

**Affiliated Doctors of Orange County, A Medical Group, Inc.**

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<b>Last Date Approved:</b>	<b>2/23/10</b>	<b>Internal:</b>	<input checked="" type="checkbox"/>
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**SUBJECT:** **Grievance Resolution Procedure**

**SCOPE:** All **ADOC**, A Medical Group, Inc. ("Affiliated Doctors of Orange County") Contracted Providers. All **ADOC** Employees.

**PURPOSE:** To provide a coordinated process for the timely and effective resolution of complaints or grievances submitted by Health Care Service Plan ("HCSP" a.k.a. "HMO") Enrollees.

To provide a standardized system for the tracking, trending, and identification of issues presenting opportunities for improvement in care and service and/or modification of the grievance process.

**POLICY:** The grievance process will be managed by the Quality Management ("QM") Department under the oversight of the **ADOC** Director/Manager, Quality Management (QM) /Credentialing and the Quality Improvement Committee (QIC). The QM staff will act as the enrollee advocate during the entire investigation and resolution process as well as assist enrollees in filing grievances. The Customer Service staff will handle inquiries and complaints, which are not grievances. If an enrollee expresses a desire to file a formal grievance, the **ADOC** Customer Service staff will direct the enrollee to the appropriate health plan member services department.

The **ADOC** Case Manager, QM/Credentialing, will have ultimate responsibility for maintaining and updating grievance policies and procedures; review and evaluation of the operations and results of the grievance process; review and assessment of trended data for identification and implementation of care, service, and/or process improvements; and for the utilization of any emergent patterns of grievances in the formulation of policy and procedure changes.

The Director/Manager will report any grievance policy changes to the **ADOC** QIC for review and approval as applicable.

The QM department will prepare a quarterly summary of grievance activity. This summary will be included in the Quarterly QM Report submitted to the QIC, HP, and/or Board of Directors.

**ADOC** will not discriminate against any enrollee solely on the grounds that the enrollee filed a complaint or grievance.

All grievance files will be maintained in a secure location for at least six (6) years.

## DEFINITIONS:

**Complaint or Inquiry** - An enrollee's written or verbal request for information, assistance, or concern with an issue (e.g., benefit question, service billing issues) that does not fall into the appeal or grievance category. A complaint can become a grievance.

**Grievance** – a written or verbal expression of an enrollee's dissatisfaction with the care or services provided. A grievance may also be a request to address an unresolved complaint/issue or a complaint that has not been resolved to the enrollee's satisfaction.

**Urgent/emergent grievances** - the case involves an enrollee where there is an imminent and serious threat to the health of the enrollee, including, but not limited to, potential loss of life, limb, or major bodily function.

**Health Care Service Plans ("HCSP", "Healthplan")** - licensed HMO or Payor that contracts with **ADOC** to provide certain health care services to its enrollees. **ADOC** recognizes that HCSP's retain the right to make final decisions on all recommendations pertaining to HCSP enrollees.

## PROCEDURE:

Enrollee (or designee), providers, HCSP staff, regulatory and/or peer review agencies, or **ADOC** employees submit verbal or written grievances to the QM department.

Since all contracted Health plans do not delegate first level grievance resolution to **ADOC**, if an Enrollee grievance is received at **ADOC**; it will be faxed to the appropriate HCSP grievance department. The Health plan's Grievance Department obtains all required medical records and responses directly from the provider(s). The Health plan will notify the providers of their review determinations directly and/or will coordinate with the QM Specialist at **ADOC** in notifying the provider.

In order to facilitate and/or assist the Health plan in obtaining Enrollee medical records from the contracted provider(s), the QM Department requests that:

- The Health plan forwards a copy of the Enrollee grievance to the **ADOC's** QM Department.
- The Health plan forward copies of the letter sent to the provider(s) requesting the medical record and/or response.

Upon receipt, all Health plan grievances and determinations will be reviewed by the QM Specialist and entered in the QI Grievance database. Grievance forms and a description of the grievance procedure shall be readily available at each facility of the plan, on the plan's website, and from each contracting provider's office or facility. Grievance forms shall be provided promptly upon request

Grievance forms must be made available in the provider offices if a member requests one. For Pacificare member's, Spanish and Chinese forms are also available on the PacifiCare Member and Provider portals.

