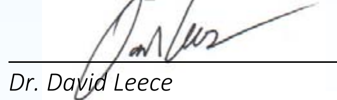
HERITAGE PROVIDER NETWORK
&
AFFILIATED MEDICAL GROUPS

GRIEVANCE PROGRAM 2018

Approval Signature:



________________________________ ____**02/28/2018**________________

Dr. David Leece Date:

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N/A 39
Yes 39
No 39
N/A 39

GRIEVANCE PROGRAM – "COMPLAINTS"

PURPOSE

Heritage Provider Network (HPN) and its affiliated Provider Groups shall ensure that complaints are processed in accordance with full-service health plan requirements and pursuant to NCQA, State, and Federal requirements. The system must provide for reasonable procedures that shall ensure adequate consideration of the member's complaints and rectification when appropriate.

HPN's quality assurance methodology is based on:

- Evaluation of complaints
- Evaluation of adverse health outcomes as well as appropriateness and quality of care
- Assessment and monitoring for trends
- Peer review of the clinical process of care
- Implementation of actions to correct identified problems
- Mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers
- Monitoring compliance/adherence to corrective action plan
- Provisions for evaluation of any corrective action plan and measurements of performance

POLICY

Each Provider Group shall establish and adopt the Heritage Provider Network Grievance Complaint Program. Staff training shall be conducted upon hire, and annually thereafter to ensure the provider group compliance to this policy, and established regulatory guidelines.

HPN and the Provider Group will not discriminate against any member solely on the grounds that the member filed a complaint, (including disenrollment or cancellation of contract), and we shall ensure that all member information is kept strictly confidential.

HPN and the Provider Group shall ensure that the linguistic and cultural needs of its member population and of those with disabilities are met. Our grievance system will ensure that all members have access to and can fully participate in the grievance process by providing assistance for those with limited English proficiency, or with a visual or other communicative impairment.

HPN and the Provider Group will ensure that member health records are available and accessible to authorized staff of their organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care or investigating member or provider quality of care concerns, complaints, and allegations of abuse, neglect, and exploitation. Member record availability and accessibility must be in compliance with Federal and State confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. 431.300 et seq.

Copies of complaints and responses shall be maintained for no less than five years, and shall include a copy of all medical records, documents, evidence of coverage and other relevant information upon which the Provider Group reached its decision. All information shall be made available to the member, provider, Health Plan, State, and/or Federal authorized representative upon request.

DEFINITIONS

"Grievance" means a written or oral expression of dissatisfaction regarding the Provider Group and/or provider, including quality of care concerns, and shall include a complaint, dispute from the full-service Health Plan.

"Complaint" is a written or oral expression of dissatisfaction regarding the Provider Group and/or provider, including quality of care concerns that remain unresolved by the next business day.

"Complainant" means the person who filed the complaint including the member, a representative designated by the member, or other individual with authority to act on behalf of the member.

"Member Inquiries" are member concerns received by telephone, facsimile, email or online by the Provider Group and resolved by the next business day following receipt. Where the Provider Group is unable to distinguish between an inquiry and a complaint, it shall be considered a complaint.

"Resolved" means that the complaint has reached a final conclusion with respect to the complaint received from the full-service Health Plan.

"Statements of Concern" are member complaints or disputes received via mail, telephone, facsimile, or e-mail. Statements of concerns are forwarded to the full-service Health Plan for resolution.

NETWORK RESPONSIBILITY

The Provider Group will proactively provide care coordination for members who have multiple complaints regarding services. This includes, but is not limited to, members who do not meet the Provider Group's criteria for case management as well as members who contact governmental entities for assistance, including State agencies.

The Provider Group must have written information available to the member or their representative about how to file a complaint with their respective health plan. This includes the quality of care complaint process available under QIO process as described in §1154(a)(14) of the Social Security Act (the Act).

MEMBER'S RIGHTS

We shall ensure that the rights of each member are maintained. There shall be no discrimination against the member (including disenrollment) on the grounds that they filed a complaint.

OUR AUTHORITY

We are not delegated by any full service Health Plan to process or resolve member complaints. We shall forward any complaints received to the Health Plan for processing. We shall conduct an internal investigation of all complaints received to better improve the quality of the services rendered to our members.

STRUCTURE

We use a defined structure to conduct quality assurance activities. The Quality Management (QM) Department processes the complaints received from the Health Plan. This department has fully trainedstaff to obtain the documents, and investigate all complaints received. An experienced QA nurse manages the department, and provides direct oversight of the grievance staff. The retrospective clinical review process is completed by the QM Medical Director.

The QM Medical director, or designated physician reviewer conducts peer review on all potential quality of care issues and may refer cases to the Quality Review Committee for more intensive review. The Quality Review Committee is composed of participating practitioners who represent primary care and commonly used specialties.

STAFF RESPONSIBILITY

Designated Physician

The Quality Medical Director, or designated physician, will review each complaint received and make recommendations based on various analyzed clinical care and administrative data. Documented evidence of the Medical Director's review shall be maintained in each case file.

1. He/she must be a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the complaint by the member.
2. The designated physician must determine that he or she is competent to evaluate the specific clinical issues presented, if he/she determines that they are competent to evaluate the specific clinical issues presented in the complaint, they can make a determination. If the designated physician determines that he or she is not competent to evaluate the specific clinical issues of the complaint, prior to making a determination, he or she shall consult with an appropriately licensed health care provider who is competent to evaluate the specific clinical issues presented. The reviewer must have the education, training, and relevant expertise that are pertinent for evaluating the specific clinical issues that serve as the basis of the complaint.
3. If there is a conflict of interest, the Medical Director or their designee involved in the review process must remove themselves from the case. No persons shall be involved in the review process of Quality Improvement issues in which they were directly involved. Another qualified reviewer must be assigned.
4. The Physician must state their rationale for making their determination, and refer back to the specific clinical practice guideline, provision in the contract, criteria, or member handbook that for which their determination was based. It must be in clear and concise language that explains how it applied to the specific health care service, or quality of care issue presented.
5. The Quality Medical Director, or designee, will institute needed or corrective action plans when potential problems or poor performance is detected. The Quality Medical Director will work collaboratively with the Credentialing Chairperson, or designee to identify, monitor and resolve issues or concerns. The Quality Medical Director has the discretion to forward these cases for peer review.

Designated Behavioral Health Care Practitioner

The Medical Director of the Provider Group's contracted Behavioral Health Care provider shall be available for assistance with member behavioral health complaints.

Quality Director and/or Quality Manager

1. The Quality Director and/or Quality Manager are designated as having the primary responsibility

for oversight of the Grievance Program, and shall continuously review the operations of the program to identify any emergent patterns of complaints to improve service/care, and to improve our policies and procedures.

2. They shall have the direct responsibility to oversee and monitor all complaints received. They will identify and report patterns of complaints to the QM Medical Director, and Quality committee to formulate policy changes and procedural improvement.

Customer Service Director and/or Customer Service Manager

The Customer Service Director and/or Customer Service Manager shall oversee and monitor all inquiries and statements of concerns received. The member shall be directed to and/or assisted in the filing a complaint with the Health Plan. The Customer Service Director/Manager or their designee will identify and report patterns of member inquiries and statements of concerns to formulate policy changes and procedural improvements.

Other Management

Management shall be responsible for the operational area that is subject to the complaint received. They shall promptly review the complaint, conduct an internal investigation, and provide a written detailed report to the Quality Director and/or Manager.

QI COMMITTEE FUNCTION

The Quality Improvement Committee oversees the functioning of the grievance program and activities conducted by the Designated Physician, and the assigned Quality Management staff. They shall be responsible to:

1. Develop, implement and oversee the Grievance Program
2. Direct the investigation of identified and suspected problems and to direct the responsible parties to implement action
3. Recommend corrective action for resolution of grievances and/or appeals
4. Institute needed or corrective action, for cases where serious harm and injury have occurred to the member
5. Recommend education/training programs
6. Recommend new policies and/or procedures, policy changes based on their findings
7. Recommend follow-up with the member and assistance as needed to ensure that the immediate health care needs are met
8. Conduct periodic review, no less than quarterly of complaints received
9. Maintain written records
10. Track and trend complaints, statements of concerns, and potential quality issues

The Quality and Credentialing committees will ensure follow-up as appropriate on potential problems or poor performance until resolution is achieved and interventions are implemented to prevent future recurrences.

