

Enrollee and Provider Complaint/Appeal Reports

Instructions:

1. The following Monthly Summary Reports MUST be submitted:

- Enrollee Complaint Report; and
- Provider Complaint/Appeal Report

2. The reports stated above must contain the following elements, and be in the format below:

Month: _____

CA#	Complaint Code	Contact Type	Complainant Source	Complainant Agency	Members ID	Medicaid/ Indigent Enrollee?	Complaint Information	Complaint Status
assigned Case number	Use the appropriate code(s) listed in 'Complaint Codes' (see the State Code list below)	How complaint was received	Use the appropriate Code listed in 'Complainant Codes' (see below)	The Agency the complaint is referring	Enrollee – enter NS ID Provider – Enter your name.	Enter for Complainant	All pertinent information concerning complaint	current status

Date of Contact	Date Acknowledged	Date Closed	Total # of days till Closed	Disposition	Resolution	Resolution Statement	County	Nature of Complaint	Comments
Date complaint is received	Date Complaint is acknowledged	Date complaint is closed	Total days complaint was open	Result of Complaint	Action taken to resolve the complaint	VO response on the approval of Resolution	County Complaint occurred	Type of Complaint	Add comments, as applicable

COMPLAINANT CODES:

<u>(B) BHO</u>	<u>(H) Hospital</u>	<u>(O) Other</u>
<u>(CDI) CD Inpatient</u>	<u>(LIP) Lic. Ind. Practioner</u>	<u>(P) Provider</u>
<u>(CDO) CD Outpatient</u>	<u>(MHI) MH Inpatient</u>	<u>(V) ValueOptions</u>
<u>(E) Enrollee</u>	<u>(MHO) MH Outpatient</u>	<u>(W) Witness</u>
<u>(F) Family</u>	<u>(N) NTBHA</u>	
<u>(Fr) Friend</u>	<u>(OAG) Other Adv Group</u>	

3. Recording Multiple Complaints:

- A. An Enrollee complaint regarding multiple issues (e.g., quality of care, access to treatment, and balance billing), should be recorded as separate complaints for each issue on the narrative summary report.
- B. Multiple complaints received from the same Enrollee regarding the same issue (e.g., provider attitude) by the same provider should be recorded as one complaint on the narrative summary report.

- C. A provider complaint about multiple unpaid or underpaid claims denied or underpaid by Contractor, and was unpaid or underpaid for the same denial code (e.g. timely submission), should be recorded as multiple complaint complaints on the narrative summary report.
- D. A provider complaint about multiple unpaid or underpaid claims, some of which were denied for multiple reasons (e.g. non-authorization, some for incompleteness, and some for incorrect information) should be recorded as separate complaints on the narrative summary report.

Complaint Codes:

Code	Code Description
(QC) Quality of Care or Service	
QC0 Other	Any quality of care complaint that can't be categorized with another code
QC4 Diagnosis	Complaint addressing a potential inaccurate, partial, missed or untimely diagnosis given by provider
QC5a Treatment inappropriate, ineffective (provider)	Complaint is regarding the level of appropriateness of treatment administered. This could involve such instances where provider treatment, including lab technician treatment, was proven to be below medial standards, is ineffective because of a misdiagnosis, inappropriate administration of the treatment, or inappropriate methodology. (focus on treatment)
QC5a2 Treatment inappropriate, Ineffective (Lab)	Complaint addressing quality of lab reports/results, timeliness, communication of critical labs, and accurate labs
QC5b Not enough time with provider	Provider does not spend adequate time with Enrollee
QC5c Provider often no shows	Provider often cancels set appointments

QC5d Provider Doesn't Review Chart or Notes	Provider does not seem to review clinical documentation/appear knowledgeable of Enrollee circumstances prior to appt. or interaction
QC5e Frequency of Service Inadequate	Provider does not see Enrollee at desired frequency per service package or Enrollee desires higher frequency
QC6a Medication error-Wrong Med Prescribed	medication prescribed by provider was incorrect
QC6b Wrong Dosage Prescribed	medication dosage prescribed by provider was not correct
QC6c Won't Prescribe Requested Medication	Enrollee states certain medication is needed, and provider refuses to prescribe requested medication(s)
QC6d Won't Prescribe Non-Formulary or Off Label	Provider will not prescribe medication not on the formulary or that has an off label benefit
QC6f –Won't Prescribe Any Medication	Enrollee states that medication is needed and provider refuses to prescribe any medications
QC7 Quality of provider credentialing	Provider generally seems unqualified for services performed
QC8 Quality of provider facility	Poor condition of facility (dirty, in disrepair, unsanitary, etc.)
QC9 Quality of goods/materials	Non-facility materials/equipment in poor condition (e.g., vehicles)
QC10 Ineffective communication (provider)	Knowledgeable, wrong information or instructions given
QC11 Quality of records/Provider documentation	Provider recordkeeping and documentation is disorganized, inadequate, inaccurate; file keeping system disorganized; discrepancies in clinical information; not meeting document requirements
QC12a Provider professional/unethical behavior	Inappropriate boundaries/relationships with Enrollees or others.
QC12b Alleged HIPAA violation	Alleged HIPAA or privacy violation by provider
QC12c Provider unethical practices	Inappropriate billing, falsifying/duplicating documentation, inappropriate Enrollee/staff ratios, etc.
QC13 Inappropriately terminated from service	Enrollee reports being discharged from services for unjustified reasons

