

TUFTS  Health Plan

## Corporate Member-Generated Grievance Policy



*11/1/09*

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Tufts Health Plan  
 705 Mt. Auburn St  
 Watertown, MA 02472

<b>Document Approval</b>		
<b>Name</b>	<b>Title</b>	<b>Dept</b>
Kimberly Botan	Manager, Provider Quality Improvement	Clinical Quality Improvement
Debra Poskanzer, M.D.	Director of Clinical Quality Improvement and Medical Affairs	Clinical Quality Improvement
Christopher Ware	Manager, Appeals and Grievances	Appeals & Grievances
Stephanie Chrobak	Director, Member and Provider Services	Member Services

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## 1 Policy Owner

The Corporate Member-Generated Grievance Policy impacts multiple departments within Tufts Health Plan. This policy identifies the specific workflow and timelines for the documentation and processing of member grievances (also known as “complaints”). Although the effective implementation of the policy is the result of collaboration among departments, two managers share responsibility for updating relevant aspects of the policy and ensuring accuracy. The ownership is shared as follows:

### Clinical Grievance Process

Manager, Provider Quality Improvement

### Administrative Grievance Process

Manager, Appeals & Grievances Department

## 2 Purpose

This document sets forth the policy and procedures for the acceptance, review and follow-up of member grievances (i.e., complaints), including primary responsibilities across departments and expected processing timeframes.

## 3 Scope

This policy governs verbal and written grievances, both administrative and clinical, for Commercial and Tufts Medicare Preferred (all products). For delegated entities, e.g., CIGNA/CareLink, PHCS, etc., please refer to the individual department’s policy for process details.

### 3.1 In Scope

The policy governs both verbal and written grievances (i.e., complaints) from Tufts Health Plan members, including Tufts Health Plan Medicare Preferred members, or the member’s authorized representative<sup>1</sup> who can act on the member’s behalf for the matter related to the grievance about the care and/or services that the member received.

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<sup>1</sup> “Authorized representative” is herein defined as an insured’s guardian, conservator, holder of a power of attorney, health care agent designated pursuant to M.G.L. c.201, family member, or other person authorized by the insured verbally or in writing or by law with respect to a specific grievance or external review provided that if the insured is unable to designate a representative, where such designation would otherwise be required, a conservator, holder of a power of attorney or family member in that order of priority may be the insured’s representative or appoint another responsible party to serve as the insured’s authorized representative.

**Note:** The Commonwealth of Massachusetts defines a grievance as “any oral or written complaint submitted to the carrier that has been initiated by an insured, or the insured’s authorized representative, concerning any aspect or action of the carrier relative to the insured, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, quality of care and administrative operations, in accordance with the requirements of 105 CMR 128.000 *et seq*”.

The state of Rhode Island defines a grievance as a “complaint.” The Rhode Island definition of “complaint” is “A contact is made by an enrollee or provider to the health plan whereby they are not satisfied with the following as they relate to the certified health plan, a health plan employee or the health care entity who operates the health plan: a) a utilization review decision; b) the quality of health care; c) any activity related to the management of the delivery of health care services.”

## 3.2 Out of Scope

On occasion, members or member representatives voice their complaints about issues that involve coverage for services, practices, or policies beyond the jurisdiction of Tufts Health Plan. The following broad categories of complaints fall outside the scope of the Member-Generated Grievance Policy:

- Complaints about incidents that occurred at a time when the complainant was not a member of Tufts Health Plan.
- Complaints about services received that are not covered services within the member’s benefits (e.g., dental care if the member does not have the relevant dental benefit, complaints about DME suppliers for orthotics if the member’s benefit plan does not cover orthotics, etc.).
- Complaints about a member’s dissatisfaction with requirements dictated by state or federal laws, or issues that fall under the jurisdiction of a regulatory agency/authority outside of the jurisdiction of Tufts Health Plan (e.g., complaint about a physician who will not release medical records without proper authorization from a member or member’s representative, etc.).
- Complaints from practitioners or providers about other practitioners or providers that are not related to a member concern.
- Complaints about organizational determinations or Peer Review Organization complaints.

**Note:** All members who lodge such complaints will be given appeals rights under applicable state and/or federal law.

This policy does not cover requests from members, or member representatives, for the formal review of initial adverse determinations.

## 4 Audience

This policy is written for all Tufts Health Plan employees who have direct or indirect contact with members and/or member representatives. It also applies to vendors and business partners who have direct contact with members or member representatives (e.g., delegated case managers, etc.).