HEARING AND SPEECH IMPAIRED

All members with hearing and speech impairment shall be provided with assistance. Such assistance shall include, but is not limited to:

1. TDD telephone number
2. Translations of grievance procedures, forms, and plan responses to grievances
3. Access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate

LINGUISTIC AND CULTURAL NEEDS

The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment.

We recognize that the hearing and speech impaired have special needs, and need to recognize their individuality and attend to their requests quickly and promptly. Our goal is to address problems experienced by children and adults who are deaf or hard of hearing and ensure their needs are met.

All members with disabilities and who have linguistic and cultural needs shall have access to and fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment.

Such assistance shall include, but is not limited to, translations of complaint procedures and forms, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Complaint forms shall be available in Spanish and English, and/or the member's language of choice. They shall be made easily accessible to the member on-line and in print and be readily available at the member's request.

MEMBER ABILITY TO FILE A GRIEVANCE

HPN, the Provider Group, each contracted facility, and practitioner shall direct its members to their respective Health Plan and will be instructed how to file a complaint with the Health Plan. Complaint forms and a brief description of the complaint procedure with the Health Plan's mailing address, URL address, and toll free telephone number or local telephone number shall be made readily available to the member upon request.

1. Members shall be encouraged to contact the full service Health Plan to file a complaint.
2. Members may contact the customer service representatives to receive assistance and advocacy in filing a complaint.
3. The Member shall be assisted in filing a complaint and complaint forms shall be provided at each location where a complaint may be submitted. A "patient advocate" or ombudsperson may be used.
4. Members may file a complaint following any incident or action that is the subject of the member's dissatisfaction.

IDENTIFICATION

Complaints are received by the Quality Management (QM) Department from the full-service Health Plan via facsimile or secured email. A grievance worksheet form will be prepared by the assigned QM staff upon receipt of the appeal and/or complaint from the Health Plan. Refer to form.

RECEIPT OF COMPLAINT FROM MEMBER

All complaints and /or appeals received by mail, email, and telephone must be forwarded to the Health Plan for handling.

By Mail or Email

For member complaints received by U.S. mail, the envelope and letter shall be date stamped. The letter shall for forwarded the same day to the Health Plan for processing.

HPN does not advise receiving or sending PII and PHI information via e-mail. The member will be referred to contact the Health Plan's Customer Service representative for filing.

By Telephone

The customer service representative will assist the member in filing a complaint to the Health Plan using one of the following methods:

1. Providing the member with the Health Plan's Customer Service telephone number which is located at the back of the membership card and/or referencing to the "HPN Health Plan Contact List."
2. Directing the member to the Health Plan's website to their on-line form. The member shall be assisted to complete the on-line form, as needed.
3. Providing the member with the Health Plan's mailing address. A form can be mailed to the member upon request, and based on their language preference.
4. Warm transfer of the member to the Health Plan's Member Services representative.

CODING OF STATEMENTS OF CONCERNS

The customer service representative must document each complaint received. Each statement of concern received is coded by category, and subcategory. These categories are used in tracking to identify complaints and appeals forwarded to the Health Plan for resolution, provider-specific issues, and system- wide trends that may need corrective action.

The Provider Group shall maintain a log, periodically reviewed by the Quality Improvement Committee. The log shall include:

1. The date of the call
2. The name of the person with the complaint
3. The complainant's member identification number
4. The nature of the complaint
5. The nature of the resolution
6. The name of the person taking the call
7. The method by which the statement of concern was filed with the respective Health Plan, to include the name of the plan representative who took the call to resolve the complaint

STATEMENTS OF CONCERNS CATEGORIES

ABUSE AND NEGLECT	The member makes an allegation of abuse or neglect.
ART OF CARING	Perceived, and/or they were not treated with dignity or respect.
CM CARE CONCERN	The member has a concern regarding the Case Management services received

CONFIDENTIALITY	The member, the family member or their authorized representative perceives, or there was an actual breach in confidentiality.
CULTURAL SENSITIVITY	Perceived, or there was actual lack of cultural sensitivity by the provider, specialist or other person.
INPT CARE CONCERN	The member has a concern regarding the inpatient services received.
LANGUAGE BARRIER	There was a language barrier between the member and the provider, and/or interpreter services / reading material was not available.
PROVIDER OFFICE	The member has a concern regarding the member provider office i.e. dirty, unsafe, uncomfortable, or cannot access due to physical barrier.
PTS RIGHTS VIOLATION	Perceived, or there were actual patient rights violations.
QUALITY OF CARE/TX	The member, family member, or legal representative has a concern regarding any care or treatment received.
REFUSAL CARE/TX	The member refuses care or treatment from a provider based on quality concerns.
ACCESS	There was an access issue that prevented the member from receiving timely service and/or treatment.
APPEALS	There is a dispute that services requested by the member or their provider was denied. These may include: coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment received by the Provider Group
BILLING ISSUES	The member has been charged for services not rendered and/or there is a billing dispute.

RECEIPT OF COMPLAINT FROM HEALTH PLAN

After the complaint is received by the full-service Health Plan, a notice is sent to the Medical Group's Quality Management Department for processing. The notice provides the details of the member's complaint, and asks for submission of documents relevant to the complaint in order to complete their investigation. The typical documents requested include: the provider's response, office staff response, medical records, and other supporting documents. The notice form is usually received by facsimile, and/or secured email.

Upon receipt of the complaint, the QM Staff fills out the grievance form, and begins processing the complaint received. Refer to Grievance form below.

CA Grievance Form

Date Received:	Date Completed:	Incident # (s):
Member / Complainant Name:	**Date of Birth:**	**Member ID:**
Grievance Filed Against / Provider or Facility Name:		

Grievance Category

☐ Routine / Standards ☐ Expedited ☐ Urgent/Concurrent ☐ Post Service

Line of Business: *(check box)*	Health Plan: *(check box)*		
☐ Commercial	☐ Aetna	☐ Cigna	☐ InterValley
☐ Medi-cal / Medicaid	☐ Anthem Blue Cross	☐ Citizens Choice	☐ LA Care
☐ Senior	☐ Blue Shield	☐ Easy Choice	☐ Molina
	☐ CalOptima	☐ Golden State	☐ Scan
	☐ Care 1st	☐ Health Net	☐ United HealthCare
	☐ Central Health Plan	☐ Inland Empire	☐ Other:

Incident Type *(check box)*

☐ Quality of Care	☐ Access	☐ Attitude and Customer Service	☐ Billing and Financial	☐ Practitioner Office Site ** Must conduct on-site inspection*

