

**North Carolina Department of Health and Human Services  
Division of Mental Health, Developmental Disabilities  
and Substance Abuse Services**

**Complaints/ Grievances and Concerns,  
Information and Referrals and  
Investigations**

**Guidelines for Customer Service Form and Quarterly  
Complaint/Grievance Trend Report**

May 2013



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## **DHHS STANDARDIZED CUSTOMER SERVICE FORM GENERAL INSTRUCTIONS**

### **Purpose**

The purpose of the **DHHS Standardized Customer Service Form** (DMH/DD/SAS Form ACS01) and the Quarterly Local Management Entity/ Managed Care Organization (LME/MCO) Complaint Reporting form is to assist in documenting and reporting concerns, complaints/grievances, compliments, investigations and requests for information involving any person requesting or receiving publicly-funded mental health, developmental disabilities, and/or substance abuse (mh/dd/sa) services from a LME/MCO, or a MH/DD/SA service provider. Quarterly reporting of complaints/grievances submitted to the LME/MCO is required by 10A NCAC 27G .0606, 42 CFR§ 438.228 and in Attachment B-Section 7.5 of the DMA contract. This standardized form is an option for LMEs/MCOs to use to document customer service issues such as concerns, complaints/grievances, compliments, investigations and requests for information.

### **Who May Use These Forms**

The DHHS Customer Service form was developed in order to have a standardized form designed to assist LMEs/MCOs in documenting customer service issues such as concerns, complaints/grievances, compliments, investigations and requests for information received by each LME/MCO Customer Service and Community Rights Office. This form is applicable to both 122C licensed and non-licensed service providers. Each LME/MCO may choose to use the form (manually or electronically), develop a database or utilize an application that is part of the LME/MCO software. Regardless of how the information is documented, the data collected must be compiled, analyzed and submitted to DMH/DD/SAS and DMA on a quarterly basis as required by 10A NCAC 27G .0609 and in Attachment B-Section 7.5 of the DMA contract.

### **What To Report And Where To Report It**

Document any concern, complaint/grievance, compliment, investigation and request for information involving any person requesting or receiving publicly-funded mental health, developmental disabilities, and/or substance abuse (mh/dd/sa) services from a local management entity (LME/MCO), or a MH/DD/SA service provider.

### **How To Complete the Customer Service Form**

- Electronically: The form is a Word document that can be completed on your computer. *Before filling out the form*, save the document with another name in order to protect your master copy of the form.
- Manually: Print the blank form and type or write in the answers, making sure your answers are legible.
- The form is available at:  
<http://www.ncdhhs.gov/mhddsas/statspublications/Forms/LMEForms/quarterlycomplaintreportform2-5-10.doc>

## CUSTOMER SERVICE FORM (ACS01- Revised April 2013) SPECIFIC INSTRUCTIONS

The staff person who receives the complaint should complete the complaint form upon receiving the complaint/grievance.

### Person Reporting Customer Service Issue

#### CUSTOMER SERVICE FORM

**Purpose:** This form is to be used by Local Management Entity/ Managed Care Organization (LME/MCO) staff to document customer service issues such as concerns, complaints, compliments, investigations and requests for information involving any person requesting or receiving publicly funded MH/DD/SA services from a LME/MCO or a MH/DD/SAS provider.

	<b>Tracking #:</b> _____
<b>Person reporting customer service issue:</b>	
<b>Date:</b> _____	
Name: _____	Phone: H: _____ W: _____ C: _____
Address: _____	
Person reporting customer service issue is:	
<input type="checkbox"/> Anonymous <input type="checkbox"/> Attorney <input type="checkbox"/> Consumer <input type="checkbox"/> Consumer advocate/representative <input type="checkbox"/> DMH/DD/SAS staff <input type="checkbox"/> Family member <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> DMA <input type="checkbox"/> LME/MCO Staff <input type="checkbox"/> Provider <input type="checkbox"/> Other (specify): _____	

- Record the date received and optional tracking number. The tracking number is developed and given by the LME/MCO.
- Record the name, address and phone numbers (home and work as applicable) of the person who is reporting the customer service issue.
- Check the category of the person reporting the concern, complaint/grievance, compliment, investigation or requesting information. If a family member is also the guardian, please check guardian only. If parent of adult child is not guardian, check family member.