	(all services included)
QC14 ADA Non-compliance	Provider is non-compliant with ADA requirements
QC15p Provider attitude inappropriate	Provider, pharmacy, lab, hospital, SPN, lab technicians rude, obnoxious, inappropriate
QC15cs BHO customer service department attitude inappropriate	BHO customer service staff rude, obnoxious, inappropriate
QC15cm Care Management attitude inappropriate	BHO care management staff rude, obnoxious, inappropriate
QC16 Provider abuse or neglect	Provider abuse, neglect, or exploitation per DFPS definition
QS17 BHO Unresponsiveness or service ineffective	BHO unresponsive, service ineffective, or poor customer service, staff not helpful or knowledgeable, wrong information or instructions given; includes Customer Services Reps & Clinical Care Managers
(AC) Accessibility/Availability	
AC0 Other	Any access related complaint that can't be categorized with another code
AC1 In-Network Provider Access	Can't access in network provider (provider not accepting more patients)
AC2 Provider selection or turnover	Provider left network, citing problems with BHO/managed care
AC4 Out -of-network Provider access	Service is not available in network but cannot see out of network provider
AC7 Continuity of Treatment	No aftercare appt given after discharge from State or community hospital. No step down level of care offered
AC8 Emergency care access	Provider will not provide emergency care (immediate care)
AC9 Delay of referral/authorization	Provider delays/refuses to facilitate transition to another provider
AC10 Delay of Necessary Treatment	Treatment is delayed by provider (ex. Supposed to begin rehab, but there's a delay due to staff problems)
AC11 Benefits access inadequate	Enrollee complains of lack of access to specific service
AC12 Lack of geo-access to treatment	distance too far to get to provider

AC13 Civil Rights non-compliance	A complaint regarding the Civil Rights Act. Such a complaint would include discriminatory denial of services based on race, age, religion, sex, political beliefs, color, or national origin. This complaint can also concern patterns of discriminatory behavior
AC14 BHO After-Hours (24 hr. coverage)	Cannot reach ValueOptions by Telephone after hours
AC15 Urgent care accessibility (MCOT & SPN)	Lack of timely access
AC16a Routine appointment availability (other service)	Can't get an appointment in a timely manner
AC16b Routine appointment availability (MD/Prescriber)	Can't get an appointment in a timely manner
AC17 Telephone access (Provider)	Put on hold excessively or for an extended period of time; dropped calls, constant busy signal, calls not returned.
AC17a Telephone access (BHO)	Put on hold excessively or for an extended period of time; dropped calls, constant busy signal, calls not returned.
AC18 Wait time in provider's office	Wait time in waiting room excessive
(UR) Utilization Review / Mgt	
UR0 Other	Any Utilization Review related complaint that can't be categorized with another code
UR3 Denial/Non pymt-Treatment (non-ER Service)	VO will not authorize routine care
UR3a Denial/Non pymt-Treatment (Denial of Disease Mgt. Service Package)	VO will not authorize requested mental health service package or parts of package
UR5a Denial/Nonpayment-Non-Formulary Medication	VO will not authorize requested medication that was not on NorthSTAR formulary
UR5b Denial/Nonpayment-Wait List	VO will not authorize medication, stating that there is a waiting list

