Office Safety
Policy & Procedure Manual

2011

Section F

(Click on the sub-sections to jump to the specific section)

POLICY NUMBER	OS-F100
POLICY TITLE	**Change of Physician by Physician**
INITIAL EFFECTIVE DATE	10/98
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

When a serious problem develops in a patient/physician relationship, the physician may request that the patient be transferred to care of another physician.

Policy

It is the policy to promote a co-operative and beneficial relationship between the physician and patient.

Procedure

1) The physician will notify the patient by registered mail requesting that the patient seek another physician.

2) The physician will notify the Medical Department and Membership Services of the request to the patient to seek the care of another physician.

3) The Medical Department reviews all requests

4) Membership Services will coordinate and assist the client to transfer to another physician.

5) The original physician remains responsible for the patient until the effective date of the transfer.

Responsibility/Department Linkages

Physician requesting the transfer / QA Assessment Department

POLICY NUMBER	OS- F101
POLICY TITLE	**Grievance / Complaint**
INITIAL EFFECTIVE DATE	09/98
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

The Member Grievance Resolution Procedure is designed to handle member issues expeditiously and equitably. The types of questions or complaints addressed include those involving benefits, program administration, and medical care quality.

Definitions

A member grievance is a member's written or verbal expression of dissatisfaction of any kind and includes all complaints and appeals.

A member appeal is a further request by a member to reverse a denied grievance.

Policy

Members are informed through Plan specific literature to contact CCHCA for medical group related concerns, and to contact the Member Services Department of their HMO for all other problems. To the greatest extent possible, CCHCA encourages all of its members to present their problems or dissatisfactions as soon as they occur. If CCHCA cannot resolve a problem, the problem, including all backup information, will be referred to the contracted HMO.

The "Member Complaint Form" must be made available to all members who wish to submit a complaint. Copies of the form are found in the Physician Manual and are available from the HMOs' Member Services. However, the use of the Member Complaint Form is not a requirement for filing a request.

When members wish to submit a grievance to CCHCA, they should contact Member Services. Members must include all pertinent information from the Plan Identification Card and the details and circumstances of their concerns or problems. In addition, members are advised in their Evidence of Coverage that they may seek the assistance of the Department of Corporations in the resolution of a grievance.

Procedure

Under state law, grievances submitted by members must, whenever possible, be resolved within 30 days. Therefore, the CCHCA must, within 30 days of receipt of a grievance

from a member, provide the member with a written statement on the disposition or pending status of the grievance. If a member is dissatisfied or needs assistance, he or she is encouraged to first contact the medical group.

CCHCA is required to periodically report to contracted HMOs the number and types of complaints received, the disposition of those complaints, and the percentage of complaints that were resolved within 30 days. All reports are logged, tracked and trended. The CCHCA grievance system is audited annually by contracted HMOs.

In the event the member perceives that the medical group is unable to satisfactorily resolve the problem, the member may submit the matter with copies of all documentation directly to the contracted HMO as a formal grievance.

If the member's grievance involves imminent and serious threat to the health of the member, including but not limited to, potential loss of life, limb, or major bodily function, the grievance must be handled expediently. Therefore, CCHCA has established procedures for handling grievances which must be handled on an expedited basis. In such instances, the member must be immediately advised in an acknowledgment letter of their right to request assistance from the Department of Corporations. In addition, the member must be notified in writing of the disposition or pending status of such grievances within 5 days of receipt.

Denial of Services

CCHCA must have a qualified medical review of any claim, emergency, or requested service before a final decision is made concerning a denial of the services. When a case does not meet the criteria for authorized services, the member must be notified in writing of the reasons for the decision by the department denying the requested service.

The written notification must indicate the service that was denied, the reason for the denial, an explanation of how to properly obtain services in the future, a description of the alternative treatment that will be covered in the case of denied service (if applicable), and a statement explaining the member's right to appeal the denial by contacting their HMO or the Department of Corporations at 1-800-400-0815. Providers may call the Provider Relations Department.

All forms and written notices to a member relating to grievances must include notification in bold 12 point type of the member's right to seek assistance from the Department of Corporations. The notice must be in the exact form set forth above under "DOC Consumer Assistance".

CCHCA cannot review or issue any denial letters for investigational or experimental procedures in cases of terminal illness. The CCHCA must notify the contracted HMO immediately about a potential case and forward all pertinent documentation by overnight mail or fax.

Responsibility/Department Linkages

Initial level grievances are handled at CCHCA where the member is enrolled, if CCHCA has been delegated this responsibility by contracted HMO. If CCHCA cannot resolve the problem, the problem, including all backup information, is referred to the contracted HMO.