## 5 Related Documentation

The following documents incorporate specific procedures and regulatory requirements affecting the grievance process:

<b>Name of Policy</b>	<b>Specific to...</b>	<b>DMS #</b>
Tufts Health Plan Medicare Preferred Member Support Administrative Grievance Procedure	Detailed explanation of the procedure for accepting and processing administrative grievances (complaints) from Tufts Health Plan Medicare Preferred members	<a href="#">1021468</a>
Tufts Health Plan Medicare Preferred Member Support Standard/Expedited Grievance Procedure	Detailed explanation of the procedure for accepting and processing standard and expedited grievances (complaints) from Tufts Medicare Preferred® members	<a href="#">1021449</a>
Tufts Health Plan Medicare Preferred Member Support Expedited Member Appeals Procedure	Detailed explanation of the procedure for accepting and processing expedited appeals from Tufts Medicare Preferred® members	<a href="#">1021428</a>
Tufts Health Plan Medicare Preferred Member Support Standard Member Appeal Procedure	Detailed explanation of the procedure for accepting and processing standard appeals from Tufts Medicare Preferred® members	<a href="#">1020985</a>
Commercial Appeals and Grievances Administrative Grievance Process	Detailed explanation of the procedure for accepting and processing grievances from commercial members	<a href="#">1025768</a>
Corporate Confidentiality Policy regarding Protected Health Information	Document related to Tufts HP guidelines for interactions with members regarding personal health information uses and disclosures	Tufts Health Plan Intranet, under Corporate Compliance
Clinical Services Record Retention Policy	Detailed explanation of Clinical Services Department policy and procedures regarding record retention and disposal.	CQI's Shared Drive
Member/Provider Appeals and Grievances Member Grievance Audit policy	Policy and procedures for conducting quarterly administrative member grievance audits.	Appeals and Grievances Shared Drive

<b>Regulation and Accreditation</b>	
CMS Requirements 42 CFR 422.564	Specification of CMS requirement that Medicare Advantage provide “meaningful procedures for timely hearing and resolution of grievances”
NCQA Standards for Members’ Rights and Responsibilities Standard RR3 “Policies for Complaints and Appeals	Standard used to specify NCQA requirements

<b>Regulation and Accreditation</b>	
MGL c. 176O, s. 7(b)(4) and s.13 (Health Insurance Consumer Protections) 105 CMR 128.000 (Health Insurance Consumer Protection Regulations)	MA statute and regulation that identifies requirements for grievance process and reporting of data
R23-17-13-CHP, Section 6.9	RI regulation that identifies requirement for grievance process  Applies to RI residents, or to members who obtain services in RI

<b>Adjunct Department-specific documents</b>		
<b>Name of Document</b>	<b>Specific to</b>	<b>Location</b>
CQI Grievance Team Policy & Procedure Manual	Identifies procedures for processing Clinical Grievances, including review and rating guidelines, and data entry requirements.	Clinical Quality Improvement Shared Drive

## 6 Policies

The following policies define the required elements of the grievance process:

### 6.1 Notification of Grievance Rights

The Tufts Health Plan member grievance process is part of the overall member satisfaction services provided by Tufts Health Plan. Members have the right to file a grievance with Tufts Health Plan, either verbally or in writing. When a member or member representative contacts Tufts Health Plan to voice dissatisfaction with the care and/or services received, the member or representative will be advised of the right to file a grievance. If the member or representative requests that a verbal grievance be filed, the Tufts Health Plan representative must document the complaint and forward the issue to the appropriate department.

### 6.2 Documentation

All member grievances must be documented in detail in the electronic call tracking system.

### 6.3 Grievance Review Timeframe

Member grievances are usually processed within 30 calendar days. The process begins on the date (receipt date) that the member's grievance is received by a Tufts Health Plan representative. In the case of grievances filed by a member's authorized representative, the process does not begin until consent to file the grievance is obtained from the member directly, given that the member is not a minor (see 7.3.2 Third Party Workflow for Commercial Grievances). Upon initiation of a grievance, the member is notified in writing that the complaint has been filed and is

being reviewed. Upon completion of the review, the member is sent a “closure letter” indicating that the review has been completed and identifying the actions taken by Tufts Health Plan staff as follow-up on the concern (see Section 6.4 *Grievance Case Closure*). The closure letter is sent to the member on or before the end of the 30-calendar day timeframe.