Descriptor Code *(check box)*

Quality of Care	Access	Attitude and Customer Service	Billing and Financial	Practitioner Office Site
☐ QC 01 Case Management	☐ AC 01 Appointment	☐ CS 01 Abuse and/or Neglect	☐ AP 01 Appeal CMS Initiated	☐ OS 1 Medical Records Ineligible
☐ QC 02 Coordination of Care	☐ AC 02 Availability Facility / No choice or service not available	☐ CS 02 Art of Caring / Not treated with dignity or respect	☐ AP 02 Appeal State Initiated	☐ OS 2 Provider office dirty or unclean
☐ QC 03 Education / Client did not receive education and training	☐ AC 03 Availability PCP / No choice or PCP not available	☐ CS 03 Behavior / Lack of courteous service / Rude	☐ AP 03 Appeal not a Covered Benefit	☐ OS 3 Provider office uncomfortable
☐ QC 04 Information / Client did not receive information about available services	☐ AC 04 Availability SCP / No choice or SCP not available	☐ CS 04 Confidentiality	☐ AP 04 Appeal not Medically Necessary	☐ OS 4 Provider office unsafe
☐ QC 05 Medical Complication	☐ AC 05 Call not returned	☐ CS 05 Cultural / Lack of cultural sensitivity	☐ AP 05 Appeal notice not given / or given late	☐ OS 5 Physical barrier to Provider's office
☐ QC 06 Medication Problems	☐ AC 06 Contact MSO Dept.	☐ CS 06 Fraud, Waste, and Abuse	☐ AP 06 Appeal Non-Contracted Provider	☐ OS 6 Other (describe)
☐ QC 07 Misdiagnosis	☐ AC 07 Transportation / Distance barrier	☐ CS 07 Language barrier or lack of interpreter services	☐ AP 07 Appeal OON Denied	
☐ QC 08 Surgical Complication	☐ AC 08 Wait time Office	☐ CS 08 Patient's Rights / Violations of Patient's Rights	☐ AP 08 Appeal Rights Violation	
☐ QC 09 Treatment Plan	☐ AC 09 Wait time Phone	☐ CS 09 Other (describe)	☐ AP 09 Claims Issue	
☐ QC 10 Other (describe)	☐ AC 10 Other (describe)		☐ AP 10 Co-Pay / Deductible	
			☐ AP 11 Other (describe)	

DOCUMENTS

- ✓ **Provider's Response attached:** ☐ n/a ☐ Yes ☐ No
- ✓ **Medical Records attached:** ☐ n/a ☐ Yes ☐ No
- ✓ **Copies of Key Documents attached:** ☐ n/a ☐ Yes ☐ No
- ✓ **Interview Notes attached:** ☐ n/a ☐ Yes ☐ No
- ✓ **Log of Witnesses attached:** ☐ n/a ☐ Yes ☐ No
- ✓ **Site Audit attached:** ☐ n/a ☐ Yes ☐ No Date of site audit: Pass: ☐ Yes ☐ No If NO, reason & F/U:
- ✓ **Management responsible for the department / operational area that was the subject of the grievance, investigated and evaluated their processes:** ☐ n/a ☐ Yes ☐ No (If yes, see attached)
- ✓ *Other: (bullet points without extraneous language)*

Rev.12/2007, 021808, 12/11/08, 1/22/2010, 05/07/2012, 05/17/2013, 08/2013
G:QM Case Summary: FORMS

1

COMPLAINT TIMEFRAMES

The Health Plan, State, and Federal agencies have set time frames by which we must adhere to. Each complaint received must meet the specified turn-around-times for completion for each element.

Complaint Time Frames	*Commercial*	*Medicaid Managed Care*	**Medicare**
Upon Discovery by Customer Service Department and/or other department.	Phone: Refer Member to the Health Plan, State, or Federal agency for filing. Letter: Must be forwarded within 24 hours to the Health Plan.	Phone: Refer Member to the Health Plan, State, or Federal agency for filing. Letter: Must be forwarded within 24 hours to the Health Plan.	Phone: Refer Member to the Health Plan, State, or Federal agency for filing. Letter: Must be forwarded within 24 hours to the Health Plan.
Member filing of complaint from date of incidence.	Health Plan 180 days	Health Plan *180 days	Health Plan 60 days
Receipt of Complaint from Health Plan and Collecting of Documents.	Forward to Health Plan within time frames specified, not to exceed 5 business days	Forward to Health Plan within time frames specified, not to exceed 5 business days	Forward to Health Plan within time frames specified, not to exceed 5 business days
Completion of Internal Investigation, including leveling and determination.	30 Calendar Days	30 Calendar Days	30 Calendar Days
Corrective Action Plan Implemented. The practitioner and/or facility is required to submit a corrective action plan if they are at fault.	45 calendar days of the event	45 calendar days of the event	45 calendar days of the event

**Regulations vary by State and Territory, in the Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia, therefore please refer to your state regulations for your State specific time frames.*

CASE FILE MAINTENANCE

A written case record shall be made for each complaint received by the Provider Group, including the date received, the staff person recording the complaint, a summary of other documents describing the complaint, and its disposition. The written record shall be reviewed by the Medical Director, his/her designee, and/or the Quality Improvement Committee. Their review shall be thoroughly documented.

CODING OF COMPLAINTS

Each complaint received from the full-service Health Plan is coded by category, and subcategory. These categories are used in tracking to identify provider-specific and system-wide trends that may need corrective action.

There are five major complaint categories:

1. Quality of Care
2. Access
3. Customer Service
4. Provider Office Site
5. Billing and Financial (Appeals) – discussed separately under the Grievance Program - Appeals

We have further subcategorized each category, as noted in the tables below. Each complaint must be assessed and evaluated. The Medical Director and Quality Director/Complaint officer will assess for trends, and recommend actions to correct identified problems.

After the problem has been corrected, the Quality Department is responsible to monitor and track complaints. This may include follow-up phone calls, letters, 1:1 meetings, and other activities to ensure that the problem has been resolved.

QUALITY OF CARE COMPLAINTS

A quality of care complaint is any real or perceived complaint by the member, his/her family member, or their authorized representative of the care received from the provider and/or Provider Group.

QUALITY OF CARE - CODING CATEGORIES

CASE MANAGEMENT	The member did not receive case management services and/or was not satisfied with the case management services rendered.
COORDINATION OF CARE	Care was not coordinated which resulted in a delay in treatment.
EDU. NOT PROVIDED	The member did not receive education and training for a medical, surgical or behavioral health / substance abuse condition or therapy, to include medications. Or, the member did not understand the education/instructions received from the provider, and the provider did not test their understanding.
INFORMATION	The member did not receive information about the services available to them.
MEDICAL COMPLICATION	The member sustained a medical complication secondary to the care provided by the provider, or other ancillary services.
MEDICATION PROBLEMS	Any medication problem. Any untoward side effects and/or complications. Polypharmacology.
MISDIAGNOSIS	The member was misdiagnosed by the provider.
SURG. COMPLICATIONS	The member sustained a surgical complication secondary to the care provided by the surgeon or other ancillary services.

TREATMENT PLAN	Treatment was not appropriate to the patient's medical condition. Was not based on best practice per nationally recognized Clinical Practice Guidelines. Member disagrees with the physician.
OTHER	Describe the exact nature of the complaint. Ensure it does not contain any bias or opinion.

ACCESS COMPLAINTS

Access complaints are real or perceived complaint by the member, his/her family member or their authorized representative of difficulty in accessing services. Service delivery includes: the provider, the specialist, the facility, any ancillary services, and all departments within the Provider Group. Each State has specific access requirements that the Provider Group must adhere to.

ACCESS TO NEEDED SERVICES – CODING CATEGORIES	
APPOINTMENT	Unable to make a regular, urgent, or emergent appointment to the PCP or Specialist within State time frames.
AVAILAB. FACILITY	The Facility cannot facilitate member services, or there is no choice or limited choice in choosing a Facility.
AVAILAB. PCP/NO PCP	The PCP is not available or there is no PCP of choice.
AVAILAB. SPC/NO SPC	The SCP is not available or there is no SCP of choice.
CALL NOT RETURNED	Telephone call was not returned within a reasonable time frame, not to exceed 24 hours, OR dependent on the patient's medical condition.
CONTACT MSO DEPT	Difficulty accessing a department may include: phone not answered, unable to leave message, etc.
TRANSPORT/DISTANCE	The geographic location creates a barrier for the member to access services and/or it exceeds thirty miles in distance from the member's residence.
WAIT TIME OFFICE	The office wait time exceeded reasonable expectations and caused the member mental or physical distress.
WAIT TIME PHONE	The wait time exceeded State standards.
OTHER	Describe the exact nature of the complaint. Ensure it does not contain any bias or opinion.

CUSTOMER SERVICE COMPLAINTS

Our primary customer is the member, the family member, and their authorized representatives. Customer service complaints are taken very seriously. Any violation of a member's rights, and/or other heinous acts taken against the member shall be reported immediately to the appropriate regulatory authority to include: Child or Adult Protective Services, County, State or Federal agency, the Attorney General's Office, and law enforcement for further research/review or action.

