ITASCA MEDICAL CARE (IMCare)
POLICY AND PROCEDURE

Title: MHCP-MC Grievances	**Index:** Grievances and Appeals
NCQA Standard #: RR 2: Policies for Complaints and Appeals	
Statute/CFR#: Minnesota Statute, Sections § 62Q.69, 62D.08, subpart 3(f), and 62D.115; Minnesota Rules § 4685.1900; 42 CFR 438, Subpart F (§§ 438.400 - 438.424)	
Effective Date: 07/01/85	**Policy Number:** 2.05.14
Written by: QI/UM Staff	**Reviewed/Revised Date:** 05/02/2018
Attachments:	

DEFINITIONS:

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

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

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

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

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

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

Health Plan Administration:

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

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

Technical Competence/Appropriateness:

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

POLICY:
Itasca Medical Care (IMCare) must have written policies and procedures for thorough, appropriate and timely resolution of enrollee grievances; and have a thorough and consistent process for addressing enrollee grievances.

IMCare's policies and procedures for registering and responding to oral and written grievances must include:

- Documentation of the substance of grievances and actions taken.
- Investigation of the substance of grievances, including any aspect of clinical involved.
- Notification to enrollees of the disposition of grievances and the right to appeal, as appropriate.
- Standards for timeliness, including standards for clinically urgent situations.
- Provisions of language services for the grievance process.

IMCare views enrollee grievances seriously and has written procedures in place for a thorough and consistent investigation and response to grievances, including grievances filed with participating providers. IMCare is committed to assuring that IMCare enrollees are satisfied with the service delivery or quality of care they receive. IMCare has an established grievance process to address enrollee's concerns or dissatisfaction about services provided, provider of care, or any other aspect. IMCare will handle all grievances in a respectful manner and will maintain the confidentiality of its enrollees at all times throughout and after the grievance process is completed. All information related to enrollee's grievances will be held in strict confidence and will not be disclosed to program staff or contracted providers, except where appropriate to process the grievance. Information pertaining to grievances will only be released to authorized individuals. It is the responsibility of the IMCare Compliance Coordinator to ensure that confidentiality is maintained, documentation is complete and accurate, and the grievance process is implemented and completed according to policies and procedures.

IMCare contracted providers are accountable for all grievance procedures established by IMCare. Contracted Providers must report grievances that are received at their facilities on a

quarterly basis. IMCare will monitor contracted providers for compliance with this requirement on an annual basis or as needed.

IMCare's Grievance System is subject to approval of the State.

- Any proposed changes to the Grievance System must be approved by the STATE prior to implementation.
- IMCare will send written notice to enrollees of significant changes to the Grievance System at least 30 days prior to implementation.
- IMCare will provide information specified in 42 CFR 438.10(g)(1) about the Grievance System to providers and subcontractors at the time they enter into a contract.
- Within 60 days after the execution of a contract with a provider (e.g. hospitals, individual providers, and clinics), IMCare must inform the Provider of the programs under contracts, and specifically provide an explanation of the Notice of Rights and Responsibilities, and Grievance, Appeal and State Appeal (aka State Fair Hearing) rights of Enrollees and Providers.

Grievances may be filed with IMCare by telephone, fax, mail, or in person. IMCare provides language services to those enrollees in need by:

- Offering oral interpretation of a document into an enrollee's preferred language.
- Notifying enrollees that documents are available in languages other than English.
- Offering language line interpretation services for registering oral appeals.

Time Frame for Resolution of a Grievance/Time Frame for Extension of Grievance Resolution

Type of Grievance	**Time frame, no extension**	**Time Frame, with extension**
Expedited		
Oral and Written	Within 72 hours, verbally and in writing	NA
Standard		
Oral Request**	Acknowledgement and Resolution within 10 days*	14 days* with extension letter***
Written Request**	Acknowledgement within 10 days*, Resolved within 30 days*	14 days* with extension letter
*calendar days		

**Oral Grievances may be resolved through oral communication, but IMCare must send the Enrollee a written decision for written grievances.

