I. SCOPE:

Complaints expressed by a Health Plan member, member representative, Health Plan staff, or affiliated practitioner/provider relating to quality of clinical care delivered by a participating practitioner/provider.

II. POLICY:

Health Plan clinical staff receive and review quality of care complaints related to practitioners and providers in their service area and coordinate peer review under the direction of the service area Medical Director.

III. PROCEDURE:

Quality of care complaints relate to care delivery issues involving alleged misdiagnosis, inappropriate management including delay or refusal in providing or arranging for care, continuity of care issues, alleged provider incompetence, and unfavorable/unexpected outcomes of care. (See attached Quality of Care Complaint Process Flowchart.)

A. Quality of care complaints sources include but are not limited to:

- Customer Service department
- Medical Services department
- Network Services department
- Sales department
- Medical Director
- Case Management Nurse
- Affiliated Practitioner/Provider
- Government Programs

B. Health Plan Internally Initiated Complaint Process – Department Role:

1. Initiates the Quality Complaint Review Form including a detailed description of the potential quality of clinical care issue. (See Attachment A)

2. Submits Quality Complaint Review Form to the Clinical Reviewer.

C. Member Initiated Complaint Process

1. Customer Service Role
   a. Member Complaints are referred to the Customer Service department for intake and initial processing.
b. The Customer Service Specialist logs the complaint and responds to the member in writing in accordance with the Health Plan Inc. Member Complaint Policy (see CS-04).

c. The Customer Service Specialist initiates the Quality Complaint Review Form utilizing it to document process.

d. Quality of care complaints are referred to the designated clinical reviewer.*

* The clinical reviewer is designated by the plan and assumes responsibility to conduct clinical case investigations. The designated clinical reviewer must be a licensed registered nurse, licensed practical nurse, or medical assistant employed by Health Plan and must report within the Quality Improvement, Medical Services, Customer Service, or Network Services department.

2. Clinical Reviewer Role:

Upon receipt, the designated clinical review staff:

a. Logs the complaint on the “Quality of Care/Service Tracking Log.” (See Attachment B)

b. Documents the process and outcomes on the Quality Complaint Review Form. (See Attachment A)

c. Initiates practitioner/provider notification within 15 days of receipt of complaint and request additional information from practitioner/provider. (Situation 1 or 2)

    The letter is signed by the Medical Director and includes:

    1) a comprehensive description of the complaint  

    2) a request for a response including copies of pertinent medical records within 14 days

    d. Upon receipt of practitioner/provider response (or if no response), the case is presented to the service area Medical Director for review.

3. The service area Medical Director:
a. Reviews the case and supporting information and renders a determination regarding presence or absence of quality of care issues.

b. If there are no identified quality of care issues, the Medical Director returns the case to the clinical review staff for documentation and case closure including:

   1) letter to practitioner/provider affirming no issue found (Situation 3)
   2) completion of the “Quality of Care/Service Tracking Log”
   3) copy of case documents placed in practitioner/provider file
   4) original case copy filed in Quality Improvement Department tracking file

c. If there are identified potential practitioner/provider quality of care issues, the Medical Director refers the case to the QI/UM Committee for review and a letter affirming the status of the complaint is sent to the practitioner/provider. (Situation 4)

D. The QI/UM Committee reviews the complaint and supporting information. A recommended course of action is determined on a case by case basis. This may include: no further action, practitioner notification and education, development and implementation of a corrective action plan, or disciplinary action.

   1. Quality Improvement Plan

   The QI/UM Committee is responsible for developing and monitoring the status of individual quality improvement plans. Individual quality improvement plans may include reinforcing plan approved clinical practice guidelines; continuing medical education for a target practice area/topic and re-audit within specified time frame; or other appropriate action.

   If the quality improvement plan achieves the desired outcome, the case is closed and the disposition is noted on the “Quality of Care/Service Tracking Log.” If the quality improvement plan does not result in desired outcome, the case and QI/UM Committee’s recommendation are referred to the Credentialing/Peer Review Committee.

   2. Disciplinary Action
If the recommended action involves disciplinary action including sanctions, restriction of privileges, or termination from the network, the case and the QI/UM Committee’s recommendation are referred to the Credentialing/Peer Review Committee.