There are two exceptions to the 30-day turn around time for grievance processing:

### **Expedited Clinical Grievances**

When complaints from a member or member’s representative pertains to clinical issues of such an urgent nature that it is determined that a delay in the review process might **seriously jeopardize** 1) the life and/or health of the member, 2) the member’s ability to regain maximum functioning, or 3) the ongoing immediate treatment of the member, the issue will be deemed an expedited grievance, and will be processed as expeditiously as the member’s clinical condition requires (see 7.4.2 *Expedited Clinical Grievances*).

### **Extension of Review**

On occasion, an issue requires additional time to complete the review. For Commercial administrative grievances, the Appeals and Grievance Analyst will contact the member and seek approval for an extension. The new due date must not be more than 30 calendar days from the original due date. If the member agrees to the extension, the Appeals and Grievance Analyst will document this agreement in the case file. The Appeals and Grievance Analyst will inform the member that the member will be receiving an extension letter. The extension notice will inform the member of the special circumstances requiring the extension and the date on which the determination is expected to be made. For Tufts Health Plan Medicare Preferred administrative grievances and clinical grievances, the member is notified in writing that the review has been extended an additional 14 calendar days. For Commercial clinical grievances, the member is notified in writing that the review has been extended an additional 30 calendar days.

## **6.4 Grievance Case Closure**

Upon completing the review of the member’s grievance, a final closure letter must be sent to the member indicating that the review has been completed, noting any results that can be shared with the member.

Information obtained as part of a peer review privileged process will not be shared with the member.

Members will be notified in writing that if they are dissatisfied with the results of the review, they have the right to a reconsideration of the review of the complaint (see Section 6.5 *Reconsideration Process*). This right will be documented in the closure letter to the member. The exception to this process is members’ grievances that involve a peer-review protected issue. Such grievances will not be offered the reconsideration process.

In addition, members who reside in Rhode Island and members who reside elsewhere, but receive services in Rhode Island, have the additional right to complain to the Rhode Island Department of Health (DOH). This right will be documented in the closure letter to the member.

## 6.5 Reconsideration Process

Commercial and Tufts Health Plan Medicare Preferred members who are dissatisfied with the review findings have the right to request that their grievance be reconsidered. When a member requests a reconsideration of a previously processed grievance, the request must be documented in the electronic call tracking system and a second review will be initiated.

A receipt letter must be sent to the member indicating the initiation of the reconsideration process, and that the grievance reconsideration review will be completed within 30 calendar days. The issue then must be reviewed by a representative/clinician who was not involved in the initial evaluation. Upon completion of the reconsideration review, a closure letter will be sent to the member (see previous Section 6.4 *Grievance Case Closure*).

## 6.6 Withdrawn Grievances

Members have the right to withdraw a grievance at any point in the process. When a member chooses to withdraw a grievance, that decision must be documented in the electronic call tracking system. In addition, if a member advises someone other than the Appeals and Grievance Analyst or the CQI Program Coordinator handling their complaint of their desire to withdraw their grievance, the appropriate analyst or coordinator must be notified immediately. The appropriate database modifications must then be made.

## 6.7 Compliments

As part of the Tufts Health Plan member satisfaction services, compliments from members about the care and/or services that they have received are processed as *compliments*. The procedure for processing compliments is identical to the procedure for processing grievances (i.e., the compliment is documented in the electronic call tracking system and forwarded to the appropriate Appeals and Grievance department for processing). Correspondence is then sent to the member and the provider to acknowledge the compliment.

## 6.8 Quality Assurance Tracking and Trending

All member grievances must be documented in the appropriate call tracking system with key elements entered into the specific databases used by each department responsible for tracking, trending, and reporting.

The CQI department will track the following *clinical grievance* data:

- Overall number of clinical grievances received
- Clinical grievance rates per 1000 members (based on member months)
- Number of clinical grievances within designated categories; specifically, 1) general quality of care issues, 2) access, 3) provider behavior, 4) office staff issues, including attitudes and service delivery, 4) environmental issues, and 5) pharmacy issues
- Case Management and Complex Case Management complaints

- Cultural/Linguistic complaints (including complaints regarding provision of language services race, color, religion, sex, sexual orientation, national origin, age, handicap, veteran status)
- Environmental issues complaints (eg. physical accessibility, physical appearance, adequacy of the waiting and examining room space, etc.)
- Percentages of clinical grievances determined to reflect a quality of care concern
- Turn-around-time for clinical grievance processing
- Compliments

The Appeals and Grievances department will track, at a minimum, the following *administrative grievance* data:

- Claims handling
- Billing and financing
- Pharmacy policies and/or procedures
- Other department policies and/or procedures
- Tufts Health Plan department and/or staff performance concerns

Grievance data and trending analyses, including recommendations where appropriate, are reported as required (refer to the following table).

