ITASCA MEDICAL CARE (IMCare)
POLICY AND PROCEDURE

Title: MHCP-MC Quality of Care Grievances	**Index:** Grievances and Appeals
NCQA Standard #:	
Statute/CFR#: Minnesota Rules § 4685.1110, Subpart 9, and § 4685.1120; Minnesota Statutes § 62D.08, subpart 3(f), and § 62D.115	
Effective Date: 8/1/01	**Policy Number:** 2.05.05
Written by: IMCare QI/UM Staff	**Reviewed/Revised Date:** 05/01/2018
Attachments:	

DEFINITIONS:

Access: Access to medical information; appointment availability; availability of specialists; services timeliness; telephone access; geographic access; lack of access due to minority, age, disability.

Communication/Behavior: Education/explanation inadequate; manner was rude or uncaring; test result delays; time spent with provider was inadequate; culturally insensitive; inadequate privacy.

Coordination of Care: Availability of information not provided from one provider to another; follow up not provided; coordination of treatment or delay due to lack of communication between providers.

Facilities/environment: Accommodations for patient needs/handicap access; cleanliness; climate, comfort or air quality; equipment cleanliness or condition; unsafe physical conditions, parking, security, signage or disrepair.

Grievance: Any complaint or dispute, other than one involving a prior authorization or referral, expressing dissatisfaction with the manner in which IMCare provides health care services, regardless of whether any remedial action can be taken. An enrollee, or the provider acting on behalf of the enrollee with the enrollee's written consent, may file a grievance, either orally or in writing, on a matter involving an enrollee's dissatisfaction with the health care received, or about any matter other than an Action, as Action is defined in 42 CFR 438.400 (b)(1).

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Health Plan Administration:

- Administration: general mailings; web or mobile technology
- Benefits: copays, preventive/non-preventive; pharmacy formulary
- Claims: EOBs; provider billing; errors
- Membership: eligibility; enrollment errors; premiums
- Network: clinic/hospital options; DME vendors; pharmacy options
- Referral and authorizations: delayed processing; denied referral

Quality of Care Complaint: An expressed dissatisfaction regarding health care services resulting in potential or actual harm to an enrollee. Quality of care complaints may include the following, to the extent that they affect the clinical quality of health care services rendered: access, provider and staff compliance; clinical appropriateness of care; communications; behavior; facility and environmental considerations; and other factors that could impact the quality of health care services.

Technical Competence/Appropriateness:

- Appropriateness: wrong test ordered
- Competence: failure to refer; outside of scope of practice or expertise;
- Diagnosis: delayed or incorrect diagnosis; lack of thorough exam
- Effectiveness: inadequate treatment; desired results not obtained
- Misadventure: procedural error; complication from treatment

POLICY:
Itasca Medical Care (IMCare) views enrollee grievances about quality of care seriously and has written procedures in place for a thorough and consistent investigation and response to grievances, including establishing that corrective action is implemented and effective in improving the identified problem. Every complaint with an allegation regarding quality of care or service will be investigated and supported by evidence, and documentation must convey this. The record must include all related documents, correspondence, summaries, discussions, consultation and conferences held. IMCare Medical Director review must be conducted as part of the investigation process when there is potential patient harm.

IMCare tracks grievances and monitors trends in order to initiate corrective action as necessary. Grievance data is reported to and evaluated by the IMCare Provider Advisory Subcommittee (PAC) and the IMCare Quality Improvement/Utilization Management (QI/UM) Committee at least quarterly, and is reported in the annual evaluation of the IMCare Quality Program.

IMCare tracks complaints in the Quality of Care module on CaseTrakker Dynamo (CTD). Tracking includes categorization of the complaint, documentation of all investigative steps, basis and assignment of severity level, and final determination/outcome. Provider documentation and any notes used in the investigation are linked to the quality of care compliant directly in CTD.