E. The Credentialing/Peer Review Committee has the authority to initiate disciplinary actions as deemed appropriate and in accordance with procedures described in the Health Plan Inc. Credentialing Plan.

F. Each service area Quality Improvement department is responsible for compiling a quarterly summary of quality of care complaint activity.

G. Any practitioner/provider with three or more quality of care complaints from a different member in a quarter is referred to the QI/UM Committee for review and recommendation as outlined in section D of this policy.

H. The quarterly summary is forwarded to the QI functional team leader for compilation of the plan wide quarterly report. Annual reports are submitted by the Medical Director to the Quality Council for review and approval.

I. The Quality Council is responsible for reviewing plan wide summary reports and recommending system wide improvement strategies if indicated.
QUALITY OF CARE OR SERVICE CODES

Case Number (YYQXXX): To assign a case number, YY denotes the last two digits of the calendar year, Q is the quarter, and XXX denotes the numeric order in which the complaint was received. This number should be applied in ascending order.

CATEGORY CODES:

QUALITY OF CARE (QC)
Issues of health care delivery
QC1 Alleged misdiagnosis
QC2 Problem with quality or completeness of examination
QC3 Problem with quality of treatment/management of physical complaint
QC4 Problem with medications prescribed
QC5 Premature discharge from hospital or facility
QC6 Other

Continuity of Care (CC)
Issues relating to failure of provider to arrange or coordinate timely delivery of care
CC1 Delayed or lack of follow-up with patient
CC2 Lack of communication in response to problems identified by other providers
CC3 Lack of Member Education from provider to staff
CC4 Poor/Lack of Updates to PCP by specialists regarding changes in patient status
CC5 Inadequate outpatient or office education
CC6 Discharge planning or inpatient teaching
CC7 Refused referral
CC8 Delay in referral or scheduling surgery or other procedure/test
CC9 Other

QUALITY OF HEALTH CARE DELIVERY SERVICE (QS)

Provider Access (QSPA)
Timeliness with which the member can obtain services from the provider
QSPA1 Telephone wait time
QSPA2 Wait time in office
QSPA3 Wait time for appointment
QSPA4 After hours access
QSPA5 Driving time
QSPA6 Other

Provider Availability (QSPAV)
QSPAV1 Closed panel
QSPAV2  Lack of specific provider/practitioner/ selection in network
QSPAV3  Unavailability of specialist/specialty services in network
QSPAV4  Other

Provider Communication (QSPC)
Ability of the member to effectively exchange information with the specified provider/practitioner

QSPC1  Interpersonal conflict
QSPC2  Inappropriate attitude
QSPC3  Rude/discourteous behavior by provider
QSPC4  Rude/discourteous behavior by staff
QSPC5  Language barrier
QSPC6  Perceived lack of time/attention/education from provider
QSPC7  Delayed/non-return of phone calls
QSPC8  Other

Provider Administrative Compliance (QSPAC)
Issues relating to failure of provider to follow Health Plan policy/procedure resulting in disadvantage to member

QSPAC1  Provider Lack of Compliance with Plan Policies/Procedures, unspecified
QSPAC2  Pharmacy and Preferred Drug List Non-Compliance
QSPAC3  Non-Par Utilization w/o Authorization
QSPAC4  Balance Billing of Contractual Write-off Amounts to Member
QSPAC5  Collection of Full Fee from Members in Advance of Service
QSPAC6  Other

Health Delivery Facility (ACF)
The physical conditions/appearance/structure of the health delivery facility

ACF1  Cleanliness
ACF2  Parking
ACF3  Handicapped access
ACF4  Seating/comfort
ACF5  Privacy
ACF6  Other

SOURCE CODES:  LINE OF BUSINESS CODES:

P  PCP Change Report  FI  Fully Insured
C  Customer Service  SF  Self-Funded/ASO
S  Sales  CD  Medicaid
M  Medical Services  CR  Medicare
N  Network Services  PP  PPO
U  Corporate  TP  Third Party Administrator
G  Government Programs
Q  Quality
O  Other
### ATTACHMENT A: QUALITY COMPLAINT REVIEW FORM