<b>Report Name</b>	<b>Reporting Cycle</b>	<b>Report Destination</b>
Quarterly Clinical Grievance Report	Quarterly	Customer Satisfaction QI Workgroup
Quarterly Administrative Grievance Reports (Commercial and TMP)	Quarterly	Customer Satisfaction QI Workgroup
Grievance Metrics	Quarterly	Quarterly Performance Improvement Team (QPIT)
Year-end Clinical Grievance Report (embedded in “Access Survey Results” report)	Annually	Quality of Care Committee
Member Complaints Against MA Practitioners	Annual	Board of Registration in Medicine
Health Plan Certification Data Report	Quarterly	Rhode Island Department of Health

## 6.9 Auditing

Member grievance audits will be conducted periodically by the department's manager or his/her designee to determine:

- turnaround time standard attainment
- adherence to closure letter requirements
- appropriate style and tone of letters

Please refer to the individual department's audit policy for process details. Results of the audit will be reported to the Manager, Clinical Quality Improvement, and the Manager, Appeals & Grievances

## 6.10 Record Retention

Records of all member grievances will be maintained in accordance with the appropriate department's Record Retention Policy.

## 7 Procedures

The following sections specify the workflow for processing grievances:

### 7.1 Acceptance and Documentation of a Verbal Grievance

The majority of grievances are received via telephone calls to the Member Services/Customer Relations departments. When members call to voice dissatisfaction with the care and/or services they have received or cannot receive, they may use statements such as:

- "I am unhappy about..."
- "I want to complain about..."
- "I can't reach my doctor's office..."
- "I need to find a new PCP because (quality of care reason specified)..."

#### 7.1.1 Notification of Grievance Rights

When such dissatisfaction is expressed, the Tufts Health Plan representative will inform the member, and/or the member's representative, of the right to file a grievance (i.e., complaint) as part of the member satisfaction services. If the member and/or the member's authorized representative chooses to file a grievance, they should be assured that the concern will be reviewed, and that written notification will be sent regarding the processing of the grievance.

**Note:** The review of member grievances is encompassed within *Healthcare Operations* as that term is defined in the HIPAA Privacy Regulations. Therefore, **members will not be asked to give consent to use their name in follow-up activities**, provided, however, that a member

*requests that his or her name not be shared with the practitioner/provider against whom the grievance is to be filed, Tufts Health Plan will comply with that request.*

### 7.1.2 Documentation of Verbal Grievances

When a member elects to file a grievance, the Member Services/Customer Relations Representative creates a Service Form (SF) to document the issue(s) of concern in the electronic call tracking system.

The following information must be included in the SF created:

- Caller's name.
- Member's name and Tufts Health Plan ID or Tufts Medicare Preferred number.
- A statement that the member<sup>2</sup> or the member's representative was given notification of grievance rights, and that he or she requested that a grievance be filed.
- Specific details regarding the nature of the complaint, including any ongoing, unmet member needs.
- If the information contained in the complaint indicates that the member needs assistance, or if the member directly requests assistance, any actions taken by the Member Services/Customer Relations representative to meet the member's needs must be documented.
- Additional information:

**Complaints about clinical issues** must include documentation of the name and provider number of the practitioner or provider against whom the complaint is lodged.

**Complaints against Tufts Health Plan or Medicare Preferred** must specify the circumstances surrounding the complaint, including any relevant information about the Tufts Health Plan or Medicare Preferred policy/benefit/procedure or employee against whom the member is filing the complaint.

- When the member's call has been completed, the Member Services/Customer Relations Representative sends the SF to the appropriate electronic grievance mailbox<sup>3</sup> for processing by the Appeals & Grievance staff (SF should be sent within 24 hours of receipt of the grievance).

**Note:** If a clinical grievance is identified during a conversation with a Tufts Health Plan Mental Health representative or case manager, a SF will be created and forwarded directly to the "Grp-Member Grievances" mailbox .

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<sup>2</sup> If a Tufts HP employee files a grievance about the care/services that the employee has received, an added level of confidentiality is afforded the employee. In this circumstance, the Member Services/Customer Relations representative will omit the employee's name in the subject line of the SF and insert the label "employee." The employee member's name and ID number should be documented only in the *Remarks* section of the SF.