IMCare maintains a file on each quality of care grievance that includes all correspondence and summaries related to the allegation(s). Conclusions must be supported, corrective action plans documented; follow-up actions noted; and, if IMCare forwards the complaint to a provider office for investigation, a written response to IMCare is required. The provider's written response must reference each allegation; identify all actions taken; conclusions must be supported; and any corrective action taken by the provider must be identified. IMCare will maintain records of quality of care complaints and their resolution and retain those records for five years.

Quality of care (QOC) complaints are referred to a quality reviewer via the IMCare grievance process (see P&P 2.05.14) after initial review and preliminary investigation by the IMCare Health Plan Compliance Coordinator.

Classification of complaints

QOC concerns are those that involve one or more of the following issues:

- Access:
  - Inability to obtain referral
  - Delays in obtaining service
  - Delays in appointment scheduling
  - Excessive wait times
  - Inability to obtain medical information
  - Lack of availability of special services
  - Inadequate geographic options
- Communication/Behavior:
  - Rude/uncaring/disrespectful
  - Rushed/didn't listen/amount of time was inadequate
  - Inadequate education/failure to provide complete explanation
  - Delay in communicating test results
  - Inappropriate behavior/culturally insensitive/inadequate communication
- Coordination of Care:
  - Failure to follow up
  - Information not provided/available at time of care
  - Multiple providers/lack of overall coordination of treatment
  - Treatment delay due to lack of communication between providers
  - Delay in referral
- Technical Competence/Appropriateness:
  - Delayed or incorrect diagnosis
  - Inappropriate treatment
  - Wrong test ordered or performed
  - Procedural error
  - Failure to refer/performing procedure or services outside the scope of practice or expertise
- Facility & Environment:
  - Facility does not physically accommodate patient needs
  - Environment not comfortable
  - Equipment malfunction
  - Cleanliness/infection control procedures
  - Unsafe physical conditions
  - Provider/clinic administration issues; business practice and process at clinic level
- MCO Administration:
  - Enrollee materials (ID cards)
  - Benefit set dissatisfaction
  - MCO membership process issues
  - Non-appealable claims or billing process issues (i.e. provider charged too much for service)
  - Violations of enrollee's rights

Quality of Care Severity Level
QOC Grievances are assigned a severity level by the IMCare Quality Director/Medical Director, based on the original grievance, the investigation, and the outcome.

Severity levels are:

Severity Level	Definition
Level 1	Little to no adverse impact to patient's health status, safety, well-being or access to care.
Level 2	Mild to moderate adverse impact on or risk to patient's health, safety and well-being, including right to respectful, dignified and culturally appropriate service or ability to obtain safe, timely and accessible care. Any adverse effects are limited and temporary.
Level 3	Significant adverse impact on or risk to patient's health and safety, breach of privacy/confidentiality or sexual misconduct. Adverse effects are serious and/or prolonged.
Level 4	Severe adverse impact resulting in death or long-term disability, including medication errors, a clinician operating outside the scope of practice and any state or federal reportable adverse events.

All QOC grievances are reviewed by the IMCare Quality Director and the IMCare Medical Director. If appropriate, a QOC grievance may also be sent for review by a practitioner "peer" in the same or similar specialty as the provider/s involved in the grievance. If the QOC grievance is related to the quality of a practitioner office site (QOC category 'Facility/Environment'), a site visit is completed (see P&P 1.08.12). Once all relevant information has been received and reviewed, the IMCare Medical Director or external reviewer makes a determination, including assigning a severity level and a recommended plan of action. The IMCare Medical Director determines whether a QOC grievance warrants review/final determination by the IMCare PAC, who would then make the final determination and plan of action (i.e. corrective action plan). (If appropriate, as determined by the Medical Director, an emergency PAC meeting is called.) The entire review process includes documentation, investigation, and follow-up.