### If Customer Service Issue Involves A Client

<b>If customer service issue involves a client:</b>	
Consumer name: _____ Phone: H: _____ W: _____ C: _____	
Address: _____	
DOB: _____ Age: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female    Disability (check all that apply): <input type="checkbox"/> MH <input type="checkbox"/> IDD <input type="checkbox"/> SA <input type="checkbox"/> UNK <input type="checkbox"/> N/A	
County of Services: _____ Medicaid County: _____ Home LME/MCO: _____ Host LME/MCO: _____	
Race/Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
Parent/Guardian: _____ Phone: H: _____ W: _____ C: _____	
Address: _____	
Funding Source(s): <input type="checkbox"/> County Funds <input type="checkbox"/> Health Choice <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Insurance <input type="checkbox"/> State Funds <input type="checkbox"/> Self-Pay	

Record all information requested if the concern, complaint/grievance, compliment, investigation or information request involves a consumer. Please note the following:

- Client Name: Record the consumer’s full name and any nickname commonly used.
- Phone Number: Record the phone number (home, work and/ or cellular).
- Address of Consumer: Record address where the consumer lives or last known residence.

- Date of Birth(DOB) and Age: Age will be listed as adult (18 years and above) or child (birth to 17). Actual date of birth will be recorded in DOB area. If you are unable to obtain the age of the consumer, please list “unknown”. If the customer service issue does not relate to a specific consumer, please list “does not apply”.
- Disability- check each of the mh/dd/sa diagnosis categories as applicable. The purpose of this information is to aid the Customer Service staff in determining the appropriate action needed. If you are unable to obtain the diagnosis of the consumer, please list “unknown”. If the customer service issue does not relate to a specific disability, please list “does not apply”.
- Medicaid County: List the name of the Medicaid county. Services may be based on this county if the person has Medicaid. Medicaid number is not needed.
- Host LME/MCO and Home LME/MCO: Information is needed in order to determine which LME/MCO will conduct provider monitoring (if needed) and home LME/MCO if this LME/MCO has to be alerted to complaint.
- Race/Ethnicity:: Information is needed for demographic statistics.
- Parent/Guardian: If the consumer is not his or her own guardian, request information about the guardian or legally responsible person. Obtain the address and phone number of the parent/guardian.
- Funding Source: The type of funding source is collected to aid the Customer Service staff in determining the appropriate response needed.

**How Customer Service Issue Was Received**

**Customer service issue was received via:**

Call   
  Customer Service Form   
  Email   
  Fax   
  In Person   
  Website   
  Written Correspondence  
 DMA Quality of Care

Check the method by which the Customer Service staff originally received this information.

**If Referred To The LME/MCO, Indicate Referral Source And Specify Which LME/MCO Or Office**

**If issue was referred to the LME/MCO, indicate referral source and specify which LME/MCO or office:**

Another LME/MCO   
  County Office   
  Provider's Office   
  DMH/DD/SAS   
  DMA   
  DHSR   
  Other  
 (Specify):

If the LME/MCO Customer Service Office staff received information from an LME/MCO or other agency, please specify the type of agency.

**Type Of Case**

**Type of Case:**  Complaint/Concern   
 Compliment   
 Information/Referral   
 Investigation   
**Priority:**  Routine   
 High

Please check the type of case received. If the case was not received as an investigation but later becomes an investigation, please remove the original case type and check investigation. A complaint/grievance or concern is any expression of dissatisfaction in writing or orally that the complainant perceives as a problem. An investigation is the process of conducting a formal inquiry into allegations related to funding, rights protection or LME/MCO responsibilities as defined by policies, rules and State and Federal laws

governing mh/dd/sas. Please check concern, complaint/grievance, compliment, investigation or information request in the “type of case” field.

**Nature Of Primary Customer Service Issue:**

<b>Nature of primary customer service issue. Issue is related to:</b> (Check only 1 Primary Issue)		
<input type="checkbox"/> Abuse, Neglect, Exploitation	<input type="checkbox"/> Basic Needs	<input type="checkbox"/> Provider Choice
<input type="checkbox"/> Access to Services	<input type="checkbox"/> Client Rights	<input type="checkbox"/> Quality of Services
<input type="checkbox"/> Administrative Issues	<input type="checkbox"/> Confidentiality/HIPAA	<input type="checkbox"/> Service Coordination Between Providers
<input type="checkbox"/> Authorization/ Payment/Billing	<input type="checkbox"/> LME/MCO Functions	<input type="checkbox"/> Other (specify): <input type="text"/>

Many concerns, complaints/grievances, compliments, investigations or information requests will have many issues, but only the primary issue needs to be checked. Please note the following:

- **Abuse, Neglect and Exploitation**- Any allegation regarding the abuse, neglect and/or exploitation of a child or adult as defined in APSM 95-2 (Client Rights Rules in Community Mental Health). **Any suspicion must be immediately reported to the local Department of Social Services and reported into IRIS (as applicable).**
- **Access to Services**- any complaint where an individual is reporting that he/she has had difficulty or not been able to obtain services
- **Administrative Issues by providers:** any complaint regarding a Provider’s managerial or organizational issues, deadlines, payroll, staffing, facilities, etc.
- **Authorization/ Payment Issues/ Billing- Provider Only:** Any complaint regarding the payment/financial arrangement, insurance, and/or billing practices regarding providers.
- **Basic Needs:** Any complaint regarding the ability to obtain food, shelter, support, SSI, medication, transportation, etc.
- **Client Rights Issue**- Any allegation regarding the violation of the rights of any consumer of mental health/developmental disabilities/substance abuse services. Clients Rights include the rights and privileges as defined in General Statutes 122C, APSM
- **Confidentiality/ HIPAA:** Any breach of a consumer’s confidentiality and/or HIPAA regulations.
- **LME/MCO Functions**- any complaint regarding LME functions such as Governance/ Administration, Care Coordination, Utilization Management, Customer Services, etc.
- **Provider Choice** - Any Complaint that a consumer or legally responsible person was not given information regarding available service providers.
- **Quality of Care** – By Providers- Any complaint regarding inappropriate and/or inadequate provision of services, customer services and services including medication issues regarding the administration or prescribing of medication, including the wrong time, side effects, overmedication, refills, etc.
- **Service Coordination Between Providers** - Any complaint regarding the ability of providers to coordinate services in the best interest of the consumer.

**Customer Service Issue Notes:**

<b>Customer service issue notes:</b> (Attach additional pages if needed)
<input type="text"/>

Document information and dates provided by the person reporting the concern, complaint/grievance, compliment, investigation or information request.

**If Customer Service Issue Is About A Provider Or Agency**

**If customer service issue is about a provider or agency:** **Provider Category:**  A  B  C  D

Provider/agency name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

If the concern, complaint, compliment, investigation or information request involves a provider or agency, provide the name, address and phone number of the provider agency. Check the category of the provider agency based on 10A NCAC 27G .0602.

**Type/ Level Of Service:**

Type/Level of Service: (Check all that apply)

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Adult Day Vocational Program  | <input type="checkbox"/> IDD Care Coordination                                       | <input type="checkbox"/> Outpatient Services             | <input type="checkbox"/> SA Intensive Outpatient                         |
| <input type="checkbox"/> Ambulatory Detoxification     | <input type="checkbox"/> Innovation Services   | <input type="checkbox"/> Partial Hospitalization         | <input type="checkbox"/> SA Comprehensive Outpt. Tx                      |
| <input type="checkbox"/> Assertive Community Tx Team   | <input type="checkbox"/> Intensive In-Home Services                                  | <input type="checkbox"/> Peer Support Services           | <input type="checkbox"/> SA Non-Medical Community Residential Tx         |
| <input type="checkbox"/> Child & Adolescent Day Tx     | <input type="checkbox"/> Long Term Vocational Supports                               | <input type="checkbox"/> Peer Support Service (B3-Only)  | <input type="checkbox"/> SA Medically Monitored Community Residential Tx |
| <input type="checkbox"/> Clinical Intake               | <input type="checkbox"/> Mobile Crisis Management                                    | <input type="checkbox"/> Psychosocial Rehabilitation     | <input type="checkbox"/> SA Halfway House                                |
| <input type="checkbox"/> Community Guide (MCO)         | <input type="checkbox"/> Medically Supervised or ADATC<br>Detox/Crisis Stabilization | <input type="checkbox"/> Psychological Evaluation        | <input type="checkbox"/> Social Setting Detoxification                   |
| <input type="checkbox"/> Community Support Team        | <input type="checkbox"/> Medication Administration                                   | <input type="checkbox"/> Psychiatric Services            | <input type="checkbox"/> Supported Employment                            |
| <input type="checkbox"/> Crisis Services               | <input type="checkbox"/> MH/SA Care Coordination                                     | <input type="checkbox"/> Residential Services (Category) | <input type="checkbox"/> Not Service Related                             |
| <input type="checkbox"/> Developmental Therapies       | <input type="checkbox"/> Multisystemic Therapy (MST)                                 | <input type="checkbox"/> Respite (MCO B3 Only)           | <input type="checkbox"/> Unknown/ Not Known                              |
| <input type="checkbox"/> Diagnostic Assessment         | <input type="checkbox"/> Non-Hospital Medical Detox                                  | <input type="checkbox"/> Respite                         |  |
| <input type="checkbox"/> Drop-In Center                | <input type="checkbox"/> Opioid Treatment  | <input type="checkbox"/> Screening, Triage and Referral  |  |
| <input type="checkbox"/> Facility-Based Crisis Program |  | <input type="checkbox"/> Sheltered Workshop              |  |
| <input type="checkbox"/> Other: _____                  |  |  |  |

Is the Provider Licensed?..... Yes  No  Licensing Agency:  DHSR  DSS

Check the type of service that is the subject of the concern, complaint/grievance, compliment, investigation or information request.