<sup>3</sup> Grievances filed by commercial members are sent to "Grp-Member Grievance"; grievances filed by MP members are sent to "Grp - SHQA."

## 7.2 Acceptance and Documentation of a Written Grievance

On occasion, members file grievances in writing. The following sections describe the procedure for processing written grievances:

### 7.2.1 Receipt of a Letter of Complaint from a Member

When a Tufts Health Plan employee receives a **letter of complaint** from a member, the following actions are taken:

- Date-stamp the letter with the receipt date.
- Deliver the letter to the appropriate grievance staff (i.e., the Appeals and Grievances department for Commercial and Medicare Preferred member grievances) on the day that it is received (in person or via confidential fax).

**Note:** If the employee cannot personally deliver the complaint letter on the same day that it is received, then the employee should do **both** of the following:

- Fax the letter to the appropriate grievance department.
- Send the original complaint letter to the grievance department via interoffice mail.

### 7.2.2 Receipt of an Email Complaint from a Member

When a Tufts Health Plan employee receives an email complaint from a member, the employee will follow the department-specific workflow to ensure that confidentiality guidelines are met and that the grievance is sent to the appropriate grievance department within 24 hours of the receipt of the email.

## 7.3 Initial Procedure for Processing Grievances: Responsibilities of the Appeals and Grievance Analyst (Analyst)/CQI Program Coordinator (Coordinator)

The following sections specify the roles and responsibilities of the Appeals and Grievance Analyst/CQI Program Coordinator:

### 7.3.1 Creating a Service Form (SF)

The Analyst/Coordinator reviews the SF and/or written complaint and then creates an electronic service form (SF) to serve as the inter-department communication tool for the review process (see specific department workflow guidelines/policy procedure manuals for instructions regarding the creation of a SF). The SF will contain adequate documentation regarding the substance of the grievance. If the Analyst/Coordinator determines that additional information is needed, the member will be contacted and asked to provide the necessary information. The Analyst/Coordinator will ensure that any actions taken by Tufts Health Plan or the practitioners, as appropriate to the grievance, will be documented in the SF.

**Grievances filed by Tufts HP employees** - These types of grievances will be afforded a higher level of confidentiality via designated reviewers within each department. In such cases, the SF subject line is designated as "employee."

If the grievance includes a complaint letter from a member, the letter is winscanned into the electronic call tracking system and attached to the SF.

**Note:** Access to the SF is limited to those employees who are involved in the review of the complaint in order to maintain member confidentiality.

### **7.3.2 Third Party Workflow for Grievances**

If a grievance for a Tufts Health Plan or Medicare Preferred member is filed by a member's representative, the grievance analyst will attempt to contact the member verbally to obtain their consent to file the grievance. If consent is obtained a receipt letter will be sent to the member. If consent is not obtained a letter will be sent to the member notifying him/her that a grievance was filed on their behalf, but could not be followed-up on due to lack of consent from the member. The SF is then closed.

### **7.3.3 Identifying and Documenting the Grievance Category**

Grievances are assigned to one of the following categories and processed per specific guidelines for each category:

#### **Administrative Grievances**

Grievances related to billing/claims issues or a member's dissatisfaction with Tufts Health Plan staff, policies, processes, or procedures that have no impact on the member's medical care or access to medical care will be processed and tracked as *Administrative Grievances*.

Examples of administrative grievances include, but are not limited to the following:

- Complaints related to billing practices by practitioners or providers that do not affect the member's ability to access healthcare services, for example: an office visit co-payment dispute or a complaint against a hospital, as they requesting the inpatient co-payment prior to/at the time of admission
- Complaints related to the administrative practices of a provider, for example: a complaint about the pre-registration questions (requested social security number, next of kin information) the facility asked the member during the admission process or complaints about their parking policy
- Complaints related to administrative practices of the pharmacy mail order provider, such as issues with their website or with their ordering forms.
- Complaint that a Tufts Health Plan employee was rude or had a bad attitude
- Complaint that the member was given inaccurate plan information from a Tufts Health Plan employee
- Complaint about premium billing or any other billing practice by Tufts Health Plan
- Complaint about any aspect of the member education or marketing materials
- Complaint about the need to have a referral for authorization of services

- Any other verbal or written complaints from members or member representatives against any Tufts Health Plan employee, department, policy, or material that has no impact on the member's medical care and does not require the review of a member's medical record

### **Clinical Grievances** (formerly known as “*non-administrative*” grievances)

Clinical grievances include verbal or written complaints from members or member's representatives, about the healthcare and/or services that a member has received or is trying to receive. Clinical grievances may be lodged against contracted or non-contracted practitioners and providers. Individuals who are no longer members of Tufts Health Plan, but were at the time of the incident, may file grievances. If the incident involved a non-member for whom Tufts Health Plan had a fiduciary responsibility regarding the proffered services (e.g., transplant donors for our members, sperm donors, etc.), then the involved party may file a complaint about the healthcare service that he or she received.