CUSTOMER SERVICE – CODING CATEGORIES	
ABUSE AND NEGLECT	Any abuse reported: ➢ Physical ➢ Medical ➢ Emotional ➢ Financial
ART OF CARING	Perceived, and/or they were not treated with dignity or respect.
BEHAVIOR	Perceived, and/or there was actual lack of courteous service and the provider, or his/her staff members were rude.
CONFIDENTIALITY	The member, the family member or their authorized representative perceives, or there was an actual breach in confidentiality.
CULTURAL SENSITIVITY	Perceived, or there was actual lack of cultural sensitivity by the provider, specialist or other person.
FRAUD, WASTE & ABUSE	The member filing an allegation of Fraud, Waste, and Abuse against the Provider Group and/or Provider.
LANGUAGE BARRIER	There was a language barrier between the member and the provider, and/or interpreter services / reading material was not available.
PTS RIGHT VIOLATION	Perceived, or there were actual patient rights violations.
OTHER	Describe the exact nature of the complaint. Ensure it does not contain any bias or opinion.

PROVIDER OFFICE SITE COMPLAINTS

An on-site visit must be conducted for all practitioner office site complaints. The HPN template shall be used by the Provider Group for all on-site surveys. It is recommended that two representatives conduct the survey, with at least one (1) individual being a licensed clinical person, as clinically indicated. Any violation of County, State or Federal rules must be reported, immediately. This includes: the Occupational and Health Safety Administration (OSHA), and county Sanitation departments.

PROVIDER OFFICE SITE – CODING CATEGORIES

MEDICAL RECORDS	The medical records are illegible and/or the member requested records and they were not received.
OFFICE DIRTY/UNCLEAN*	The provider's office was dirty or unclean.
OFFICE UNCOMFORTABLE*	The provider's office was uncomfortable.
OFFICE UNSAFE*	The provider's office was unsafe.
PHYSICAL BARRIER*	There is a physical barrier preventing the member from access to the office.
OTHER	Describe the exact nature of the complaint. Ensure it does not contain any bias or opinion.

*An on-site office visit must be conducted by the Provider Group.

INVESTIGATION OF THE COMPLAINT

The Provider Group shall conduct an internal review of all complaints received.

1. Complaint received by secure email or facsimile from the Health Plan.
2. Provider Group representative fills out the complaint form worksheet, noting the complaint and/or appeal as stated by the member in "parenthesis."
3. A case "incident" file is opened in the EZ-CAP customer service module, indicating the date received.
4. Quality of care issues are identified and a preliminary assessment of the severity of the issue is completed.
5. Prioritization of action(s) needed to resolve immediate care needs, when appropriate.
6. Request of medical records and supporting documents from the provider(s) relevant to the case.
7. Request of provider response. Openly communicate with the involved provider(s) to obtain their written response to the allegation.
8. Documentation of any/all conversations relevant to the case in the EZ CAP data base system.
9. Research, including, but not limited to: a review of the event(s), documentation of conversations, quantitative and qualitative analysis of the research, which may include root cause analysis. Examination of medical records upon receipt, and communication with involved provider(s) if additional information is required.
10. Preliminary review for completeness. The case file is forwarded to the assigned physician reviewer.

PHYSICIAN REVIEW OF THE COMPLAINT

The Physician reviewer shall:

1. Review the complaint received.
2. Review the provider's previous history of compliance, and/or quality of care issues.
3. Review trend reports.
4. Conduct research, including, but not limited to: a review of the log of events,

documentation of conversations, and medical records review, mortality review, etc.

5. Complete a quantitative and qualitative analysis of the research, which may include root cause analysis.
6. Prioritize action(s) needed to resolve immediate care needs when appropriate.
7. Record his/her expert opinion; and criteria used to make determination. A written response from or summary of the documents received.
8. Assign a severity level (complaints only).
9. Determine if the complaint was substantiated, unsubstantiated, or unable to determine.
10. Recommend interventions to resolve, and prevent similar incidences from recurring.
11. Determine if the complaint shall be forwarded to the department management responsible for the deficient operational area that is the subject of the complaint or appeal review.
12. Determine if the complaint shall be forwarded to the Quality and/or Credentialing committee(s) for additional peer review.
13. Report his findings to the Quality and/or Credentialing committees.
14. Report to the Health Plan, if indicated.
15. Report to the appropriate County, State or Federal regulatory authority and/or agency, if indicated.

The Quality and/or Credentialing committee shall review individual cases resulting in member harm. This shall be done on a case-by-case basis, relating to individual or practice issues. The committee may refer cases to non-affiliated specialty providers for review and recommendations.

The committee shall review quarterly track and trend reports. If significant negative trends are noted, the committee may consider making it the topic for one of its performance improvement activities to improve the issue resolution process itself, and to make improvements that address other system issues raised in the resolution process.

GRIEVANCE RESOLUTION CODES

The Medical Director, or assigned physician reviewer will assign a grievance resolution status for each grievance and appeal received. The status codes are:

- **In Favor** – The complaint or appeal was "Substantiated" and found in favor of the member.
- **Not In Favor** – The complaint or appeal was "Not Substantiated" and found in favor of the provider, or Provider Group.
- **Unable to determine** – There was insufficient evidence to make a determination, and the Provider Group was "Unable to Substantiate" the member's complaint.
- **Withdrawn** – The complaint or appeal was withdrawn at the Health Plan level by the member, or the provider.
- **Dismissed** – The complaint or appeal was dismissed at the Health Plan Level by the member or provider
- **Null** – a case remains open.

SEVERITY LEVELING

Upon completion of the investigation the individual case is assigned a severity level according to the Severity Leveling Table at the end of this section. The table identifies criteria for each severity level and associated corrective action. Each level of severity is accumulated and tracked for each provider. Once trends are identified, corrective actions are implemented against the provider. Refer to table next page.

Severity Leveling & Action Plans for Quality Management Committee Cases

Level	***Description***	***Examples***	***Severity Level may be assigned by:***	***Corrective Action***	**Evidentiary Documents and Follow-up to Include:**
0	No quality of care issue identified.	Example: Patient medical record in total conflict with complaint	Quality Director / Manager Physician Reviewer Medical Director Quality Improvement Committee	Track At Minimum Letter to Physician of Findings and Outcome Educational Letter, As Appropriate	Initial Grievance Notice from Health Plan Completed Grievance Form Supporting Documents Letter to Physician Education Letter, if applicable Quarterly Grievance Report to QIC Annual QIC Provider Performance Monitoring Worksheet
1	Member experienced adverse administrative issue(s), attitude/communications issue(s) or known/expected complication(s) occurred that is not due to negligence or poor/improper technique.	Example: Liver biopsy performed with hemorrhage resulting in death one week post op (no indication in op report of intraoperative complications; known complication)	Physician Reviewer Medical Director Quality Improvement Committee	Track At Minimum Letter to Physician of Findings and Outcome Educational letter, as Appropriate	Initial Grievance Notice from Health Plan Completed Grievance Form Supporting Documents Letter to Physician Education Letter, if applicable Quarterly Grievance Report to QIC Annual QIC Provider Performance Monitoring Worksheet
2	Confirmed quality issue in which care had potential for minimal to moderate adverse effect(s) on the patient.	Example: Inadequate medical record documentation Mildly abnormal lab findings and no indication of appropriate follow-up Issues that are identified	Physician Reviewer Medical Director Quality Improvement Committee	Track for further occurrence Letter to Physician of Findings and Outcome Implementation of new, or change in existing policies Individual verbal counseling	Initial Grievance Notice from Health Plan Completed Grievance Form Supporting Documents Letter to Physician Education Letter, if applicable Notation/ Summary report of verbal 1:1 Counseling signed by