Grievance forms can be obtained in the following ways:

- \* Log onto the PacifiCare Member Portal at:  
www.pacificare.com
- \* Log onto the PacifiCare Provider Portal at:  
www.pacificare.com
- \* Call PacifiCare Customer Care at 1-800--624-8822
- \* Call your UnitedHealthcare Provider Advocate

### **A. Customer Service Determinations**

1. If the grievance is identified as a Customer Service Issue related to Service, Provider Communication, Access and no quality of care issues are identified, the QM Specialist will enter the review determination in the QM Data Base, trending the Provider (Attachment A).
2. The QM Specialist completes the Provider Network Management Service/Access Form (Attachment B) and with a copy of the grievance forwards the information to the Network Management Supervisor. Upon receipt of the form, Network Management will send a Notification Letter (Attachment C) with a copy of the grievance to the named Provider(s). A copy of the letter and grievance will be kept in the Provider's Network Management file so the identified issues can be addressed with the Provider and staff during the Network Management Department's provider office visits.
3. A grievance report for all providers will be presented to **ADOC** Quality Review Committee on a quarterly basis to identify provider/IPA trends and required corrective action plans.
4. If a Customer Service Issue with an immediate or potential quality of care issue is identified by the QM Specialist, and has not yet been reviewed by the Health plan, the QM Specialist will assist in resolution of the issue and coordinate review activities with the Health plan (obtaining responses, medical records as appropriate). The case will then be presented to Quality Review Committee for review and the QM Specialist will notify the provider(s) of the review determination. The QM Specialist will enter the Quality Review Committee review determination in the QM Data Base as indicated in Attachment A and D.

### **B. Quality of Care Determinations:**

1. If the grievance is identified as a quality of care issue and the Health plan determines there are no quality of care (QOC) issue(s) identified, the QM Specialist will enter the review determination in the QI Data Base, trending the Provider as indicated in Attachment A. The Health plan will notify the Provider of their review determination.

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The **ADOC** QM Specialist will forward a copy of the Health plan's review findings to the provider(s) if the Health plan's correspondence is addressed to **ADOC**.

2. If the Health plan identifies a quality of care issue, the case will be presented to the Quality Review Committee for review of the issue and Health plan findings. The Quality Review Committee determinations will be reported to the Health plans, if there is a discrepancy in the determinations. The QM Specialist will notify the provider(s) in writing of the Quality Review Committee review determination and of any corrective action plans, as appropriate. The QM Specialist will then enter the Quality Review Committee review determination(s) in the QM Data Base (Attachment A).
  3. A grievance report for all providers will be presented to **ADOC's** Quality Review Committee on at least quarterly or every 6 months to identify provider/IPA trends and required corrective actions plans.
  4. PMG/IPA employees will be given copy of this policy and procedure on an annual basis for education on the grievance process.
  5. Provider relations will send policy to all providers via fax.
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**ATTACHMENT A: AFFILIATED DOCTORS OF ORANGE COUNTY QUALITY INDICATORS**

*Quality of Care Levels*

Indicator code \_\_\_\_\_ POD \_\_\_\_\_ **MEMBER NAME** \_\_\_\_\_

<i>Outcome</i>					
0 NO ADVERSE	I MINOR ADVERSE	II MODERATE ADVERSE	III SERIOUS ADVERSE	IV DEATH	
<i>QUALITY OF CARE</i>					
<b>LEVEL A:</b> ACCEPTABLE QUALITY	<b>LEVEL B:</b> BORDERLINE	<b>LEVEL C:</b> MODERATE QUALITY ISSUE IDENTIFIED		<b>LEVEL D:</b> SERIOUS QUALITY ISSUE IDENTIFIED	
<i>Provider Trending Codes</i>					
	PHYSICIAN "D"	MEMBER "M"	HOSPITAL "H"	ANCILLARY "A"	IPA "I"
1.1 DOCUMENTATION					
1.2 COMMUNICATION					
1.3 ACCESS					
1.4 SERVICE					
1.5 DISENROLLMENT					
1.6 CHANGE PCP					
1.7 NONCOMPLIANT					
1.8 PATIENT COUNSELING					
2.1 SURG COMPLICATION					
2.2 POST-SURG OMPPLICATION					
2.3 MEDICAL COMPLICATION					
2.4 DELAY IN DX, TX					
2.5 DEATH OF PATIENT					
2.6 HOSPITAL RE-ADMIT					
3.1 ADMIN ISSUE					
3.2 SYSTEMS					
4.0 MED MISMGMT					
4.1 MED MGMT APPR.					