If CCHCA has not been delegated the responsibility for handling initial level grievances, all grievances are immediately referred to the contracted HMO.

QA Assessment Department

POLICY NUMBER	OS- F102
POLICY TITLE	**Member Appeal**
INITIAL EFFECTIVE DATE	10/98
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

Management of Member Appeal

Policy

To assure timely and appropriate resolution of member concerns by the Health Plan

Procedure

1. All denial letters should refer the member to Health Plan to appeal any denial. If the member calls or visits Member Services with an appeal, the department will assist the member in contacting the appropriate department at the contracted HMO.

2. The contracted HMO will contact the appropriate department of the medical group for additional manner.

3. The medical group shall provide the information requested by the contracted HMO in a timely manner.

Responsibility/Department Linkages

Quality Assessment Department, Member Services

POLICY NUMBER	OS- F102 (UHC HMO)
POLICY TITLE	**Member Appeal**
INITIAL EFFECTIVE DATE	10/98
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	UnitedHealthCare Commercial

Purpose

Management of Member Appeal

Policy

To assure timely and appropriate resolution of member concerns by the Health Plan

Procedure

1. All denial letters should refer the member to UnitedHealthCare to appeal any denial. If the member calls or visits Member Services with an appeal, the department will assist the member in contacting the appropriate department at the contracted HMO.

2. The contracted HMO will contact the appropriate department of the medical group for additional manner.

3. The medical group shall provide the information requested by the contracted HMO in a timely manner.

Responsibility/Department Linkages

Quality Assessment Department, Member Services

POLICY NUMBER	OS- F103
POLICY TITLE	**Members' Rights and Responsibilities**
INITIAL EFFECTIVE DATE	10/98
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

To ensure that members receive quality care that is professionally delivered in a respectful and professional manner.

Policy

It is the policy to demonstrate a commitment to treating members in a manner that respects their rights.

Procedure

1) Members have the right to voice grievances about the organization or the care provided. In turn, there is a timely and organized system(s) for resolving members' complaints and formal grievances. *See Complaints/Grievance Policy and Procedure.*

2) Members will participate in the decision-making process involving their health care.

3) Members will be treated with respect and recognition of their dignity and need for privacy.

4) Members will have the right to obtain the name, qualifications, and titles of the professionals providing their care. This information can be obtained through discussion with the health care provider , Health Plan or Medical Group.

5) All participating providers will display a copy of the members' rights and responsibilities in appropriate languages at their office.

6) All providers ensure that the confidentiality of specified patient information and records is protected and maintained. See Protected Patient's Information Policy and Procedure.

7) Members will have a right to a candid discussion of appropriate of medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

8) Members can make recommendations regarding the members' rights and responsibilities policies to the Health Plan/Medical Group.

9) Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

10) Health Plan/Medical Group will distributes members' rights and responsibilities statement to:
    a. existing members
    b. new members
    c. existing practitioners
    d. new practitioners

Responsibility/Department Linkages

The physician(s), nursing and office staff. / Quality Assessment Department

POLICY NUMBER	OS- F104
POLICY TITLE	**Non-Compliance**
INITIAL EFFECTIVE DATE	10/98
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

Document patient non-compliance with plan of care

Policy

Provide quality care to all patients

Procedure

Physician shall document plan of care and discussion with patient in medical record. If the patient does not follow the proposed plan of care and the physician feels that in doing so the patient's health and well-being maybe seriously compromised the physician will do the following:

1) A notification (Exhibit A) is sent by certified mail to the patient with copies filed in the medical record; sent to the medical group and HMO.
2) If there is no response from the patient, a second notification (Exhibit B) is sent by certified mail to the patient with copies filed in the medical record; sent to the medical group and HMO.
3) Continued non-compliance requires, a final notice(Exhibit C) is sent by certified mail to the patient with copies filed in the medical record; sent to the medical group and HMO. Patient may be disenrolled with the medical group.

Responsibility/Department Linkages

Physician(s) / QA Assessment Department

POLICY NUMBER	OS-F105
POLICY TITLE	**Members' Right to File an Appeal or Grievance**
INITIAL EFFECTIVE DATE	01/05
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP
LINES OF BUSINESS	All

Purpose

Inform members of their rights and the method for filing a grievance and/or appeal.

Policy

Information about the process for members who wish to file a grievance or appeal is available at provider sites.

Procedure

1. If a member requests information on how to file a grievance or appeal, copy the enclosed member flyer entitled "Your Right to File an Appeal or Grievance" in the member's preferred language and give to the member.

2. If the member has further questions, refer to Member Services.

3. If the member requests a Grievance Form, the forms are found in Section OS-F101 of the Office Safety Manual.

Department Linkages

Member Services.