***An extension of timeframes of resolution of grievances of 14 days is available for standard (not expedited) grievances if the enrollee or provider acting on behalf of the enrollee requests the extension or IMCare justifies both the need for more information and that an extension is in the enrollee's interest. IMCare will provide written notice to the enrollee or the provider acting on

behalf of the enrollee, using the 14-day extension letter, of the reason for the decision to extend the timeframe if IMCare determines that an extension is necessary. The enrollee must be informed of their right to an expedited grievance if they do not agree with the extension of the time frame. IMCare must issue a determination no later than the date the extension expires. The STATE may review IMCare's justification upon request.

Handling of Grievances

- IMCare must mail a written acknowledgement to the enrollee or provider acting on behalf of the enrollee, within ten days of receiving a written grievance, and may combine it with IMCare's notice of resolution if a decision is made within the ten days.
- IMCare must maintain a log of all Grievances, oral and written.
- IMCare must not require submission of a written grievance as a condition of IMCare taking action on the grievance.
- IMCare must give enrollees any reasonable assistance in completing forms and taking other procedural steps; including but not limited to, providing interpreter services and toll-free numbers that have adequate TTY number.
- The individual making a decision on a grievance shall not have been involved in any previous level of review or decision-making.
- If IMCare is deciding a grievance regarding the denial of an expedited resolution of an appeal or one that involves clinical issues, the individual making the decision must be a Health Care Professional with appropriate clinical expertise in treating the enrollee's condition or disease. IMCare shall make a determination in accordance with the timeframe for an expedited appeal.

Complaint Outcomes and Definitions

Complaint Outcome	Definition
Referred to Quality Review	To Quality of Care for Investigation
Complaint Acknowledgement	IMCare is unable to prove or disprove that allegations/incident occurred
Complaint Acknowledged/Action Taken	IMCare is able to prove allegations/incident is substantiated
Complaint Acknowledged/No action taken	IMCare is able to prove allegations/incident is not substantiated/did not occur
Withdrawn	Complaint is withdrawn

Notice of Disposition of a Grievance

- Oral grievances may be resolved through oral communication. If the disposition, as determined by the enrollee, is partially or wholly adverse to the enrollee, or the oral grievance is not resolved to the satisfaction of the enrollee, IMCare must inform the enrollee that the grievance may be submitted in writing. IMCare must also offer to provide the enrollee with any assistance needed to submit a written grievance, including an offer to complete the grievance form, and promptly mail the completed form to the enrollee for his/her signature. Oral resolution must include the results of IMCare's investigations and actions related to the grievance, and IMCare must inform the enrollee

of options for further assistance through the Managed Care Ombudsman (1-800-657-3729) and/or review by the Minnesota Department of Health (1-800-657-3916).
- When a grievance is filed in writing, IMCare must notify the enrollee in writing of its disposition. The written notice must include the results of IMCare's investigation, IMCare's actions relevant to the grievance, and options for further review by the Managed Care Ombudsman (1-800-657-3729), and the Minnesota Department of Health (1-800-657-3916).

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

IMCare tracks Grievances and monitors trends in order to initiate corrective action as necessary. Grievance data is reported to and evaluated by the Provider Advisory Subcommittee, and the Quality Improvement/Utilization Review Committee. IMCare's Grievance procedures are designed to be in compliance with Federal Regulations, Minnesota Statutes and Rules, and Minnesota Department of Human Services contract requirements.

PROCEDURE:

1. The enrollee, authorized representative (or the provider acting on behalf of the enrollee with the enrollee's written consent) may initiate a grievance by:
   a. Contacting IMCare's Compliance Coordinator via telephone, in person, by fax, in writing, etc.
      ◆ NOTE: a grievance must be initiated on a matter involving a enrollee's dissatisfaction with the health care received, or about any matter other than an action, as action is defined in 438.400(b)(1).
   b. Describing the nature of the grievance to IMCare.

