Title:	File Audit- Member Complaints and Appeals				
Department/Line of Business:	SWHP				
Approver(s):	VP CMO, SWHP				
Location/Region/Division:	Quality Improvement				
Document Number:	SWHP.QLI.006.P				
Effective Date:	4/11/2017	**Last Review/ Revision Date:**	4/11/2017	**Origination Date:**	09/1/1997

LINE OF BUSINESS

This document applies to the following line(s) of business:
All SWHP & ICSW

DEFINITIONS

When used in this document with initial capital letter(s), the following word(s)/phrase(s) have the meaning(s) set forth below unless a different meaning is required by context. Additional defined terms may be found in the BSWH P&P Definitions document.

Authorized Representative - an individual who acts on behalf of an individual through consent or under applicable law. An organization may establish procedures for determining whether an individual is authorized to act on behalf of one of its members. For urgent care decisions, an organization allows a health care practitioner with knowledge of the member's medical condition (e.g., a treating practitioner) to act as the authorized representative.

Complaint – an oral or written expression of dissatisfaction.

Appeal – a request to change an adverse decision made by the organization. A member or authorized representative of a member may appeal any adverse decision.

Grievance (Medicare Only) - any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame. 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.

POLICY

Scott & White Health Plan (SWHP's) Dispute Resolution Department is responsible for reviewing and resolving all member/enrollee complaints, appeals, and grievances. SWHP's Customer Advocacy Department is the first line of contact for members. Customer Advocacy obtains information from the member and forwards all complaints, appeals, and grievances to Dispute Resolution for investigation and resolution. Request to overturn SWHP clinical and administrative determinations are forwarded to Medical Directors for review. Dispute Resolution maintains documentation of all aspects of the investigation and resolution of a case in unique files.

PROCEDURE

On a quarterly basis, the Quality Improvement (QI) Department conducts file audits of grievances, complaints, concerns and appeals to evaluate Dispute Resolution files for compliance with Texas Department of Insurance (TDI), Centers for Medicare and Medicaid Services (CMS), Health and Human Services Commission (HHSC), and National Committee for Quality Assurance (NCQA) requirements. File audits are conducted for services including medical, behavioral health, and pharmacy, include all complaints and appeals related to both clinical and non-clinical aspects of careQI collects data from all sources of members' complaints and appeals.

QI selects a random sample of at least 10 closed complaint files per month per region and 1 closed appeal file per quarter per region for Commercial and Medicaid. QI selects a random sample of at least 3 closed grievance/complaint files per month per region and 1 closed appeal file per quarter per region for Medicare. If there are fewer than the number of complaints and appeals defined for audit, all are audited. QI utilizes a File Review Worksheet to evaluate the timely processing of grievances, complaints, concerns and appeals. Each file is reviewed for timeliness and completeness.

A. Timeliness: SWHP adopted the goal that 98% of member complaints/concerns and appeals are resolved in accordance with the timeliness standards set forth in the related policies: 1) SWHP.STR.101.P Complaint Policy and Procedure, and 2) SWHP.STR.103.P Appeal Policy and Procedure.
B. Completeness: Each file will be reviewed to ensure the presence of the following information: documentation of complaints and actions taken, investigation, notification to member, and right to appeal.

QI collaborates with Dispute Resolution to complete a quantitative and qualitative analysis. The findings and recommendations are presented to the Quality Improvement Sub-Committee (QIS) for approval and determination of next steps. Corrective action plans are developed and implemented when opportunities for improvement are identified.

ATTACHMENTS

None.

RELATED DOCUMENTS

Complaint Policy and Procedure (SWHP.STR.103.P)
Appeal Policy and Procedure (SWHP.STR.101.P)

REFERENCES

2017NCQA Health Plan Accreditation Standards, Ql 4 Member Experience
2017 NCQA Health Plan Accreditation Standards, RR 2 Policies and Procedures for Complaints and Appeals
2017 NCQA Health Plan Accreditation Standards, Appendix 9
TAC Rule 11.1902;
Medicare Managed Care Manual Chapter 13. Sec 10.1
Texas Medicaid Managed Care Contract, Attachment B1, Section 8.1.5.9 Member Complaint and Appeal Process
Texas Medicaid Managed Care Contract, Attachment B1, Section 8.2.6 Medicaid Member Complaint and Appeal System