of the receipt of the appeal request.

## **Documentation and Reporting of Significant Incidents**

DBHIDS/CBH instituted a centralized process for reporting all Significant Incidents. CBH serves as a clearinghouse for this process. The policy applies whenever a provider reports a significant incident involving adult and child DBHIDS/CBH members of mental health and drug and alcohol services, whether they are: CBH members receiving in-plan services, or county-funded individuals receiving supplemental funding through the Office of Addiction Services, including those served by the Behavioral Health Special Initiative (BHSI). Please also see bulletin 15-06.

### **Reportable Significant Incidents include, but are not limited to, the following:**

- ◆ Death of a member
- ◆ Restraints (physical, mechanical, and chemical)
- ◆ Seclusion
- ◆ Homicide (committed by a member who is receiving services or has been discharged within 90 days)

- ◆ Suicide attempt (with or without medical intervention)
- ◆ Act of violence requiring medical intervention (includes intervention provided by nurse/physician), by or to a member (mental health provider only if committed by member)
- ◆ Alleged or suspected abuse (physical, sexual, verbal, financial) of or by a member
- ◆ Adverse reaction to medication and/or medication error administered by a provider (includes Medication Assisted Treatment dispensing errors)
- ◆ Any physical ailment or injury that requires non-routine medical attention at a hospital on an emergency, outpatient, or inpatient basis (this includes visits to urgent care)
- ◆ Neglect which results in injury or hospital treatment (committed by mental health provider)
- ◆ Missing person: a child who has not returned to home or facility within 4 hours, or an at-risk adult who has not returned home or facility within 24 hours (includes filing of a police report)
- ◆ Police involvement or arrest (excludes involuntary commitments (302s))
- ◆ Fire, flood, or serious property damage at a site where behavioral health services are delivered or a facility where members reside
- ◆ Infectious disease outbreak at a provider site
- ◆ All non-routine discharges from inpatient, residential rehabilitation (drug & alcohol), children's residential treatment, detoxification, or methadone maintenance treatment (i.e., administrative/ involuntary discharges or leaving a facility against medical or facility advice (AMA, AFA))
- ◆ Any sexual contact involving a minor, non-coerced or otherwise, that occurs at a provider site
- ◆ Presence of contraband (illicit substances and synthetic cannabinoids) at a bed-based facility.

### **Reporting Process:**

1. A copy of all reportable incidents must be faxed to the Quality Management Department at (215) 413-7132 on the [Significant Incident Report](#) form within 24 hours of an occurrence or upon notification of an occurrence. All Significant Incident Report forms must indicate the Provider Number in section seven. Reports of children who have not returned home or to the facility within four hours must be reported immediately.

EXCEPTION: All Long Term Structured Facilities (LTSR) and Community Residential Rehabilitation programs (CRR) will only enter the reportable incident into the Home and Community Services Information System (HCSIS) within 24 hours of the occurrence.

2. A death that occurs at a provider facility must be reported immediately to the CBH Psychiatric Emergency Services (PES) line at (215) 413-7171.



3. When an internal investigation is warranted, the provider must submit a copy of the investigative report to CBH within 14 days of the incident. Investigative reports must clearly document how the incident was investigated and the findings of the investigation, including any corrective actions taken to prevent future occurrence. Investigative reports may be faxed to the Quality Management Department at (215) 413-7132 or mailed to:

Community Behavioral Health  
Quality Management Department  
801 Market Street, 7th Floor  
Philadelphia PA 19017

NOTE: If an investigation is not completed within the designated 14 days, the provider must notify the Quality Management Department of the investigation status, including preliminary findings, and a projected investigation completion date.

4. Incidents involving alleged physical abuse, sexual abuse, and/or neglect of children must be reported to the Pennsylvania Department of Human Services (PA DHS). Providers are mandated by the PA DHS to report incidents directly by calling the Commonwealth's Childline at (800) 932-0313 or submitting the information via the online portal, <https://www.compass.state.pa.us/cwis/public/home>.

5. Providers must submit the PA DHS notification letter (indicated/unfounded) to the Quality Management Department upon receipt. If the provider has not received a notification letter, but has received a verbal communication from the PA DHS, provider must notify the Quality Management Department of the date the verbal determination was provided and the name of the investigator providing the verbal determination. If an allegation is deemed indicated or a Licensing/Approval/Registration Inspection Summary Violation is issued the provider must submit a copy of the Licensing/Approval/Registration Inspection Summary Violation and the corresponding Corrective Action Plan submitted to the PA DHS.

6. Incidents involving alleged physical abuse, sexual abuse, and/or neglect of an adult between 18 and 59 years old, who has a physical or mental impairment that substantially limits one or more major life activities, must be reported to the PA DHS. Providers are mandated by the PA DHS to report incidents directly by calling the Commonwealth's Protective Services Hotline at (800) 490-8505.

7. A missing person who is considered to be at-risk should be reported to the Acute Services Mental Health Delegates by faxing a Missing Person Report Form to (215) 732-2508. The form will be forwarded to all Crisis Response Centers (CRC), so that the CRC can notify the provider if the member presents at a CRC. The Mental Health Delegate phone number is (215) 685-6440.

## Where to Send Significant Incident Reports

All reportable incident must be faxed to CBH Quality Management	Fax: (215) 413-7132
Investigative reports may be faxed or mailed to CBH Quality Management	Fax: (215) 413-7132 Mail: Community Behavioral Health Quality Management Department 801 Market Street, 7 <sup>th</sup> Floor Philadelphia PA 19017
Incidents involving the suspected abuse/neglect of children must be reported to the Commonwealth's Childline.	Childline phone number: (800) 932-0313  Online: <a href="https://www.compass.state.pa.us/cwis/public/home">https://www.compass.state.pa.us/cwis/public/home</a>
An at-risk missing person should be reported to the Acute Services Mental Health Delegates.	Fax Missing Person Report form to (215) 732-2508  Mental Health Delegate phone number (215) 685-6440
Death of a member at a provider facility must be reported to the CBH PES Line.	PES Line phone number (215) 413-7171
Incidents involving the suspected abuse/neglect of an adult between 18 and 59 years old, who has a physical or mental impairment that substantially limits one or more major life activities, must be reported to the Commonwealth's Protective Services.	Protective Services Hotline at (800) 490-8505

## “Provider Preventable Conditions” Reporting

In accordance with the PA Department of Human Services’ (DHS) Medical Assistance Bulletin, titled "Provider Preventable Conditions" (July 1, 2012), providers must submit a Self Report Form to Community Behavioral Health upon the identification of a Provider Preventable Condition, to include HealthCare-Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC's). Please see the Bulletin, available at the following link: [http://www.pa.gov/cs/groups/webcontent/documents/bulletin\\_admin/p\\_036063.pdf](http://www.pa.gov/cs/groups/webcontent/documents/bulletin_admin/p_036063.pdf). The DPW bulletin clearly defines PPC, HCACs, OPPCs and the self reporting requirement in more detail and also includes a direct link to the Self Report Form.