HEALTHWEST

Policy and Procedure

No. 04-028

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Customer Service Department

Approved by: Subject: Choice of Provider

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Rich Francisco, Executive Director

I. POLICY

HealthWest will provide consumers with a Choice of Provider to the extent possible, as appropriate, within sound clinical judgement, and as resources are available.

II. PURPOSE

To ensure consumers are given a choice of providers and a process to change providers if requested.

III. APPLICATION

All individuals served by HealthWest.

IV. DEFINITIONS

A. Contraindication:
Any condition, especially of disease, which renders some particular line of treatment undesirable or improper.

B. Action:
1. Denial or limited authorization of a requested Medicaid or non-Medicaid service, including the type or level of service.

2. Reduction, suspension, or termination of a previously authorized Medicaid or previously provided non-Medicaid covered service.

3. Denial, in whole or in part, of payment for a Medicaid or non-Medicaid covered service.

4. Failure to make an authorization decision and provide notice about the decision within standard time frames.

5. Failure to provide Medicaid or non-Medicaid services within standard time frame.

6. In regard to Medicaid covered services, failure of the CMH to act within the time frames required for disposition of grievances and appeals.

7. For a resident of a rural area with only one PIHP, the denial of a Medicaid enrollee's request to exercise his or her right to obtain services outside the network.

C. Grievance:
An expression of dissatisfaction about any matter relative to a Medicaid or non-Medicaid covered service, which does not involve a rights complaint or an adverse action. Possible subjects for grievances include but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the individual served. All change of provider requests are handled as grievances.

D. Indication:
A particular line of treatment which is desirable or proper.

E. Medically Necessary:
Services deemed reasonable and necessary for a person receiving services' current condition.

F. Mental Health Professional:
Applicable mental health professionals regarding this procedure include Psychiatrist, Physician's Assistant, Nurse, Occupational Therapist, Speech Therapist, Physical Therapist, Master Level Clinician, Supports Coordinator and Direct Care Provider.

V. PROCEDURE

A. If a consumer is not satisfied with his or her provider, the individual or parent/legal guardian of the individual can request a change of service providers.

B. The individual receiving services, or parent/legal guardian, can request a change in service provider at any time in the treatment process.

C. All change of worker requests are handled as a formal grievance which Customer Service staff will process.

D. To reduce barriers for individuals requesting a change of worker, there are several submission methods,
    I. The individual can request form C248, "Individual Receiving Services Change of Request" to any of their assigned staff or clerical team member. The form then gets sent to the Customer Service staff.

II. The individual can inform any of their assigned staff, clerical personnel, or Customer Service staff about their desire to change providers. That staff member will then complete form C248 on the individual's behalf. The form is then submitted to Customer Service Staff

E. The "Individual Receiving Services Change Request" form is then sent to The Customer Service staff. Customer Service staff treat the submission of C248 as a grievance.

I. After receiving the request, Customer Service staff have 5 days to submit the request to the appropriate department and team member(s) for a decision.

II. Within 5 days of receiving the request the Customer Service staff will also send a "receipt of grievance letter" to the individual.

III. Within 5 days of receiving the request, the team member(s) will make a determination about the change, either granting the change or denying it, and inform the Customer Service staff of the decision.

IV. Customer Service staff will mail out a "letter of resolution" to the individual within 5 days.

V. If the change of provider is granted and this change leads to a disruption or delay in services (as outlined in the IPOS) a Notice of Adverse Benefit Determination will be issued to the individual.

VI. Decisions should be determined based on sound clinical judgement, limitation of available staff and resources. The rationale for the decision must also be documented in the clinical record.

VII. While the Customer Service staff will send a letter of resolution, the team member who made the decision will also inform the individual of the determination.

VIII. Staff

IX. Following determination of a response to the request, the completed form is scanned into the electronic clinical record.

VI. REFERENCES

Mental Health Code: 330.1713
42 CFR Part 438.6(m)

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