		for tracking and trending			Physician P & P new or revision to existing Quarterly Grievance Report to QIC Annual QIC Provider Performance Monitoring Worksheet
3	Confirmed quality issue which resulted in minimal to moderate adverse effect(s) on the patient.	Example: Emotional distress Prolonged treatment	Physician Reviewer Medical Director Quality Improvement Committee	Track for further occurrence Letter to Physician of Findings and Outcome Ongoing monitoring Implementation of new, or change in existing policies Individual verbal counseling Individual written counseling "Lessons Learned" presentation to staff	Initial Grievance Notice from Health Plan Completed Grievance Form Supporting Documents Letter to Physician Education Letter Notation/ Summary report of verbal 1:1 Counseling signed by Physician Written Warning signed by Physician Ongoing Sanction / Complaint Log QIC Meeting Minutes "Lessons Learned" presentation. P & P new or revision to existing Quarterly Grievance Report to QIC Annual QIC Provider Performance Monitoring Worksheet
4	Confirmed quality issue in which care had potential for a significant adverse effect(s) on the patient or resulted in moderate adverse effect(s).	Example: "Potential": Evidence of inappropriate administration of IV fluids (e.g., incorrect rate or fluid), medication error. Corrected prior to development of	Physician Reviewer Medical Director Credentialing Committee Quality Improvement Committee	Track for further occurrence Letter to Physician of Findings and Outcome Ongoing monitoring Implementation of new, or change in existing policies Individual written counseling Mandated CMEs	Initial Grievance Notice from Health Plan Completed Grievance Form Supporting Documents Initial Letter to Physician of findings and CAP Written Warning signed by Physician Quarterly Monitoring Letters

		significant complication		Establishment of preceptor program Limitation of privileges Report to Credentialing	Ongoing Sanction / Complaint log Evidence of completion of CME's Evidence of completion of Preceptor Program QIC Meeting Minutes Peer Review Meeting Minutes "Lessons Learned" presentation. P & P new or revision to existing Quarterly Grievance Report to QIC Annual QIC Provider Performance Monitoring Worksheet
5	Confirmed quality issue in which care resulted in significant adverse effect(s) on the patient.	Example: "Resulted": Evidence of inappropriate administration of IV fluids (e.g., incorrect rate or fluid), medication error. Errors not corrected in a timely manner and significant harm results (e.g., pulmonary edema, CHF)	Physician Reviewer Medical Director Credentialing Committee Quality Improvement Committee	Track for further occurrence Letter to Physician of Findings and Outcome Ongoing monitoring Implementation of new, or change in existing policies Individual written counseling Mandated CMEs Establishment of preceptor program Limitation of privileges Report to Credentialing	Initial Grievance Notice from Health Plan Completed Grievance Form Supporting Documents Initial Letter to Physician of findings and CAP Written Warning signed by Physician Quarterly Monitoring Letters Ongoing Sanction / Complaint log Evidence of completion of CME's Evidence of completion of Preceptor Program QIC Meeting Minutes Peer Review Meeting Minutes "Lessons Learned" presentation. P & P new or revision to existing Quarterly Grievance Report to QIC Annual QIC Provider Performance Monitoring Worksheet
6	Confirmed quality issue in which care resulted in	Example: Patient presented with	Physician Reviewer Medical Director	Track occurrences Letter to Physician of	Evidentiary Documentation is dependent on Peer Committee

	patient mortality.	signs and symptoms of an MI and no cardiac work up occurred. Patient treated for gastric distress. Resulting in acute MI with subsequent mortality	Credentialing Committee Quality Improvement Committee	Findings and Outcome Ongoing Monitoring Implementation of new, or change in existing policies Individual written counseling Mandated CMEs Establishment of preceptor program Limitation of privileges Termination of participation Report to Credentialing May Report to MBOC	determination Initial Grievance Notice from Health Plan Completed Grievance Form Supporting Documents Initial Letter to Physician of findings and CAP Letter of termination of participation, as applicable MBOC 805 report, as applicable Written Warning signed by Physician Quarterly Monitoring Letters Ongoing Sanction / Complaint log Evidence of completion of CME's Evidence of completion of Preceptor Program QIC Meeting Minutes Peer Review Meeting Minutes "Lessons Learned" presentation. P & P new or revision to existing Quarterly Grievance Report to QIC Annual QIC Provider Performance Monitoring Worksheet

FEEDBACK WITH THE MEMBERS

The Provider Group is not delegated member communication for complaints or appeals. Member communication regarding the disposition of each complaint received is maintained by the full-service Health Plan.

At the conclusion of each complaint received the Provider Group may follow-up with the member to ensure their needs were adequately met and to coordinate their care. This may include, but is not limited to:

1. Advocating for the member and providing assistance to ensure that their immediate healthcare needs are met.
2. Coordinating care conferences to discuss the member's and/or caregiver's needs.
3. Providing member counseling, and education on processes or health care needs.
4. Establishing a member contract agreement.
5. Changing their placement.
6. Changing their provider.
7. Making changes to their treatment plan.
8. Immediate authorization of services, if previously denied. To include a telephone call the same business day, notifying the member of the reversal of the initial determination.

FEEDBACK TO PROVIDERS

Providers receive feedback on quality assurance activities, including results of grievances received, and credentialing quality reviews. Feedback may occur as written counseling, notification of corrective action plans, notification of system-wide policy and procedure changes, or provider profiling reports.

See example next page.

EXAMPLE (1) PROVIDER FEEDBACK

Insert Logo ***NAME OF MEDICAL GROUP***

Insert Provider's Name
Address

Date: Insert Date

RE: Insert Member's Name
Member ID#: Insert Member's ID Number
DOB: Insert Member's DOB

Dear Dr. Insert Provider's Name:

We wish to take this opportunity to thank you and your staff for the courtesy and cooperation exhibited during our quality of care internal review process on the above-mentioned member. The Grievance is, as stated by the member:

All material submitted was reviewed by our Quality Improvement Committee. The following determination(s) was made.

Grievance Category:	*Severity Level*	*In favor of Member / Not in favor of Member/ Unable to Substantiate*
1.		
2.		
3.		
4.		
5.		

The Quality Improvement Committee (QIC) leveling system is:

Level 0: No quality of care issue identified
Level 1: Member experienced adverse administrative issue(s), attitude/communications issue(s) or known/expected complication(s) occurred that is not due to negligence or poor/improper technique.
Level 2: Confirmed quality issue in which care had potential for minimal to moderate adverse effect(s) on the patient.
Level 3: Confirmed quality issue which resulted in minimal to moderate adverse effect(s)on the patient.
Level 4: Confirmed quality issue in which care had potential for a significant adverse effect(s) on the patient or resulted in moderate adverse effect(s).
Level 5: Confirmed quality issue in which care resulted in significant adverse effect(s) on the patient.
Level 6: Confirmed quality issue in which care *resulted* in patient *mortality*.

Secondary to our Findings, the QIC, and Medical Director, recommended the following interventions and/or corrective actions:

REQUEST FOR RECONSIDERATION

The provider has the opportunity to request reconsideration of any complaint received, resulting in sanctions or penalties against the provider. The provider's request must be made in writing. The request and any supporting documentation are to be submitted to the Medical Director, or designee for appropriate re-review. It shall be presented at the Credentialing Peer Review committee for reconsideration. Decisions made by the Credentialing Peer Review committee on reconsiderations are considered final.

CORRECTIVE ACTION

The Provider Group may take action to correct both individual problems and patterns of problems in the delivery system. HPN has defined the types of issues requiring corrective action and the types of corrective actions to be taken. Each individual corrective action includes the responsible party and a

timetable for completion. In the event of noncompliance the corrective action is intensified up to and including termination.