**Provider Licensure**

Check if the provider is licensed and by whom (DHSR, Licensing Agency or DSS)

## Residential

**Residential**

**Is Residential an issue in the complaint?**  Yes  No      **Was consumer involved in DOJ settlement?**  Yes  No

**Residential Type:**

<input type="checkbox"/> Own home	<input type="checkbox"/> Parents'/ Guardian's Home	<input type="checkbox"/> PRTF (Question Below)
<input type="checkbox"/> Therapeutic Foster Care		<input type="checkbox"/> Level III
<input type="checkbox"/> Supervised Living A (Adult with Mental Health Concerns)		<input type="checkbox"/> Family Care Home
<input type="checkbox"/> Supervised Living 5600 B (Minor with Intellectual/Developmental Disabilities)		<input type="checkbox"/> MH Apartment - Supervised
<input type="checkbox"/> Supervised Living 5600 C (Adult with Intellectual /Developmental Disabilities)		<input type="checkbox"/> Level IV
<input type="checkbox"/> Supervised Living 5600 D (Minor with Substance Abuse Concerns)		<input type="checkbox"/> SA Halfway House
<input type="checkbox"/> Supervised Living 5600 E (Adult with Substance Abuse Concerns)		<input type="checkbox"/> Other
<input type="checkbox"/> Supervised Living 5600 F (Alternative Family Living)		<input type="checkbox"/> No Residential Services
<input type="checkbox"/> Unsupervised Alternative Family Living		

**If PRTF, Residential Location:**  In-State     Out-of-State within 40 mile radius     Out of State outside of 40 mile radius

Did the person discuss the issue with the provider/agency? .....  Yes     No  
 Did the person give permission to use his/her name during discussion about this issue with the provider/agency?  Yes     No

**Issue in the Complaint:** Check “Yes” or “No” if residential is an issue in the complaint.  
**Residential Type:** Check the type of residential services that are involved in this complaint.  
**Was DOJ involved in DOJ settlement (In Reach, Tenancy Supports, etc.):** Check “Yes” or “No”.

**PRTF Residential Location:** Check if In-state, Out of State within 40 miles or Out of State outside of the 40 mile radius.

## Action Taken By LME/MCO:

**Action taken by LME/MCO:**

Shared the customer service issue with the provider/agency/person(s) involved.  
 Provided the information requested.  
 Facilitated informal discussion/resolution with the provider/agency involved.  
 Facilitated informal discussion/resolution within the LME/MCO.  
 Provided information on how to initiate a Medicaid appeal or LME/MCO complaint process.  
 Conducted Investigation. Person(s) investigating concern: \_\_\_\_\_  
 Concern was:  Substantiated     Partially Substantiated     Not Substantiated.  
 Based on findings:  No further action needed     Recommendations provided     Corrective Action Plan     Other Actions  
 Date report of findings issued: \_\_\_\_\_ Number of days from date received until report of findings issued: \_\_\_\_\_  
 Date Plan was received: \_\_\_\_\_ Plan was:  Accepted     Returned For Revision  
 Date Plan was resubmitted: \_\_\_\_\_ Resubmitted Plan was:  Accepted     Not Accepted  
 Date of Follow-up review: \_\_\_\_\_ Corrective actions were:  Successful     Unsuccessful  
 Referred to:  DHSR     DMH/DD/SAS     DMA     DSS     Licensing Board     Other (Specify) \_\_\_\_\_ Date: \_\_\_\_\_  
 For:  information     action (specify): \_\_\_\_\_

Please check the action completed by LME/MCO for a resolution of the issue.

- If an investigation is completed by LME/MCO staff, please complete all sections of the “Conducted Investigation” field.
- If information was referred to the local Department of Social Services, Division of Health Service Regulation, DMA (including Program Integrity) and/or Division of Mental Health/Developmental Disabilities/Substance Abuse Services, please complete all sections of the “Referred To” field.



## Summary of Concern Issue(s), Investigations and Actions Taken

**Summary Of Issue(s), Investigation, and Actions Taken** (Include dates) (Attach additional pages if needed):

█

Please record the steps taken toward resolution of the issue. Please include dates of the actions.

## Final Disposition

**Final Disposition:** [Action(s) taken include dates]

█

Please include a statement and date about the final action/resolution of the issue.

## Resolution

### Resolution

Issue(s) was(were):  Resolved/Completed  Partially Resolved  Unresolved

Resolved by:  LME/MCO  DHSR  DMH/DD/SAS  DSS  DMA (includes Program Integrity)  
 Licensing Board  Pending

Outcome of Complaints that were NOT Investigated:

- Information or technical assistance was provided to complainant
- Worked with Provider for Resolution
- Referred to Community Resource or Advocacy Group
- Referred to External Licensing or State Agency
- Referred to Another LME/MCO for resolution
- Mediation with parties

Resolution was Appealed:

- N/A
- 2<sup>nd</sup> Level Review to Client Rights Committee
- 2<sup>nd</sup> Level Review to LME/MCO Director
- Provider Appeal Panel

Number of Calendar Days from Receipt to Completion: █

Number of Working Days from Receipt to Completion: █

Date Resolved: █

**Written feedback of final disposition/resolution was provided to:**

█

Please also check whether the issue was resolved/completed, partially resolved or unresolved.