### **Expedited Clinical Grievances** (formerly known as “*expedited non-administrative* grievances”)

Expedited clinical grievances include verbal or written complaints from members or member representatives regarding clinical issues of such an urgent nature that it is deemed that a delay in the review process might *seriously jeopardize* 1) the life and/or health of the member, and/or 2) the member's ability to regain maximum functioning, or 3) is an issue that poses an interruption in the ongoing *immediate* treatment of the member.

Examples of expedited clinical grievances may include, but are not limited to:

- Member is having pain and cannot reach the PCP's office
- Member is currently out of medications due to a delay in delivery of the order from managed mail
- Member is scheduled for upcoming surgery, and the PCP will not release necessary medical records
- Member is unable to reach the practitioner's office to schedule an urgent appointment

**Note:** Unusual or infrequent situations are described within Section 7.6 *Special Circumstances*.

#### **7.3.4 Written Acknowledgment to the Member of the Receipt of a Grievance**

Each member who files a grievance will be sent written notification that the complaint has been received and will be reviewed. The receipt letter must include the following information:

- **Verbal administrative grievances** –within 48 hours of receipt, the grievance analyst will reduce the verbal grievance to writing to verify the analyst's understanding of the member's concern.

- **Verbal clinical grievances**-within 5 business days of receipt, the grievance program coordinator will reduce the verbal grievance to writing to verify the program coordinator's understanding of the member's concern.
- **Written administrative and clinical grievances** – within 5 calendar days of receipt, the grievance analyst will send written notice to the member confirming the receipt of the member's letter/email.
- **Verbal /Written grievances from Medicare Preferred Members** - within 5 calendar days of receipt, the grievance analyst will send written notice to the member confirming the receipt of the grievance.
- **Expected review timeline** – the member is notified that the grievance will be reviewed within 30 calendar days for Clinical and Administrative Grievances. If a member representative filed the grievance, the timeline does not begin until the member's consent is obtained (*See 7.3.2, Third Party Workflow for Commercial Grievances*).

**Note:** Since expedited grievances are processed quickly due to the urgent nature of these concerns, a single receipt/closure letter may be sent to a member upon completion of the review.

Upon completion of the receipt letter to the member, the grievance analyst will initiate the review of an administrative or clinical grievance.

## 7.4 Grievance Review Process

All member grievances are reviewed by the designated review teams. The following details the review process:

### 7.4.1 Administrative Grievances

Administrative Grievances are processed within the Appeals & Grievance department (for grievances filed by both Commercial and Medicare Preferred members). The grievance analyst must take any necessary follow-up actions deemed appropriate (to the extent possible) to rectify the situation for the member and prevent possible future occurrences of similar issues. For the process for handling administrative grievances, refer to the *Tufts Health Plan Medicare Preferred® and Commercial Administrative Grievance Policies* included in the section, *Related Documents*.

**Note:** If the member's complaint is related to a standard business policy or process within Tufts Health Plan that is unlikely to change as a result of the grievance, the issue of concern is documented in the appropriate database for future tracking and trending purposes. No specific action may be taken at that time or at any time in the future to change the policy/procedure. The closure letter to the member will include a brief explanation of the purpose of the policy/procedure.

### 7.4.2 Expedited Clinical Grievances

For the definition of "expedited clinical grievances," please refer to 7.3.3.

### 7.4.3 Clinical Grievances Review Process

All Clinical Grievances are sent electronically to the Clinical Quality Improvement (CQI) department for review via the Member Grievances electronic mailbox. The Appeals and Grievances Coordinator monitors the Member Grievances mailbox and distributes the grievances based on the grievance case assignment specific to the team workflow within CQI.