IMCare's quality assurance program conducts ongoing evaluation of complaints that are related to quality of care. The evaluations shall be conducted as follows:

1. Problem identification – identify the existence of actual or potential quality problems or identify opportunities for improving care through:
    a. Ongoing monitoring of process, structure, and outcomes of patient care or clinical performance including the complaints; and
    b. Evaluation of the data collected from ongoing monitoring activities to identify problems or potential problems in patient care or clinical performance.
2. Problem selection – IMCare shall select problems or potential problems in patient care or focused study based on the prevalence of a problem and its impact on patient care or professional practices.
3. Corrective action – IMCare shall identify and document any recommendations for corrective action designed to address the problem. The documentation of corrective action shall include:

   a. Measurable objectives for each action, including the degree of the expected change in persons or situations;
   b. Time frames for corrective action; and
   c. Persons responsible for implementation of corrective action.
4. Evaluation of corrective action – IMCare shall monitor the effectiveness of corrective actions until problem resolution occurs. Results of the implemented corrective action are documented and communicated to the Itasca County Board of Commissioners and involved providers.

QOC grievance data is reported to the IMCare PAC and QI/UM Committee quarterly, as applicable. IMCare tracks and trends all quality of care grievances. IMCare reports on quality of care grievances by provider and issue/classification. Access to quality of care grievances in CTD is limited to management and the compliance areas.

Effective January 1, 2018, IMCare must report complaint/grievance data to the Minnesota Department of Health (MDH) annually, in a format developed, implemented and distributed by MDH. Reporting is due on April 1st of the each year for the year ending December 31st of the previous year. The first report is due April 1, 2019. The report includes the number of complaints received and the category of each complaint as defined in the reporting format.

IMCare requires providers/facilities who are the subject of QOC grievances to provide written assurance that they have processed the grievance internally, according to their grievance processes, and have implemented corrective action if appropriate.

IMCare requires providers who are the subject of QOC grievances to provide written assurance that they have processed the grievance internally, according to their grievance processes, and have implemented corrective action if appropriate. The provider's written assurance must include a response to each allegation identified; identify all actions taken; conclusions must be supported; and any corrective action taken identified.

A copy of all QOC Grievances will be forwarded to the medical secretary responsible for credentialing, to be filed in the appropriate credentialing file, to be reviewed during re-credentialing.

PROCEDURE:
Quality of Care (QOC) complaints are referred to a quality reviewer via the IMCare grievance process (see P&P 2.05.14) after initial review and preliminary investigation by the IMCare Health Plan Compliance Coordinator.

1. The IMCare Quality Director will:
   a. Review the grievance information.
   b. Send a letter to the provider/facility involved in the grievance informing them of the grievance and requesting that the following information be submitted to IMCare within 14 days of receipt of the letter:
      i. Reference each allegation of quality of care

   ii. Include copies of all relevant medical records and documentation of discussions, consultations or conferences held related to the allegation(s)
   iii. Include documented support for your findings
   iv. Include a description of any corrective action taken, including a copy of the written plan and any interventions performed related to the allegation(s)
   v. Include documentation of the resolution, or plan for resolution, of the allegations(s)
c. Contact the facility if a response is not received within 14 days.
d. If the QOC grievance is related to the quality of a practitioner office site (QOC category 'Facility/Environment'), initiate a site visit (see P&P 1.08.12).

2. An IMCare Provider notified of a quality of care compliant or grievance by IMCare will:
   a. Conduct an internal investigation of all identified allegations, documenting related discussions, consultations, or conferences held related to the allegations. Provider documentation must support conclusions.
   b. Identify and document follow-up actions.
   c. Develop and implement corrective action, if warranted.
   d. Monitor compliance of corrective action, adjusting outcomes as necessary, to achieve compliance.
   e. Provide a written response to the quality of care grievance to IMCare. The response must include reference to each identified allegation; identify all actions taken by provider, conclusions must be supported; and any corrective action taken must be identified.
   f. Report progress with corrective action to IMCare.
   g. Provide written assurance to IMCare regarding corrective action compliance attainment, as requested.