Information requests are resolved/completed when the requested information is provided or when you have properly referred the person to another resource. A complaint/grievance or concern is considered resolved/completed when the consumer/citizen accepts the outcome, withdraws his/her concern/complaint, referral to an appropriate state or licensing agency is made, or when no further action can be taken to assist the consumer. Please follow timeframes in Rules 10A NCAC 27G .0606, .0607 and

.0609 and the Policy for Consumer Complaints to an Area/County Program (DMH/DD/SAS Communication Bulletin #38). Per 10A NCAC .0606, LME/MCO staff should contact the state or local government agency to whom they referred the complaint in order to **determine the actions the State or local government agency has taken in response to the complaint.** Examples of when no further action can be taken include legal actions that require an attorney, restrictions of rules and laws, issues that are not within the scope of responsibility of the LME/MCO, person has exhausted all available steps in the complaint/grievance process, etc. In these cases, information and/or referral source is provided to consumer/citizen in addition to the reason that CSCR staff can take no further action. Investigations are resolved/completed when LME/MCO has completed all steps of their investigations and has mailed the final report to all applicable individuals (such as the complainant) and involved agencies. This includes any follow-up or corrective action reports that are generally completed by the Quality Management team at the LME/MCO.

**Note: Please also include the number of calendar days from receipt to completion, including days of investigation by other agencies. (The number of days that DSS, DHSR, DMA (including Program Integrity) or DMH/DD/SAS was involved is reported in the “Action Taken By LME/MCO” Section.)** Please also provide a listing (and dates) to whom written feedback regarding the final disposition was provided.

## QUARTERLY REPORTING OF COMPLAINTS

The collection of data regarding complaints/grievances and the reporting of these complaints/grievances to DMH/DD/SAS and DMA is required by 10A NCAC 27G .0609 and in Attachment B-Section 7.5 of the DMA contract. LMEs/MCOs are required to report aggregate information on complaints/grievances using a form provided by the DHHS. Compliments, requests for information and investigations do not need to be reported on this report.

### When To Report

Since many complaints/grievances result in an investigation or provider monitoring, there is a 45 day delay in reporting following the end of the quarter in order to obtain the outcome/resolution information for each complaint grievances.

### What/Where To Report

Aggregate information on complaints that is reported to the LME/MCO Customer Service Office is submitted via the Quarterly Report to DMH/DD/SAS and DMA. For each type of complaint, report:

- (1) the total number of complaints grievances received by the Customer Service Office,
- (2) the total number of persons (by category) who are reporting complaints grievances,
- (3) the age (if applicable) of the consumer involved in the complaint grievances,
- (4) the disability of the consumer (if applicable) involved in the complaint grievances,
- (5) the primary nature of the complaint grievances /concern \*
- (6) patterns and/or trends you have found in your internal QI process (e.g. high numbers of complaints grievances regarding one issue), and
- (7) how you are addressing any problems you have found in those patterns or trends.

The Customer Service form and Quarterly Complaint Trend Report templates are available at:  
<http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm#Forms>

**Direct Any Questions To:**

DMH/DD/SAS Customer Service and Community Rights Team  
Phone: (919) 715-3197 Fax: (919) 733-4962

or

**dmh.advocacy@ncmail.net**

## Glossary

“Complaints/Grievances or Concerns” means an expression of dissatisfaction about any matter other than an action, as “action” is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State Fair Hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

"DHSR" means the Division of Health Service Regulation, 701 Barbour Drive, Raleigh, N.C. 27603.

“Information/Referrals” are either direct requests for information or requests regarding an agency, group, person or service.

“Investigation” is the process of conducting a formal inquiry into allegations related to funding, rights protection or LME/MCO responsibilities as defined by policies, rules and State and Federal laws governing mh/dd/sas. This includes targeted monitoring that is completed by the LME/MCO.

“LME/MCO” means Local Management Entity/ Managed Care Entity.

“Medicaid Appeals” refer to Medicaid recipients filing appeals to DMH/DD/SAS, in accordance with Federal Law Federal Law (42CFR 431. Sub-Part E) and DMH/DD/SAS policy.