<i>Risk Management Codes</i>					
5.1 MED INCIDENT					
5.2 FALL/INJURY					
5.3 CONSENT					

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Quality of Care Levels**

Potential quality of care concerns identified via the QM process will be categorized for assessment, intervention, and resolution as follows:

**Patient Outcomes:**

- O** No Adverse
- I** Minor Adverse
- II** Moderate Adverse
- III** Serious Adverse
- IV** Death

**Severity Levels:**

- A** Acceptable quality. Meets professionally recognized standards of practice.
- B** Borderline quality of care issue identified
- C** Moderate quality of care issue identified that involved a deviation from professionally recognized standards of practice.
- D** Serious quality of care issue identified that involved a significant deviation from professionally recognized standards of practice. Immediate intervention is required.

**ATTACHMENT B**

CUSTOMER SERVICE/ACCESS ISSUE

**TO:** \_\_\_\_\_  
**DIRECTOR, PROVIDER NETWORK MANAGEMENT**

**FROM:** \_\_\_\_\_  
QUALITY MANAGEMENT SPECIALIST/EXT.

**DATE:** \_\_\_\_\_

**RE:**       **MEMBER:**       \_\_\_\_\_

**HEALTHPLAN:** \_\_\_\_\_

**ID #:**            \_\_\_\_\_

**PROVIDER (S):**   \_\_\_\_\_

**OR SYSTEMS**

**REASON (S):**   \_\_\_\_\_

**CUSTOMER SERVICE ISSUE**

The Quality Management Department will be trending the named provider(s) for the reason(s) listed above. We have attached a copy of the Member grievance received from the Health plan addressing customer relation's issues regarding service and/or communication. Please notify the Provider of the concern and place a copy of the complaint in the named provider's file. We ask your support in addressing these types of customer service issues with the Provider in your future meetings with their office.  
Thank you for your assistance in this matter.

**ACCESS ISSUE**

The Quality Management Department has received the attached Member grievance from the Health plan, which identifies a Provider access issue. Please inform our department of how Provider Network Management is addressing this concern, e.g., addition of new providers in that specialty, etc so we can respond to the Health plan, as needed.  
We appreciate your support and assistance in this matter.

**ATTACHMENT C**

DATE

PROVIDER  
ADDRESS  
ADDRESS

RE: PATIENT NAME

ID: ID#

Dear PROVIDER

Affiliated Doctors of Orange County Quality Management Department has received the attached complaint submitted to the Health plan by the above referenced Member. The Member's complaint describes certain interactions with you and/or your staff that were perceived by the Member as poor customer service. The description of the incident is based solely on the Member's perception and is not, at this time, a reflection of Affiliated Doctors of Orange County or the Health plan's view of this matter. We believe that it is helpful to inform our providers of the patient's perception concerning customer service issues because a positive patient-physician relationship is essential to quality healthcare.

While we are not requesting any specific response from you at this time, we want you to be aware that the Quality Management Department trends all complaints in order to identify whether specific patterns may be developing that would require further investigation.

**As a reminder, this letter is confidential and is non-discoverable pursuant to California, Evidence Code Section 1157, as long as it remains in the Quality Management process. Therefore, DO NOT FILE any correspondence concerning this matter, such as this letter, in the patient's medical record.**

If you feel you or your staff might benefit from a customer focus class, please take advantage of the "Art of Caring" class sponsored by Affiliated Doctors of Orange County. To inquire about attending an Art of Caring class, please contact our department at ext. XXXX.

We value the care that you provide our members and trust that you will find this information helpful in maintaining superior relationships with them.

Sincerely,

[Name]  
Director,  
Provider Network Management  
Attachment