3. Once all of the necessary documentation has been received, the IMCare Quality Director and IMCare Medical Director will meet to discuss the grievance and:
   a. Investigate all the concern(s) identified in the grievance, including review of all relevant information (i.e. medical records).
   b. If appropriate, send the QOC grievance to a practitioner "peer" in the same or similar specialty as the provider/s involved in the grievance for review.

4. The IMCare Medical Director or Peer Reviewer will:
   a. Review the grievance information.
   b. Request additional relevant information from the provider/facility as needed.
   c. Investigate the concern(s) identified in the grievance, including review of all relevant information (i.e. medical records).
   d. Make a determination, including a recommended plan of action.

5. The IMCare Medical Director will:
   a. Determine whether a QOC grievance warrants review/final determination by the IMCare PAC. If so, present the grievance information and Medical Director/Peer Reviewer recommendations to the IMCare PAC for discussion. (If appropriate, as determined by the Medical Director, an emergency PAC meeting will be called.)

6. The IMCare Provider Advisory Subcommittee (PAC) will:
   a. At the discretion of the IMCare Medical Director, review individual QOC grievances and make the final determination regarding any further action by IMCare, including the necessity of a corrective action plan.
   b. Analyze QOC grievance data quarterly.

7. The IMCare Medical Director will:
   a. Document the investigation, review findings, and determination, as well as the reason for the determination in CTD.

8. The IMCare Quality Director will:
   a. Assign the appropriate severity level in CTD.
   b. Send a letter to provider/facility informing them of the determination and plan of action (i.e. need for a corrective action plan).
   c. Send a letter to the enrollee to inform him/her of the grievance resolution.
   d. If a corrective action plan is recommended:
      i. monitor the effectiveness of corrective action until problem resolution occurs;
      ii. document implementation and results of the corrective action plan; and
      iii. update PAC once the corrective action plan is completed/resolved.
   e. Forward a summary of the grievance to the IMCare Medical Secretary responsible for credentialing to file in the provider's/facility's file.
   f. Forward all written grievance documentation to the IMCare Health Plan Compliance Coordinator to file.

9. The IMCare Health Plan Compliance Coordinator will:
   a. Maintain a file on each grievance. Files must include all correspondence and summaries related in discussions, consultations, or conferences held related to the allegation(s). Conclusions must be supported; corrective action plans documented; follow-up actions noted; and if the plan forwards the complaint to a provider office for investigation, a written response to the plan is required.
   b. Prepare a quarterly QOC grievance report to be presented for review and analysis by the IMCare PAC and QI/UM Committee.
   c. Prepare and submit the annual Complaint Reporting template for reporting of complaints to MDH by April 1st of each year for the period ending December 31st of the previous year.
   d. Prepare grievance files for MDH and other external audits. Grievance data is also reported periodically to the Itasca County Board of Commissioners and the Compliance Committee, and is aggregated for the annual Program Evaluation.
   e. Monitor the grievance activity to determine if there are constant variables that require additional training and/or education of staff or providers. Monitoring includes tracking and trending according to provider and type of quality of care issue.
   f. Track the QOC grievance to ensure all appropriate steps have been taken.

QOC Grievance Tracking Process

The Health Plan Compliance Coordinator will ensure these tasks have been completed:

1. Grievance started in CTD;
2. Grievance received by Quality Director;
3. Quality Director sends initial letter to provider/facility informing them of the grievance and requesting additional information;
4. Documentation from provider/facility is received, and contains all the required information;
5. Medical Director documents the investigation, review findings, and determination, as well as the reason for the determination, in CTD;
6. Quality Director sends a letter to provider/facility informing them of the determination and plan of action (i.e. need for a corrective action plan).
7. Quality Director sends resolution letter to enrollee;
8. Substantiated grievance are included in the provider's credentialing file and considered in the provider's re-credentialing process;
9. Monitor corrective action, through desired outcomes and compliance attainment, and report progress to the PAC;
10. Track and trend grievances for review according to provider and type of quality of care issue.