“Policy for Consumer Complaints to an Area/County Program (DMH/DD/SAS Communication Bulletin #38)” refers to the policy distributed by DMH/DD/SAS regarding the receipt and processing of consumer complaints. This policy can be found on the DMH/DD/SAS website at the following address:

<http://www.ncdhhs.gov/mhddsas/communicationbulletins/Archive/2005/commbulletin038/commbulletin038-total.pdf>

"Provider Category" means the type of facility in which a client receives services or resides. The provider category determines the extent of monitoring that a provider receives and is determined as follows:

- (a) Category A - facilities licensed pursuant to G.S. 122C, Article 2, except for hospitals; these include 24-hour residential facilities, day treatment and outpatient service;
- (b) Category B – G.S. 122C, Article 2, community based providers not requiring State licensure,
- (c) Category C - hospitals, state-operated facilities, nursing homes, adult care homes, family care homes, foster care homes or child care facilities and
- (d) Category D - individuals providing only outpatient or day services who are licensed or certified to practice in the State of North Carolina.

## **Applicable Administrative Rules**

### **10A NCAC 27G .0606 AREA AUTHORITY REQUIREMENTS CONCERNING COMPLAINTS PERTAINING TO ALL PROVIDER CATEGORIES**

(a) The area authority or county program shall respond to complaints received concerning the provision of public services pertaining to all provider categories. The area authority or county program shall:

- (1) establish a written notification procedure to inform each client of the complaint process concerning the provision of public services. The procedure shall include the provision of written information explaining the client's right to contact the area authority or county program, the DMH/DD/SAS, DFS and the Governor's Advocacy Council for Persons with Disabilities;
- (2) seek to resolve issues of concern through informal agreement between the client and the provider and document the attempts at resolution; and
- (3) develop and implement written policies for receiving, processing, referring, investigating and following up on complaints. The policies shall include:
  - (A) safeguards for protecting the identity of the complainant;
  - (B) safeguards for protecting the complainant and any staff person from harassment or retaliation;
  - (C) procedures to receive and track complaints;
  - (D) procedures to assist a client in initiating the complaint process;
  - (E) procedures for encouraging the complainant to communicate with the provider to allow for resolution of the issue;
  - (F) methods to be used in investigating a complaint;
  - (G) options to be considered in resolving a complaint, including corrective action and referral to the DMH/DD/SAS, DFS, DSS or other agencies as required; and
  - (H) procedures governing appeals made by the provider;

(b) When the area authority or county program refers the complaint to the State or local government agency responsible for the regulation and oversight of the provider, the area authority or county program shall send a letter to the complainant informing them of the referral and the contact person at the agency where the referral was made.

(c) The area authority or county program shall contact the State or local government agency where the referral was made within 120 days of the date the area authority or county program received the complaint to determine the actions the State

or local government agency has taken in response to the complaint. The area authority or county program shall ensure the State or local government agency's response is provided to the complainant and the client's home area authority or county program, if different.

*History Note: Authority G.S. 122C-112.1; 143B-139.1;  
Temporary Adoption Eff. July 1, 2003;  
Eff. July 1, 2004.*

#### **10A NCAC 27G .0607 COMPLAINTS PERTAINING TO CATEGORY A OR CATEGORY B PROVIDERS EXCLUDING ICF/MR FACILITIES**

(a) The area authority or county program shall respond to complaints received concerning the provision of public services pertaining to Categories A and B providers within its catchment area, except ICF/MR facilities.

(b) The area authority or county program shall make contact with the provider when investigating a complaint. The area authority or county program shall state the purpose of the contact and inform the provider that the area authority or county program is in receipt of a complaint concerning the provider.

(c) The area authority or county program shall complete the complaint investigation within 30 days of the date of the receipt of the complaint.

(d) Upon completion of the complaint investigation, the area authority or county program shall submit a report of investigation findings to the complainant, the provider and the client's home area authority or county program, if different. The report shall be submitted within 10 working days of the date of completion of the investigation. The complaint investigation report shall include:

- (1) statements of the allegations or complaints lodged;
- (2) steps taken and information reviewed to reach conclusions about each allegation or complaint;
- (3) conclusions reached regarding each allegation or complaint;
- (4) citations of law and rule pertinent to each allegation or complaint; and
- (5) required action regarding each allegation or complaint.

(e) The provider shall submit a plan of correction to the area authority or county program for each issue requiring correction identified in the report. The plan of correction shall be submitted to the area authority or county program within 10 working days from the date the provider receives the complaint investigation report. The corrective actions shall not exceed 60 days from the date of the complaint investigation report.

(f) The area authority or county program shall review and respond in writing to the provider's plan of correction with approval or a description of additional required information. The area authority or county program shall respond to the provider within 10 working days of receipt of the plan of correction.

(g) The area authority or county program shall follow-up on issues requiring correction in the investigation report no later than 60 days from the date the plan of correction is approved.