Medical Director and/or Committee Actions for Complaints Received

1. No Action Needed
2. An Education Letter to the provider. This may include, but is not limited to, in-service attendance sheets and training objectives. A copy of the letter must be retained in the case file.
3. Verbal Counseling - there must be a documented record of the verbal counseling, to include a letter to the provider reiterating what was stated.
4. Corrective Action Plan (CAP) – A letter to the provider with attached CAP with a due date for completion, generally within ten (10) business days. There must be follow-up visit by a Provider Group representative(s) to ensure that the corrective action was completed.
5. Written Counseling or Directive – A letter to the provider stating the actions that must be taken and the time frame for completion. There must be documented evidence of follow-up by the Provider Group that corrective action was completed.
6. Intensified Retrospective Review – The Provider Group may conduct a detailed retrospective review of the complaints received. A retrospective review may include the review of the member's records. A determination will be made by committee based on the findings.
7. Concurrent Review – The Provider Group may conduct a detailed concurrent review of all complaints received, against a provider. A proctor will be identified to review the member's medical record, and actually observe the physician's work. A determination will be made by the committee based on the findings.
8. Prospective Proctoring – A review by the proctor of the member's chart and the member personally before treatment. The proctor must have the clinical expertise, and experience to accurately evaluate the provider's performance. The proctor shall validate whether or not the provider is competent. The proctor shall assess the provider's clinical knowledge, knowledge of the equipment; and knowledge of the procedure.
9. Panel Review – The Medical Director shall appoint three (3) unbiased physicians, each with the clinical expertise and experience, to adjudicate the case. The panel shall meet, review the case file, and make a final determination. Refer to "Attachment A" for Guideline.
10. Mandatory CEUs – The Medical Director, per recommendations from the QIC and Credentialing committee(s), shall ensure enrollment of the provider into a continuing education class respective to the complaint filed. The provider shall submit evidence of completion. A record shall be maintained, to include certificate of completion.

Assessment of Effectiveness of Corrective Action

Upon completion of corrective action, the QM department continues to monitor quality of care complaints filed against the identified provider. A focused audit may also be conducted to determine the effectiveness of corrective action. This information is forwarded to the QM Medical Director for his/her determination of decline or cessation of the related issue.

In cases in which the established corrective action does not appear to have been effective, the QM Medical Director presents the issue(s) to the peer review committee for recommendations as to further action. Such action may include, but not be limited to, those identified in the Severity Leveling Table.

For system-wide policy and procedures changes, the QM department assesses the effectiveness of system modifications through monitoring of quality of care complaints. A focused audit may also be conducted to determine effectiveness.

COORDINATION WITH RISK MANAGEMENT

For cases identified as potential risk management issues, the QM Department advises the Corporate Compliance / Legal Department of the issue and forwards the case file for review. Corporate Compliance and Quality Management coordinate their efforts where they overlap to ensure better alignment of patient safety initiatives and use of resources.

COORDINATION WITH CREDENTIALING

The Credentialing Department maintains a Sanction log of all actions taken against physicians.

A grievance trend report is forwarded to the Credentialing Chair for review and determination as to whether or not actions should be taken against a practitioner/facility organization. This report is reviewed annually, and is trended for three consecutive years. The report contains the following information:

1. The provider was placed on a corrective action plan for a quality of care issue
2. There were multiple grievances filed against the provider
3. The severity of grievances filed against the provider
4. Any utilization management issues of over and under utilization
5. Member satisfaction surveys demonstrated levels of dissatisfaction
6. The provider was limited in his/her privileges
7. Report filed against the provider to the Board of Medical Examiners
8. Report filed against the provider to the Board of Dental Examiners
9. Loss of Medicaid and/or Medicare privileges

EXAMPLE PHYSICIAN CREDENTIALING TREND REPORT

Quality/Utilization Management Provider Performance Monitoring

□□PCP X □□Specialist X Provider ID:

Name: Degree: . Specialty:

Member Complaint/Grievance History					
Severity Levels	2012	2013	2014	2015	Totals

0					
1					
2					
3					
4					

5					
6					
Total					

If any, Medical Record Review Date:				N/A	Yes	No
Deficiencies identified.						
Follow up visit required.						

If any, Site Audit Date:				N/A	Yes	No
Deficiencies identified.						
Follow up visit required.						

Member Satisfaction Survey	N/A	Yes	No
Deficiencies identified.			

Quality Management Issues	N/A	Yes	No
Negative QM Trends Identified			
Access Survey Compliance			

Utilization Management Issues	N/A	Yes	No
Negative UM Trends Identified			
If applicable, PCP ER/Urgent Care Ranking %			

Comments

(Optional):____

______________________________ ________________

Coordinator Date

______________________________ ________________

Quality Director Date

DISPUTE RESOLUTION PROCESS FOR PROFESSIONAL COMPETENCE OR CONDUCT

The Provider Group may terminate a provider for professional competency and/or conduct, or quality of care issues; and may do immediate suspension or termination for concerns for consumer safety. The Provider Group must notify the Health Plan immediately of all termination based on competence or conduct.

Terminations for professional competency, conduct or quality of care

Contracted providers may dispute the Provider Group's decision to terminate a contract for lack of professional competence or for professional misconduct. Examples of these disputes include, but are not limited to:

1. Belief that a quality of care issues exists
2. Adverse action taken by a hospital
3. Disciplinary action taken by a licensing board
4. Trend or pattern of quality of care issues

If a provider is terminated for professional competency and/or conduct:

1. The provider will be notified in writing of the reason for the termination
2. The provider may request reconsideration in writing not later than 30 calendar days after receipt of notice of termination
3. The Credentialing Committee, consisting of at least 3 qualified individuals with at least one participating clinical peer provider, will consider the reconsideration request
4. The Committee will notify the provider within 10 business days of its decision
5. If the provider is not satisfied with the committee decision, a second level appeal may be requested not later than 30 calendar days of the receipt of the committee decision
6. A panel of three individuals, who did not participate in the first level decision, including at least one participating provider who is a clinical peer of the appealing provider, will consider the second level appeal
7. The panel's decision is final and will be communicated to the provider in writing, via certified mail, within 10 business days of the decision

Immediate Suspension or Termination related to concerns for Consumer Safety

If a Medical Director believes a provider is practicing in a manner that poses a significant risk to the health, welfare, or safety of consumers, the Provider Group can either immediately suspend or terminate the provider.

If the circumstances require an investigation to know whether the concerns are justified, the Provider Group will immediately suspend the provider contract and conduct an expedited investigation. If the circumstances do not require an investigation to know whether the concerns are justified, the Provider Group will immediately terminate the provider contract.

Examples of circumstances that might result in immediate suspension or termination include, but are not limited to:

1. Insufficient or no professional liability insurance
2. Sanction by Medicare/Medicaid
3. Exclusion from any Federal Programs
4. A change in license status
5. Fraudulent activity

When a suspension or termination occurs:

1. The provider is immediately removed from the provider directory
2. The provider is notified of the suspension or termination in writing. The notification will include the reason for the suspension or termination
3. The provider may request reconsideration in writing not later than 30 calendar days after receipt of notice of termination

4. The Credentialing Committee, consisting of at least 3 qualified individuals with at least one participating provider who is a clinical peer, will consider the reconsideration request
5. The Committee will notify the provider within 10 business days of the decision
6. If the provider is not satisfied with the committee decision, a second level appeal may be requested not later than 30 calendar days of the receipt of the Committee decision
7. A panel of three individuals, who did not participate in the first level decision, including at least one participating provider who is a clinical peer, will consider the second level appeal
8. The panel's decision is final and will be communicated to the provider in writing, via certified mail, within 10 business days

DISPUTE RESOLUTION PROCESS FOR ADMINISTRATIVE MATTERS

Disputes regarding administrative matters may arise when a contracted provider wishes to protest the Provider Group's decision that the provider has breached the provider's participation agreement, or violated of Provider Group policy. Examples of administrative disputes include, but are not limited to:

1. Non-compliance with administrative terms in the participation agreement or Provider Operating Guide
2. Billing the member improperly
3. Failure to submit requested medical records

When an administrative dispute occurs:

1. The Provider Group will send a letter to the provider detailing the contractual breach or administrative violation
2. The provider may request reconsideration in writing not later than 30 days after receipt of the notice
3. An authorized representative of the organization not involved in the initial decision on the subject of the dispute will consider the written reconsideration
4. The authorized representative's decision is final and will be communicated to the provider in writing within 30 calendar days

REPORTING TO REGULATORY AGENCIES

The Provider Group will refer, and report to appropriate regulatory agency; Child or Adult Protective Services, the respective State and Federal agency and licensing agency, the Attorney General's Office, Child or Adult Protective Service, and/or law enforcement agency for further research/review or action on statements of concerns, complaints, or appeals received which resulted in an adverse negative outcome to the member.