#### Role of the CQI Program Coordinator

The program coordinator assigned to the grievance has the following responsibilities:

- Conducts an initial review of the issue in order to determine whether or not the information is complete enough to conduct the review, and whether or not the issue of concern presents the need for an immediate review by a clinician.
- If the coordinator determines that a clinical reviewer should be consulted, the coordinator will follow up with the clinician. Advice from the clinician will be documented in the SF, and any necessary action directed by the clinician will be followed.
- Otherwise, upon receiving the grievance, the CQI program coordinator enters the grievance data into the secured quality assurance (QA) databases.
- Collects all grievance-related documentation (e.g., SFs, additional correspondence, etc.).
- Winscans all relevant correspondence into the electronic call tracking system.
- Categorizes the grievance using the CQI Grievance Screens (general categories include: Provider Behavior, Quality Issue, Access Issues, Office Staff Issues, Pharmacy Issues, Environmental Issues, Other issues). For a detailed listing of grievance categories, see the *CQI Grievance Team Policy & Procedure Manual*.
- Completes a two-year QA database query of the practitioner or provider named in the grievance to assess the number of previous complaints and the presence of issue trends.
- Documents in the SF if the practitioner or provider meets criteria as a ‘Provider of Concern.’ **Note:** This designation is based on specified thresholds within the CQI department guidelines; see the *CQI Grievance Team Policy & Procedure Manual* for details of those guidelines and actions taken when threshold is met.
- Conducts an initial review of “non-flagged” and “flagged” grievances, and determines what follow-up is indicated (consult with the clinical reviewer as needed).
- Conducts follow-up as deemed necessary (e.g., contact practitioner/provider to obtain additional information; forward to another Tufts Health Plan department for review and comments).
- Presents follow-up information for flagged grievances to clinical reviewer for final case rating and closure instructions.
- May assign a final rating to *non-flagged* grievances.
- Sends a response letter to the member and to the provider and closes all necessary QA databases.

## Role of the Clinical Reviewer

At a minimum, all flagged clinical grievances are reviewed by a clinician (i.e., nurse practitioner, RN, and/or a Tufts Health Plan medical director). The specific functions of the clinical reviewer (nurse or MD) are as follows:

- Provides support and consultation to staff in key departments regarding the processing of clinical grievances.
- Reviews each grievance, and determines what actions, if any, are needed for follow-up.
- Reviews the additional information when the follow-up has been completed.
- Rates the grievance for severity of the clinical issue and for preventability.

**Note:** The severity/preventability rating scale can be found in the *CQI Grievance Team Policy & Procedure Manual*.

- Documents the review findings in the actiongram of the SF, including specification of the type of member closure letter to be sent by the CQI Program Coordinator.
- Returns the SF to the CQI Program Coordinator for data entry and closure processing.

## 7.5 Closing the Grievance

When the review of the member's grievance is complete, the CQI Program Coordinator sends a final closure letter to the member. The closure letter includes the following information:

- A statement that the review is complete.
- Results of the review that can be shared.

**Note:** Information that was obtained through the peer review privileged process may not be shared with the member.

- If appropriate, a statement informing the member of the right to a reconsideration of the review of the complaint if he or she is not satisfied with the review process/findings.

**Note:** Letters to members who reside in Rhode Island and members who reside elsewhere, but receive services in Rhode Island must include a statement that these members have the additional right to complain to the Rhode Island Department of Health (DOH).

## 7.6 Special Circumstances

This section covers special or unique circumstances related to member complaints.

### 7.6.1 Identification of an Appeal Issue within a Grievance

When a member's complaint includes a concern indirectly related to an organization determination, appeal or benefit issue that is normally addressed within the appeals process, the primary grievance issue will be processed according to the usual procedure, and the member will be given appeals rights to follow up on the appeal-related concern within the receipt letter or verbally.

Example- Member is dissatisfied with care received during a stay at a skilled nursing facility (i.e., grievance issue). In addition, the member reports a delay in receiving the notice of non-coverage resulting in being billed for two days of the facility stay (appeal issue).

The grievance is processed according to the standard procedure. If the member wishes to file an appeal, the issue will be forwarded to the appropriate appeals analyst (Appeals & Grievances for Commercial members and Medicare Preferred members).

### **7.6.2 Complaint Containing an Administrative and Clinical Grievance**

When a member's complaint concerns an issue related to both an administrative grievance and a clinical grievance, it will be analyzed upon receipt to determine whether or not to process the complaint as two separate issues or to combine the issues. This decision will be made jointly between the CQI program coordinator and the clinical reviewer as needed.