(h) The area authority or county program shall refer investigation of a complaint concerning a Category A provider to DFS, or a Category B provider to DMH/DD/SAS when the area authority or county program is a party to the complaint.

(i) The area authority or county program shall provide information regarding the disposition of the complaint to the complainant and the client's home area authority or county program, if different, as soon as the investigation is concluded.

(j) The area authority or county program shall maintain copies of complaint investigation, resolution and follow-up reports for Category A and B providers for review by the Department of Health and Human Services.

*History Note: Authority G.S. 122C-112.1; 143B-139.1;  
Temporary Adoption Eff. July 1, 2003;  
Eff. July 1, 2004.*

#### **10A NCAC 27G .0609 AREA AUTHORITY OR COUNTY PROGRAM REPORTING REQUIREMENTS**

(a) The area authority or county program shall review, not less than quarterly, level II and level III incidents, complaints concerning the provision of public services and local monitoring results as part of its quality improvement process as set forth in Rule .0201(a)(7) of this Subchapter.

(b) The area authority or county program shall provide a report based on the review specified in Paragraph (a) of this Rule. The report shall be submitted to DMH/DD/SAS, the local Client Rights Committee and the Governor's Advocacy Council for Persons with Disabilities quarterly on a form provided by the Secretary via electronic means.

The report shall include the following:

- (1) summary numbers of the types of complaints, incidents and results of local monitoring;
- (2) trends identified through analyses of complaints, level II and level III incidents and local monitoring; and
- (3) use of the analyses for improvement of the service system and planning of future monitoring activities.

History Note: Authority G.S. 122C-112.1; 143B-139.1;

Eff. July 1, 2004.

### **Codes of Federal Regulations**

<u>§438.228</u>	Grievance systems
<u>§438.400</u>	Statutory basis and definitions.
<u>§438.402</u>	General requirements.
<u>§438.404</u>	Notice of action.
<u>§438.406</u>	Handling of grievances and appeals.
<u>§438.408</u>	Resolution and notification: Grievances and appeals.
<u>§438.410</u>	Expedited resolution of appeals.
<u>§438.414</u>	Information about the grievance system to providers and subcontractors.
<u>§438.416</u>	Recordkeeping and reporting requirements.
<u>§438.420</u>	Continuation of benefits while the MCO or PIHP appeal and the State Fair Hearing are pending.
<u>§438.424</u>	Effectuation of reversed appeal resolutions.

#### **§ 438.228 Grievance systems.**

(a) The State must ensure, through its contracts, that each MCO and PIHP has in effect a grievance system that meets the requirements of subpart F of this part.

(b) If the State delegates to the MCO or PIHP responsibility for notice of action under subpart E of part 431 of this chapter, the State must conduct random reviews of each delegated MCO or PIHP and its providers and subcontractors to ensure that they are notifying enrollees in a timely manner.

§ 438.400 Statutory basis and definitions.

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:

Action means—

In the case of an MCO or PIHP—

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service;

(4) The failure to provide services in a timely manner, as defined by the State;

(5) The failure of an MCO or PIHP to act within the timeframes provided in § 438.408(b); or

(6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.

Appeal means a request for review of an action, as “action” is defined in this section.

Grievance means an expression of dissatisfaction about any matter other than an action, as “action” is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State Fair Hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

**§ 438.402 General requirements.**

(a) The grievance system. Each MCO and PIHP must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system.

(b) Filing requirements —(1) Authority to file. (i) An enrollee may file a grievance and an MCO or PIHP level appeal, and may request a State Fair Hearing.

(ii) A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State Fair Hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.

(2) Timing. The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the MCO's or PIHP's notice of action. Within that timeframe—

(i) The enrollee or the provider may file an appeal; and

(ii) In a State that does not require exhaustion of MCO and PIHP level appeals, the enrollee may request a State Fair Hearing.

(3) Procedures. (i) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO or the PIHP.

(ii) The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.

#### **§ 438.404 Notice of action.**

(a) Language and format requirements. The notice must be in writing and must meet the language and format requirements of § 438.10(c) and (d) to ensure ease of understanding.

(b) Content of notice. The notice must explain the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take.

(2) The reasons for the action.

(3) The enrollee's or the provider's right to file an MCO or PIHP appeal.

(4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State Fair Hearing.

(5) The procedures for exercising the rights specified in this paragraph.

(6) The circumstances under which expedited resolution is available and how to request it.

(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(c) Timing of notice. The MCO or PIHP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§ 431.211, 431.213, and 431.214 of this chapter.



- (2) For denial of payment, at the time of any action affecting the claim.
- (3) For standard service authorization decisions that deny or limit services, within the timeframe specified in § 438.210(d)(1).
- (4) If the MCO or PIHP extends the timeframe in accordance with § 438.210(d)(1), it must—
  - (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and
  - (ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
- (5) For service authorization decisions not reached within the timeframes specified in § 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.
- (6) For expedited service authorization decisions, within the timeframes specified in § 438.210(d).