2. IMCare Compliance Coordinator will:
   a. Determine if the grievance is expedited or standard, and indicates this on CaseTrakker.
      i. An expedited review is indicated either by request or by the nature of the grievance. If an expedited review is requested or indicated, immediately forward to the QI/UM nurse or other health care professionals with appropriate clinical expertise in treating the enrollee's condition or disease. See P&P 2.05.05 for Quality of Care;
      ii. If the grievance is regarding the denial of an expedited resolution of an appeal, or the extension of resolution time frames, the IMCare Compliance Coordinator will process as an expedited review.
   b. Determine if the grievance is oral or written, documents this on CaseTrakker, and follows the appropriate time frame.
   c. Record the grievance information in CaseTrakker on the day it is received. Complete details and investigation of the grievance must be documented.
   d. Determine if:

i. The grievance is a quality of care concern or other issue. If quality of care issue, continues to resolve any underlying issues (i.e. second opinion, provider change, alternate services), and immediately forward the quality of care portion to, IMCare Associate Director, IMCare Medical Director, or other health professional with appropriate clinical expertise in treating the enrollee's condition or disease, and who was not involved in any previous level of review or decision –making with the issue;
ii. Update the grievance event on CaseTrakker as referred to quality, to create a task and Quality of Care Grievance in CaseTrakker for the quality reviewer, and follows the policy outlined in 2.05.05.

e. Within 72 hours of receipt of an expedited grievance, informs the enrollee (or representative) verbally of the findings and determination regarding the grievance, and follows up with written notice generating the Resolved – Grievance letter on CaseTrakker. Includes a descriptive explanation of the grievance issue, the investigation, and the resolution. Includes enrollee rights, language block, and compliant block in the mailing.
f. If resolves an oral grievance to the enrollee's satisfaction, the issue is considered resolved and the investigation and resolution is documented on CaseTrakker.
    i. Generate the Acknowledged and Resolved- Grievance letter to the enrollee on CaseTrakker within ten days. Includes a descriptive explanation of the grievance issue, the investigation, and the resolution;
    ii. Include enrollee rights, language block, and compliant block in the mailing.
g. If the staff enrollee cannot resolve an oral grievance (not reduced to writing) to the enrollees satisfaction, inform the enrollee that the grievance may be submitted in writing, explains the enrollee's rights, offers information for a written grievance, and offers assistance with completing the written grievance. **Note: The enrollee does not have to submit the grievance in writing as a condition of IMCare taking action.**
h. If the grievance is in writing, acknowledge the grievance within ten days, and resolves the grievance within 30 days. Documents the investigation and resolution on CaseTrakker.
    i. If the written grievance can be resolved to the enrollee's satisfaction within ten days, generate the Acknowledged and Resolved – Grievance letter on CaseTrakker. Include a descriptive explanation of the grievance issue, the investigation, and the resolution. Includes Enrollee Rights and Language Block and Compliant Block with mailing.
    ii. If the written grievance cannot be resolved in ten days, generates the Acknowledgment Letter - Grievance on CaseTrakker. Include a descriptive explanation of the grievance issue and notes an investigation will follow. Includes enrollee rights, language block, and compliant block in mailing. Resolve the grievance within 30 days, and follow up with Resolution Letter – Grievance on CaseTrakker. Include a descriptive explanation of the grievance issue, the investigation, and the resolution. Include enrollee rights, language block, and compliant block in mailing.
i. Generate the 14-day extension letter on CaseTrakker if the grievance cannot be resolved in the time frame, and if the enrollee (or representative) requested the extension, or an extension is in the best interest of the enrollee. Include in the letter that the enrollee may

file an expedited grievance if they do not agree with the extension of the time frame. Resolves the grievance within 14 days, and follow up with Resolution Letter – Grievance on CaseTrakker. Include a descriptive explanation of the grievance issue, the investigation, and the resolution. Include enrollee rights, language block, and compliant block in mailing.

j. Maintain a file on each grievance.
k. Generate the Oral and Written Grievance Reports on CaseTrakker, and submits them to DHS quarterly. The process for quarterly reporting is in the Business Office Manual.
l. Maintain copies of any additional documentation and CaseTrakker entry for additional reporting to the Provider Advisory Committee and External QI/UR. Prepare grievance files for MDH and other external audits. Grievance data is also reported periodically to the Itasca County Board of Commissioners and the Compliance Committee, and is aggregated for the annual Program Evaluation.
m. Prepare and submit the annual Complaint Reporting template for reporting of complaints to MDH by April 1st of each year for the period ending December 31st of the previous year.
n. Monitor the grievance activity to determine if there are constant variables that require additional training and/or education of staff or contracted and/or delegated providers.