Initial reporting may be made verbally, but must be followed by a written report within one business day. The Provider Group must ensure that member health records are available and accessible to authorized staff of their organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care or investigating member or provider quality of care concerns, complaints, and allegations of abuse, neglect, exploitation, and Healthcare Acquired Conditions.

Member record availability and accessibility must in in compliance with Federal and State confidentiality laws. Information must be available to regulatory agencies upon request.

REPORTING TO HEALTH PLAN

If an adverse action is against a practitioner/facility organization due to a quality of care concern, the Provider Group will report the adverse action to the Health Plan when a the practitioner's or facility organization's affiliation with the Provider Group is suspended or terminated because of quality of care issues.

1. The Provider Group will report to the Health Plan any deviation or suspected deviation from State or Federal program requirements or regulations that impact one or more beneficiaries
2. The Provider Group will fully disclose to the Health Plan all circumstances surrounding the event to assist them in the completion of their investigation
3. The Health Plan will be notified upon discovery for all events that place the member in immediate jeopardy
4. The Health Plan will be notified verbally and in writing within 24 hours of all other incidents. All documents relevant to the case shall be obtained by the Quality Department in collaboration with the Risk Department.
5. The case documents shall be submitted to the Health Plan within 7 days of incident
6. The Provider Group will cooperate with Federal and State designated agencies, and the Health Plan in the resolution, and closure of all events resulting in harm to the member

TRACKING AND TRENDING

Heritage Provider Network and the Provider Group track quality of care investigations to identify trends or patterns of issues that may be either provider specific or system-wide. If significant negative trends are noted, the issue may be considered as the topic for a performance improvement activity to improve the issue resolution process itself, and to make improvements that address other system issues raised in the resolution process.

The grievance system will track grievances under categories of Commercial, Medicare, and Medicaid/other contracts. For those individual case reviews that are presented to the peer review committee, a provider trend/pattern report is prepared. This report is made available to the committee during the corrective action discussion of the case to ensure appropriate progressive corrective action.

1. On a quarterly basis, category reports are prepared for a rolling 12-month period. These reports are analyzed prior to the committee meetings by the QM Director/Manager and the Medical Director to determine potential system-wide problems that may need a change in policy and procedure.
2. On a quarterly basis, provider profiling tracks the total number of complaints and concerns for individual providers and identifies outliers
3. On a quarterly basis, provider-specific reports by issue category are prepared for a rolling 12- month period

These reports are analyzed by the QM Director/Manager and the Medical Director to determine potential trends/patterns by individual provider. For those providers who appear to have a problem with his/her practice pattern as identified by multiple occurrences in the same category, the Medical Director may institute corrective action.

1. The grievance systems shall track and monitor grievances received by each respective Health Plan.

The report shall be presented to the QIC and Credentialing Committee quarterly for review.

2. The QIC shall conduct an aggregate analysis of grievances and appeals to track and trend potential issues and barriers to care.
3. Evidence of review will be documented in the committee meeting minutes. Meeting minutes will be signed by the respective committee chairperson and the Medical Director and/or Quality Director/Manager.

Reports submitted to the QIC and Credentialing Committees shall include and not be limited to:

SOC REPORTS
1. Track the number of SOC's 2. Track SOC's by category, and sub-type 3. Track SOC by LOB 4. Total # SOC's per provider 5. Logs of SOCs received, and forwarded to the Health Plan for resolution

PROGRAM EVALUATION

There is an annual written evaluation of the complaints received and the overall effectiveness of the program that is reviewed and approved by the Quality committee. Benchmark goals are established by HPN and each Provider Group which is noted in their evaluation. The program evaluation includes:

1. A summary of aggregate scores and ongoing activities that address the quality and safety of clinical care and quality of service
2. A trending of measures to assess performance in the quality and safety of clinical care and quality of service
3. An analysis of the results, including barrier analysis
4. An evaluation of the overall effectiveness of the Grievance Plan, including progress toward influencing network wide safe clinical practices
5. The impact the process has had on the need for Grievance Plan revisions and modifications
6. Findings that will be used to develop and improve member satisfaction for the upcoming year

If significant negative trends are noted, HPN and the Provider Group will consider making it the topic for one of its performance improvement activities to improve the issue resolution process, and to make improvements that address other system issues found.

ATTACHMENTS

Letter to Provider

Insert Provider's Name Address

Date: Insert Date

RE: Insert Member's Name

Member ID#: Insert Member's ID Number DOB:
Insert Member's DOB

Dear Insert Provider's Name:

On Insert Date Grievance received, we received a grievance from Insert Name of Health Plan Health Plan for the following member expressed concern:

State member's grievance.

Insert Name of Provider Group is required to investigate all concerns expressed by our members and/or their legal representatives. As such, we require your detailed written response. Attached are the "Provider Grievance Response Form" and the "Medical Record Pull List" for you to complete.

Due to Federal and State regulations and their timelines, your written response, together with all supporting documents, is needed as soon as possible, and no later than Insert Date . Please submit your response to attention to:

Insert Name Insert
fax number

This correspondence is confidential. Please do not discuss it or any aspect of this investigation with the member or any member representative, as doing so may compromise the protected nature of the peer review process and subject you to otherwise preventable liability exposure in the event of litigation.

You will receive a written response of the outcome of our review by certified mail after closure of the case file. We thank you in advance for your assistance in bringing an understanding to this member's concern.

Sincerely, Name
and Title Phone
number

Grievance Response Form

[Provider Group Logo]

[Provider Group Address]
[City, State, ZIP] [Telephone Number] [TTY (Hearing Impaired)]

PROVIDER GRIEVANCE RESPONSE FORM

(Responses may be submitted under separate cover)

Provider's Name: Date of Service:

(1) Individual filing the grievance: Member [Member's Name]

Staff on behalf of Member Family Member

Member's legal representative

Please provide a complete description about the events surrounding the grievance:

What happened? Who was involved? What date the event occurred? Where did the event occur? Are any other mitigating circumstances?

Did you remember to attach all relevant supporting documents, and the member's Medical Records?

Name of person completing this form: Name: __

Job Title:________________Ext:____________

When completed, please return this report and any additional pages to: [QA Department] of [Provider Group] [Mailing Address]

Insert Medical Group Name

Grievance Provider File Pull List

TO: Provider Name

DATE REQUESTED: Insert Date

MEMBER NAME #: DATES OF SERVICE #:

Pull and Send a completed copy of the below noted items in the order requested.

1. ☐ Time Line of events, actions, and processes, from earliest to latest

☐ Specific Information: Copies of all medical records associated with this issue, may include copies of denials, and referral requests.