#### **§ 438.406 Handling of grievances and appeals.**

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

- (1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- (2) Acknowledge receipt of each grievance and appeal.
- (3) Ensure that the individuals who make decisions on grievances and appeals are individuals—
  - (i) Who were not involved in any previous level of review or decision-making; and
  - (ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.
    - (A) An appeal of a denial that is based on lack of medical necessity.
    - (B) A grievance regarding denial of expedited resolution of an appeal.
    - (C) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

- (1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.
- (2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal—

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's estate.

### **§ 438.408 Resolution and notification: Grievances and appeals.**

(a) Basic rule. The MCO or PIHP must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.

(b) Specific timeframes —(1) Standard disposition of grievances. For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 days from the day the MCO or PIHP receives the grievance.

(2) Standard resolution of appeals. For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(3) Expedited resolution of appeals. For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(c) Extension of timeframes —(1) The MCO or PIHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—

(i) The enrollee requests the extension; or

(ii) The MCO or PIHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.

(2) Requirements following extension. If the MCO or PIHP extends the timeframes, it must—for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.

(d) Format of notice —(1) Grievances. The State must establish the method MCOs and PIHPs will use to notify an enrollee of the disposition of a grievance.

(2) Appeals. (i) For all appeals, the MCO or PIHP must provide written notice of disposition.

(ii) For notice of an expedited resolution, the MCO or PIHP must also make reasonable efforts to provide oral notice.

(e) Content of notice of appeal resolution. The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the enrollees—

(i) The right to request a State Fair Hearing, and how to do so;

- (ii) The right to request to receive benefits while the hearing is pending, and how to make the request; and
  - (iii) That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the MCO's or PIHP's action.
- (f) Requirements for State Fair Hearings —(1) Availability. The State must permit the enrollee to request a State Fair Hearing within a reasonable time period specified by the State, but not less than 20 or in excess of 90 days from whichever of the following dates applies—
- (i) If the State requires exhaustion of the MCO or PIHP level appeal procedures, from the date of the MCO's or PIHP's notice of resolution; or
  - (ii) If the State does not require exhaustion of the MCO or PIHP level appeal procedures and the enrollee appeals directly to the State for a fair hearing, from the date on the MCO's or PIHP's notice of action.
- (2) Parties. The parties to the State Fair Hearing include the MCO or PIHP as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

#### **§ 438.410 Expedited resolution of appeals.**

- (a) General rule. Each MCO and PIHP must establish and maintain an expedited review process for appeals, when the MCO or PIHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.
- (b) Punitive action. The MCO or PIHP must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.
- (c) Action following denial of a request for expedited resolution. If the MCO or PIHP denies a request for expedited resolution of an appeal, it must—
- (1) Transfer the appeal to the timeframe for standard resolution in accordance with § 438.408(b)(2);
  - (2) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.

#### **§ 438.414 Information about the grievance system to providers and subcontractors.**

The MCO or PIHP must provide the information specified at § 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

#### **§ 438.416 Recordkeeping and reporting requirements.**

The State must require MCOs and PIHPs to maintain records of grievances and appeals and must review the information as part of the State quality strategy.

#### **§ 438.420 Continuation of benefits while the MCO or PIHP appeal and the State Fair Hearing are pending.**

- (a) Terminology. As used in this section, “timely” filing means filing on or before the later of the following:

- (1) Within ten days of the MCO or PIHP mailing the notice of action.
  - (2) The intended effective date of the MCO's or PIHP's proposed action.
- (b) Continuation of benefits. The MCO or PIHP must continue the enrollee's benefits if—
- (1) The enrollee or the provider files the appeal timely;
  - (2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
  - (3) The services were ordered by an authorized provider;
  - (4) The original period covered by the original authorization has not expired; and
  - (5) The enrollee requests extension of benefits.
- (c) Duration of continued or reinstated benefits. If, at the enrollee's request, the MCO or PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:
- (1) The enrollee withdraws the appeal.
  - (2) Ten days pass after the MCO or PIHP mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached.
  - (3) A State Fair Hearing Office issues a hearing decision adverse to the enrollee.
  - (4) The time period or service limits of a previously authorized service has been met.
- (d) Enrollee responsibility for services furnished while the appeal is pending. If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in § 431.230(b) of this chapter.

#### **§ 438.424 Effectuation of reversed appeal resolutions.**

- (a) Services not furnished while the appeal is pending. If the MCO or PIHP, or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO or PIHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.
- (b) Services furnished while the appeal is pending. If the MCO or PIHP, or the State Fair Hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the PIHP or the State must pay for those services, in accordance with State policy and regulations.