UR5c Denial/Nonpayment-Medicaid Enrollee with Prescription not covered by Vendor Drug	VO will not authorize a medication for a Medicaid Enrollee that is not covered by Vendor Drug (Medicaid)
UR5d Denial/Nonpayment-Administrative Reasons (Pre-Cert Problems, Fax Problems, Dosage Override, NS # not Recognized, etc.	Authorization not given due to Pre-Cert Problems, Fax Problems, Dosage Override, NS # not Recognized, Incorrect diagnosis, etc.
UR6 Hospital Admission/Discharge	A complaint regarding the Enrollee's discharge or admission to an inappropriate facility. Example: Enrollee was discharged from hospital to go home, instead of to a nursing home.
UR7 Continuation of services/Hospital	VO will not authorize continued stay in hospital
UR8 Denial of authorization of care	VO will not authorize care for requested level of service
UR9 Pre-authorization issues	Denied claims due to lack of timely authorization; authorization process is cumbersome; claim not received; claim lost.
(CP) Complaint Procedure	
CP0 Other	Complaint Procedure related complaint that can't be categorized with another code
CP1 BHO complaint procedure	Complaint resolution process is inadequate in its ability to address the grievance, it is unnecessarily lengthy, extremely difficult to follow, or discourages clients from filing complaints.
CP2 BHO appeal process	Complaint regarding a MCO's appeals process; MCO is not following the proper steps in an appeal process.
(PC) BHO Contract w/ Provider	
PC0 Other	Provider contract related complaint that can't be categorized with another code
PC1 BHO pre-conditions for contract	BHO has unreasonable requirements for contracting; BHO's contract with provider has not been followed; credentialing problems preventing

	provider getting into network
PC2 Financial incentives	Physicians' financial incentives are inhibiting the number of referrals provided and the treatment provided to patients. Example: Member feels physician in MCO has financial incentives to keep cost low and it has negatively affected the quality of care, access to care, and so forth received.
PC3 Denial, delay of payment, balance bill	Non-payment of claim for reason not related to authorization (timely, Enrollee ineligible, other health insurance, recoupment, etc.)
PC4 Reimbursements or capitation	Rate paid was incorrect; claims reconciliation
PC5 BHO retaliation	A complaint by the provider of a material loss or harm caused by the MCO, such as payment withholding, threat of, defamation of, or restriction of professional standing or practice, or other MCO measures that cause direct harm to the provider.
PC7 Tort liability shift to provider	A complaint by the provider that the MCO is holding the provider solely liable for a responsibility that is either solely a MCO or a shared MCO/provider responsibility.
PC8 Distribution of enrollees	A complaint regarding the assignment of no more than 1,500 members across all participating managed care plans in the Service Area.
PC9 STP participation	A complaint regarding the MCO not making a good faith effort to seek participation from each significant traditional provider in the Service Area.
PC10 Physician requested disenrollment	A complaint by the Enrollee, regarding the request from their PCP for their disenrollment. A PCP may request that a member be reassigned to a different PCP because of a pattern of member noncompliance with Medical advice or office decorum.
(MC) BHO Contract with State	

MC0 Other	BHO contract related complaint that can't be categorized with another code
MC2 Material change made in contract	MCO's complaints regarding material that was changed in their contract with the State agency without their knowledge.
MC3 BHO to BHO communications	Complaint is regarding the lack of coordination between MCO's. As managed care evolves, more and more MCO's are working together to provide services. They have to communicate effectively to be able to provide the best possible care.
(EC) BHO Obligation to Enrollees	
EC0 Other	Enrollment related complaint that can't be categorized with another code
EC5 Denial/Nonpayment for ER care	Member of provider complaint about denial of emergency room services
EC6 Claims reimbursement/balance billing	Balance billing by provider to Enrollee
EC6a Co-pays	Enrollee complaining that provider is charging them co-pays or other fees
EC8 BHO retaliation	Enrollee complains of denial of benefits, loss of MCO coverage, defamation of character, or MCO disclosure of Enrollee confidential information because of the Enrollee's concern that the MCO is retaliating or harassing the Enrollee
EC9 Confidentiality of medical info	A complaint by the Enrollee that the MCO released unauthorized confidential medical information. The complaint is regarding the unauthorized disclosure of certain confidential medical information such as diagnosis, evaluation, and or treatment.
EC10 Experimental/investigation procedure.	A complaint by the Enrollee that the provider is suspected of or is using experimental or investigatory medical procedures on the patient
EC11 Enrollment, reenrollment, cancellation	Enrollment problems, re-enrollment problems or disenrollment problems

EC12 Incorrect enrollee information	Enrolling provider or hospital submits financial or other documentation, with inaccurate, incomplete, disqualifying, or contradictory information
EC13 Cultural Competency	A complaint regarding the inability of individuals and or systems to provide services effectively to people of all cultures, races, ethnic backgrounds and religions, in a manner that affirms the worth and protects the dignity of individuals, families, and communities.
(MK) Marketing	
MK0 Other	Marketing related complaint that can't be categorized with another code
MK3 Marketing ethics violations	Complaint regarding the MCO's publications and or tactics. MCO may not be following the guidelines set forth by the State agency; therefore, marketing unethically. Example: A MCO signs up an individual to a policy without their knowledge
MK4 Marketing guidelines violations	MCO complains about the State agency's marketing guidelines; MCO may feel that the guidelines are too harsh and or unfair.
(MS) Miscellaneous Complaints	
MSO Other	Miscellaneous complaint that can't be categorized with another code