### **7.6.3 Receipt of Additional Information from the Member**

On occasion, a member who has filed a grievance will call the CQI Program Coordinator, whose name is included in the initial receipt letter, to offer additional or clarifying information regarding the circumstances surrounding the grievance issue/event.

The CQI Program Coordinator will determine if the information constitutes additional information about the existing grievance, or if the information represents a completely new issue.

If the CQI Program Coordinator determines that the member is offering a new, unrelated complaint, the member will be asked if he or she wants to file an additional grievance. If the member wants to file an additional grievance, the analyst will process the new grievance in line with the standard procedures. If the member does not want to file a new grievance, the information obtained during the call will be documented in the SF of the current grievance.

Any new information will be communicated to the key review team members as soon as possible.

If a member calls to add information after the grievance review has been completed, the CQI Program Coordinator will review the member's statements in order to ascertain whether or not the information is directly related to the previous grievance, or if it represents a new grievance.

If the information is considered by the member to be an adjunct to the previous grievance, but no additional action is being requested, the reviewer(s) of the previous grievance will be notified of the additional information documented in the original grievance SF.

If the information provided by the member is related to the previous grievance and additional action is being requested by the member, the CQI Program Coordinator will re-open the grievance. Upon completion of the re-opened grievance, if necessary, the rating will be changed and the CQI Program Coordinator will send another response letter to the member in regards to the additional information.

#### **7.6.4 When a Member Calls to Complain, But Declines to File a Grievance**

##### **Complaint issue that does not pose an ongoing concern**

If the member, or member's authorized representative, chooses not to file a grievance, and it is unlikely that the issue of concern will affect the member's health or continuing access to healthcare services, the concern will not be filed as a grievance.

The decision of the member or authorized representative not to file a grievance will be documented in the electronic call tracking system.

##### **Occurrence**

If the member, or member's authorized representative, chooses not to file a grievance, but the complaint appears to be serious enough to warrant a review by a clinical reviewer the CQI Program Coordinator will consult with the Clinical Reviewer to determine whether or not an "Occurrence" (the investigation of a quality issue that does not involve the member) will be filed.

In this case, no correspondence will be sent to the member, but the issue will be reviewed to the extent deemed necessary.

#### **7.6.5 Risk Management Related Issue**

If the issue presented by the member or authorized representative meets one of the following Member Risk Management criteria, the CQI Program Coordinator/Member Services/Customer Relations representative will notify his or her operational risk management contact person. The following issues are included within this category:

- Threatened or actual litigation involving Tufts Health Plan
- Threatened or actual public exposure adverse to Tufts Health Plan
- Threatened or actual Division of Insurance or other regulatory agency involvement
- Fraud, suspected or actual
- Politically sensitive issue
- Irate member or escalating issue
- Threatening behavior by a member to harm self or others (accepted only if further designated criteria are met)
- External factors which adversely affect the delivery of member benefits
- Potential or actual breach of member confidentiality or privilege
- Suspected, alleged, or actual abuse of member

## **8 Policy Management**

The following sections identify overall components for effective policy management:

## 8.1 Compliance

Staff members within the Appeals & Grievance department and the Clinical Quality Improvement department will monitor compliance with respect to:

- Timeliness of processing member grievances
- Quality of documentation
- Appropriateness of workflow (i.e., SFs sent to the appropriate I-MAX mailbox)
- Completeness of process

If staff members deviate from the policy guidelines, the issue(s) of concern will be addressed with the staff member's supervisor/manager. Issues related to a Member Service Representative's need for additional training will be forwarded to the appropriate training staff.

## 8.2 Effectiveness

To monitor the effectiveness of the Member-Generated Grievance Process, the owner-managers, or their designated representatives will review the process on a regular basis to identify opportunities for change/improvement.

Suggestions that would result in substantial policy changes will be implemented in a policy *revision* per the usual internal policy change process. Suggestions that would result in an operational workflow change within a given department that would not affect the workflow of other departments will be implemented through changes in the relevant department policy and procedure manual.

**Example:** Changes in the severity/preventability rating scale or clinical grievance category coding would be updated in the *CQI Grievance Team Policy and Procedure Manual*.

In addition, the *Quarterly Grievance Report* will be presented to the Customer Satisfaction QI Workgroup for discussion.

## 8.3 Maintenance

This policy is jointly owned by the Tufts Health Plan Appeals & Grievances department, and the Clinical Quality Improvement department (see *Policy Owner* section for specific contacts).

The owner-managers will review this policy as needed. The owner-managers herein must approve any requests for revision of the policy or procedures at least every two years.