Complaint Procedure:

The person responsible for the maintenance of records and for the supervision of the complaint process is the office manager. A specific set of records must be maintained to document each complaint filed. Records include the reason for complaint, date filed, consequent actions and final disposition. These records will be centrally maintained by the office manager.

The office manager should encourage patients to resolve individual problems or concerns, without initiating a formal complaint procedure, by contacting the office manager for verbal resolution of the problem or concern. The office manager must respond to the inquiry within three (3) working days of the submission.

In the event that the problem has not been settled at the informal level and the patient is still dissatisfied, he/she will be advised to notify the office manager in writing. Complaints must be submitted within 30 days of occurrence, unless good cause can be shown for not filing the complaint during the 30 days.

In the case of a medical or quality of care complaint, the investigation of the complaint will include referral to the medical director, but the process will remain the same. The office manager will provide written acknowledgment of receipt of the complaint to the patient within five (5) days; the complaint will be investigated and a response sent to the patient no later than 30 days following the initial filing of the complaint with the office manager. The patient or any interested party may submit written data, which will remain part of the file.

If the patient is not satisfied with the response, he/she may appeal to the complaint committee. The patient will be advised in writing of his/her right to appeal. The complaint committee shall develop and maintain written guidelines for investigating complaints and conducting informal hearings. Receipt of the complaint by the compliant committee will be acknowledged within five (5) days and resolution suggested within 30 days. The finding and recommendations of the committee will be final.

If the patient is dissatisfied with the decision of the complaint committee, he/she will be advised of the right to appeal to the state insurance commissioner or his/her health plan’s grievance manager. Impact Medical Services will cooperate with the insurance companies and the patient during the appeal process.

The Impact Medical Services’ manager will include in his/her annual report to the health plan, the number of complaints filed, a compilation of the underlying causes, and the resolution of the complaints.

Procedure – Inquiries

1. Patient calls Impact Medical Services' personnel with inquiry.

2. Impact Medical Services' employee secures any and all information needed from patient and contacts appropriate personnel involved with complaint.

If the inquiry is bill-related:
Impact Medical Services' employee contacts the billing supervisor; if a question of medical necessity, refers to medical personnel.

All relevant information should be secured from billing before a response is made to the patient. Medical necessity will be determined by medical personnel. All other problems (e.g., service or delivery problems, clarification of covered benefits) are referred to by appropriate departments.

3. Impact Medical Services' personnel will respond to patient within three (3) working days; either with resolution or current status and time frame for resolution. At the end of the investigation, reports findings to patient and advises patient of right to file a written complaint with Impact Medical Services.

Note: the written complaint must be filed within 30 days of occurrence of the source of complaint.

Impact Medical Services' employee will complete a written record inquiry/complaint form (Attachment A) and files.

Complaint Procedure:

1. Patient submits a complaint in writing to the Impact Medical Services' Director of Operations.

2. Director of Operations logs the complaint in complaint log (Attachment H) and completes a written record inquiry/complaint form (Attachment A).

Note: additional entries are made to the log as appropriate steps in the complaint procedure are completed. It is critical that the complaint log be kept up-to-date.

3. Director of Operations acknowledges receipt of the complaint in writing within five (5) working days of receipt (Attachment B).

Note:

- The acknowledgement also includes a request for the patient to complete a complaint form (Attachment C) and return it within ten (10) days.
- If the complaint form is not returned within 30 days, a telephone call is made to the patient. If there is no response from the call, the complaint is filed.

4. The Director of Operations investigates the complaint, secures any necessary additional information and decides upon a resolution.

    a. If the complaint involves a medical or quality of care issue, the office manager refers the complaint to the medical director.

5. The Director of Operations notifies the patient in writing of the resolution within 30 working days from the date on which the complaint is received (Attachment E).

Note: the patient is also notified at the time of his/her right to appeal the decision to the complaint committee. The Director of Operations must be notified in writing within 30 days if an appeal is desired.

6. Patient notifies Director of Operations within 30 days of desire to appeal.

7. Director of Operations notifies complaint committee immediately of appeal request and forwards all files and supporting documentation to the complaint committee.

8. Complaint committee notifies the patient of receipt of the appeal request (Attachment F) within five (5) days of receipt of patient's letter.

9. The complaint committee meets and issues its decision within 30 days of receipt of the patient's written request for appeal (Attachment G).

    a. If the appeal is related to medical issue, the issue must be referred to the quality improvement committee.

Note: this referral and consideration must be handled expeditiously since a decision must be rendered within the 30 day time frame.

10. If the patient is dissatisfied with the decision of the complaint committee, he/she will be advised of the right to appeal to the state insurance commissioner or their health plan's grievance manager. The Impact Medical Services' Director of Operations will cooperate with the commissioner or health plan's grievance manager and the patient during the appeal process.