- ☐ Admission Summary
- ☐ CNA Records (ADL)
- ☐ Consent Forms
- ☐ Consultations Reports
- ☐ Denial Notices
- ☐ Diagnostic Reports
- ☐ Discharge Summary
- ☐ Discharge/Teaching Instructions
- ☐ Emergency Department Reports (ALL)
- ☐ Face Sheets
- ☐ Graphics Sheets
- ☐ History and Physical
- ☐ Hospital Progress Notes
- ☐ Initial Determination/Authorizations
- ☐ Itemized Claim
- ☐ Lab Reports/Results
- ☐ MDS & Care Plans
- ☐ Medication Sheets
- ☐ Notices of Non-Coverage Letters
- ☐ Nursing Notes
- ☐ Nutritional Records
- ☐ Office Visits Notes ***(All Practitioners)***
- ☐ Operative Reports
- ☐ Phone Records
- ☐ Anesthesia Records
- ☐ Photos of Therapy
- ☐ Physicians Orders ***(including telephone orders)***
- ☐ Physician Progress Notes
- ☐ Physician Referral/Request Forms
- ☐ Primary Provider Group Response
- ☐ Procedure Report
- ☐ Radiology Reports/X-rays
- ☐ Social Worker Notes
- ☐ Specialist Reports
- ☐ Therapy Notes (ALL)-(PT, OT, ST)
- ☐ Transfer Forms
- ☐ Treatment/Skin Care Records
- ☐ Wound Care Records
- ☐ Other:

Send all requested materials to: Attn:
Quality Management Department

Letter of Receipt of Provider's Response

Date: Insert Date

RE: Insert Member's Name

Member ID#: Insert Member's ID Number DOB:
Insert Member's DOB

Dear :

Insert name of Provider Group is in receipt of your written response and/or supporting documents for the grievance received from the Insert name of HP Health Plan for the following member expressed concern: Insert member's stated grievance.

The grievance will be reviewed by our Quality Medical Director, and/or designee. Should additional information be needed, you will be contacted.

A written response of the outcome of our review will be sent to you by certified mail after closure of the case file. We appreciate, and thank you for your assistance.

Sincerely,

Name and Title Phone
number

Grievance Warning Letter #1

Insert Provider's Name Address

Date: Insert Date

RE: Insert Member's Name

Member ID#: Insert Member's ID Number DOB:
Insert Member's DOB

Dear Name of Provider:

RE: WARNING LETTER #1 PROVIDER DETAILED RESPONSE NOT RECIEVED

On insert the date the initial request was sent, we requested your written response and/or the supporting documents to a grievance from Insert Name of HP Health Plan for the following member expressed concern: Insert member's stated grievance.

To date, we have not received your written response and/or the supporting documents as requested. Name of Provider Group is required to investigate all concerns expressed by our members and/or their legal representatives. As such, we require your immediate written response, and all relevant supporting documents. Please send to:

Insert Name Insert
Fax number

Network providers are contractually required to cooperate with quality improvement activities. Avenues for participation include timely response to grievances, and calls from our Customer Service and Quality Management Departments.

You will receive a written response of the outcome of our review by certified mail after closure of the case file. We thank you in advance for your assistance.

Sincerely,

Name and Title
Phone number

Grievance Warning Letter #2

Insert Provider's Name Address

Date: Insert Date

RE: Insert Member's Name

Member ID#: Insert Member's ID Number DOB:
Insert Member's DOB

RE: WARNING LETTER #2 PROVIDER RESPONSE NOT RECIEVED

On insert all dates letters sent, we requested your written response and/or supporting documents to a grievance from insert name of HP Health Plan for the following member expressed concern: Insert member's stated grievance.

To date, we have not received your written response and/or the supporting documents, as requested. As such, we require your immediate attention. Send your response to:

Insert address Insert
fax number

Please be advised, network providers are contractually required to cooperate with quality improvement activities. Failure to substantially meet one or more "Conditions of your Contract" is a cause for termination of participation. As such we request your immediate response.

Should a response not be received, the case file will be reviewed by our Medical Director to determine if penalties should be imposed. To prevent any untoward action by committee, please forward to us your response by the due date.

We thank you in advance for your assistance.

Sincerely,

Name and Title
Phone number

Provider Group CAP Response Letter

Insert Provider's Name Address

Date: Insert Date

RE: Insert Member's Name

Member ID#: Insert Member's ID Number DOB:
Insert Member's DOB

Dear :

Insert name of Provider Group is in receipt of your corrective action plan (CAP) for the grievance received from the Insert name of HP Health Plan for the following member expressed concern: Insert member's stated grievance.

The CAP was reviewed by our Quality Medical Director, and/or designee, and was found .
As a reminder:

We appreciate, and thank you for your assistance. Sincerely,

Provider Group Response to Health Plan

Insert Health Plan's Name Address

Date:

RE: Insert Member's Name

Member ID#: Insert Member's ID Number DOB:
Insert Member's DOB

Allegation Against: Insert Provider's Name Date of
Service(s): Insert DOS, if applicable

Dear Insert Health Plan's Name:

On Insert *Date*, we received a grievance from Insert Name Health Plan regarding the aforementioned member, Insert Member's Name . This member filed a grievance against Insert *Provider's Name*.

Attached for your review is a copy of the provider's response, medical records, and other supporting documents as indicated. This case is being forwarded to the Insert Provider Group's Quality Improvement Committee (QIC) for review.

Should you require additional information, please do not hesitate to contact us, thank you. Sincerely,

Name and Title Phone
number

Yes = 1   No = 0   N/A - not applicable

Enter the appropriate score for the element being audited. Yes responses are entered as the number one (1), No responses are entered as number zero (0), and if not applicable use N/A

A. Physical Accessibility *	Yes	No	N/A	Comments
1. Access to building is adequate, evidence by reasonable parking and/or feasible public transportation within walking distance.				
2. Accommodations for persons with disabilities are available, evidenced by designated parking, loading zone, and/or public transportation within close proximity to the building. This includes the following:				
A. External ramp (if applicable)				
B. Automatic entry option or alternative access method				
C. Elevator for public use (if applicable)				
D. Restroom equipped with large stall and safety bars or other reasonable accommodation.				
Inside Office				
1. Emergency medications (injectable epinephrine, Benadryl) are available on-site.				
2. There is a procedure for the management of non-medical emergencies (i.e., earthquakes).				
3. There is a procedure for handling medical emergencies appropriate to the patient population.				

B. Physical Appearance/Safety *	Yes	No	N/
1. The office waiting room is well lighted			
2. The office waiting room is clean and orderly			
3. The office hours of operation are posted or available on request			
4. The examining room(s) is/are clean and orderly			
Safety			
1. Inside exit signs are clearly visible.			
2. Evacuation plan is posted, inside building, in a visible location.			

C. Adequacy of Waiting and Examining Room Space *	Yes	No	N
1. Waiting room seating capacity is adequate			
2. The number of exam rooms per practitioner is adequate			

D. Adequacy of Equipment **	Yes	No	N
1. Fire protection equipment is up-to-date, accessible and in working order			
2. Refrigerator thermometer temperature is maintained and documented daily at 35° - 46° Fahrenheit			
3. Medications are not accessible to patients and stored in a separate refrigerator from food, drinks, and personal items			
4. Radiology technologist(s) license(s) is/are current			
5. Radiology equipment maintenance documentation is current			
6. Routine maintenance of autoclave is documented			
7. Cold chemical sterilization containers are dated List chemicals being used: ____			

E. Availability of Appointments*** (Title 28, § 1300.67.2.2.)	Yes	No	N
1. Non-urgent appointments are scheduled within _____ calendar days			
2. The average wait time is less than _____ minutes from the scheduled appointment time			
3. Urgent visits are scheduled within _____ hours / days			

F. Medical Record Keeping [*] (*Note to reviewer: This is not a chart audit. There is no minimum requirement for number of charts. A model chart or blinded chart may be used.*)	Yes	No	N
1. Patient medical records have a secure/confidential filing system			
2. Patient medical records have legible file markers			
3. Forms and methodology for filing within a chart is consistent			
4. Patient medical records can be easily located			
5. Refusal of interpretation services is documented in the chart, if applicable *(California Health & Safety Code)****			
6. Medical record documentation is signed with practitioner credentials *(CMS)*** Note: Handwritten signature or initials; signature stamp or authenticated electronic signature on the medical record AND credentials either next to the provider's signature or pre-printed with the provider's name on the group practice's stationery. If the provider of service is not listed on stationery, then the credentials must be part of the signature for that provider.			

** Category required by NCQA.*
*** Category required by CMS.*
****Question required by DMHC.*

Corrective Action Plan (CAP) Follow-Up

Deficiency # and Description	Date of Comment	Comment (Note here how deficiency was adequately addressed, why it is excused