<table>
<thead>
<tr>
<th>Type of Complaint:</th>
<th>Quality of Service:</th>
<th>☐</th>
<th>Reason Code:</th>
</tr>
</thead>
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<tr>
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<td>Quality of Care:</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Date Received:</td>
<td>Received By:</td>
<td>Mo/Day/Year:</td>
<td>Source Code:</td>
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<tr>
<td>Provider:</td>
<td>Full Name:</td>
<td>Provider ID Number:</td>
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<tr>
<td>Member:</td>
<td>Full Name:</td>
<td>Member Number:</td>
<td></td>
</tr>
<tr>
<td>Member:</td>
<td>Daytime Phone Number:</td>
<td>Line of Business:</td>
<td></td>
</tr>
<tr>
<td>Summary:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notification:**
- Date Member Notified: __________
- Route to: QI Dept. ☐ Network Services ☐

**Internal Review:**
- Date Provider Notified: __________
- Action/Comments: __________

**Medical Director Review:**
- Summary: __________
- Signature: __________ Date: __________

**Consultant Review:**
- Name: __________
- Date Sent: __________ Date Returned: __________
- Payment Requested: __________
- Comments: __________

**QI/UM Committee:**
- Review Date: __________
- Comments: __________
- Signature QI/UM Chair: __________ Date: __________

**Case Closed:**
- Date: __________ Entered in Provider File: __________
INSTRUCTIONS FOR COMPLETING THE QUALITY COMPLAINT REVIEW FORM

1. Type of complaint: assigned by complaints/grievance coordinator in customer service.

2. Reason code: assigned by complaints/grievance coordinator in customer service.

3. Received by: name of person that identified or took the complaint.

4. Date Complaint Received: indicate date person that identified or took the complaint became aware of complaint.

5. Source: your department; source codes are as follows:
   - Customer Services: C
   - Government Programs: G
   - Medical Services: M
   - Network Services: N
   - Primary Care Physician Change Report: P
   - Quality: Q
   - Sales: S
   - Corporate: U
   - Other: O

6. Provider: indicate provider full name (first and last name are helpful) and provider ID number, if known. Location of office/facility is helpful if the provider number is not known.

7. Member: indicate member full name and Health Plan number and Line of business.

8. Summary: Brief summary of the complaint. Be as complete and specific as possible re: situation, date of occurrence and if the person presenting the complaint is not the member, please identify that person by first and last name and their relationship to the member as well as a daytime telephone number in case we need to contact them for clarification or more information.

9. Forward form to Customer Service for initial processing. Customer Service will send the form to the appropriate department for investigation.
Situation 1

Dear Dr:

Health Plan recently received a complaint from MEMBER NAME regarding health care services you provided.

Specifically, the member expressed the following concerns:

IDENTIFY MEMBER ALLEGATIONS

So that we can understand what occurred, please forward your comments and a summary of the care provided, along with a copy of PATIENT’S NAME medical records from DATE to DATE. You will be notified after our review of this matter has been completed.

To facilitate our review, please respond within 14 days of receipt of this letter. I appreciate your cooperation in this matter.

Sincerely,

Medical Director
Situation 2

Dear :

Health Plan maintains an ongoing quality improvement program and reviews services provided to our members using clinical indicators. The hospital admission for MEMBER NAME was identified for review, as during his/her hospitalization MEMBER NAME (DESCRIPTION OF OCCURRENCE.)

So that we may better understand the issues involved, please forward your comments on this incident, and any additional information you can provide regarding this case. Information helpful to our review of this incident would include your investigation of how this incident occurred as well as any corrective action taken.

It will facilitate our review if you could respond within 14 days from receipt of this letter. I appreciate your cooperation in this matter.

Sincerely,

Medical Director
Situation 3

Dear:

As you are aware, Health Plan received a complaint from MEMBER NAME regarding health care services you provided. Based upon our review of your response and the PATIENT'S medical records, no quality of care issue was identified, therefore, no further action is required by you at this time.

Health Plan takes complaints involving quality of care issues seriously. If any further issues are brought to our attention, you will be notified.

Thank you again for your cooperation in this matter.

Sincerely,

Medical Director
Situation 4

Dear Dr:

As you are aware, Health Plan received a complaint from MEMBER NAME regarding health care services you provided. Based upon our review of your response and PATIENT’S medical records, this issue is being referred to the Quality Improvement /Utilization Management Committee. You will be notified of the results of the committee’s review.

Thank you again for your cooperation in this matter.

Sincerely,

Medical Director

refer.ltr