This list is subject to changes; contact your local agencies for exact notification process.

a. Plan Board of Directors
b. Department of Insurance or other agency.

A. Complaint Log

Description/Purpose: Medicare requires maintenance of an accurate, up-to-date complaint log in each office available for inspection at any time by departments of insurance and health plan. The log should be used as follows:

1. Record all complaints on the complaint log. These sheets must be maintained in a 3-ring binder divided by months.

2. Assign a case number to the complaint and to a corresponding individual written record inquiry/complaint sheet (attachment b). Use the written record inquiry/complaint sheet during investigation. Use a 7-digit number with a "wc" prefix. (e.g., wc-60409 = written complaint received in April (04) 2006 and it was the 9th (09) complaint received in April).

3. During the investigation, complete additional complaint log information. At the end of the investigation, transfer the summary of the resolution to the complaint log.

Column heading/
Line caption item description

Referral source	Enter name of person/unit referring the complaint, if any. If there is no referral, indicate direct.
Case #	Enter the 7-digit case number assigned to the complaint (e.g., wc-60409).
Date rec'd co.	Enter the date the complaint was received at the Impact Medical Services
Date rec'd office	Enter the date the office received the complaint.
Rec'd by	Enter the signature of the person receiving the complaint.
Assigned to	Enter the name of the person who will handles /oversee the complaint.
Subscriber	Enter the subscriber's name.
Patient	Enter the person's name if complaint concerns someone other than patient.
Rel.	Enter the relationship of person complaining for patient (e.g., spouse, child).
Health plan name	Enter health plan name.
Id no.	Enter the id number.

Line caption item description

Complaint codes	enter the code number for the subject of the complaint (see telephone inquiry record for sample code numbers). Expand these codes as new subject areas.

Date first resp by Market	Enter the date on which the first response to the patient was sent (i.e., compliant form). Enter date complaint form was received.
Date appeal letter	Enter the date on which the letter containing decision and notification of patient's right to appeal decision to complaint committee was sent.
Decision code	Enter a code number for the decision.
Appeal	Enter yes or no, as appropriate to indicate if complaint was appealed to complaint committee.
Date final disposition	Enter the date of letter with the final decision of the appeal.

CODES

Complaint code

Di – Delivery issue

Si – Service issue

Qi – Quality issue

Phi – protected health information issue

Decision code

01 – Overturn

02 – Denied

03 – Pending additional information

04 – Decision upheld

05 – PHI violation occurred

06 – No PHI violation occurred

Attachment A

☒ Complaint phoned in ☐ Complaint Mailed in

Date Complaint received in office: **REQUIRED** Person taking complaint: **REQUIRED** Complaint given by: **REQUIRED** Assigned to:	Medicare HICN #: **REQUIRED** Internal Case #: For database use patient wishes to remain anonymous: ☐ Yes ☐ No
Patient Name: **REQUIRED** Patient Address: **REQUIRED** Patient Phone Number: **REQUIRED**	
Nature of Complaint/Inquiry ☐ Billing(1) ☐ Delivery Service(3) ☐ Quality of Care(2) ☐ HIPAA(9) ☐ Service provided by Respiratory Therapist (7) ☐ Coverage Issue(6) ☐ Education Issue(4) ☐ Other(8)	Date(s) acts or omissions are to have occurred: Inventory Item: If Applicable Serial Number: If Applicable
Description of complaint: **REQUIRED** Was an Impact Medical Services' employee contacted about this complaint inquiry/act or omission? ☐ y ☐ n Name of employee.	
Actions taken to resolve the complaint: **REQUIRED**	
_____ _____ Signature Representative Date	

B. Section Below for Authorized Impact Medical Services' Personnel Use Only

Investigation:

☐ Yes

☐ No – Name of person making decision for no Investigation: **REQUIRED IF NO INVESTIGATION**

Date Handled by Referred to Action taken Further action needed

Follow up:

Date Resolved

Final Decision Reason **Required Information**

If No investigation was conducted, please explain reason:

☐ The problem has been resolved.(1)

☐ Patient satisfied with the equipment, supplies, and service provided. (2)

☐ There was a mis-communication and the matter has been clarified. (3)

☐ The patient is using the equipment and it works properly. (4)

☐ Other (5)

Attachment B

Form Letter: Receipt of Complaint

Re: written complaint wc _____ - __ (case #)

Dear _____:

This letter is to acknowledge receipt of your complaint dated _____.

Please complete the attached complaint form and return it to the address found at the end of the form within 10 working days.

This case number has been assigned to your complaint for investigation purposes: _____. Please use this number on all future correspondence.

A full investigation will begin when we receive your form and we will notify you of your decision by 30 working days from receipt of form.

Please be aware that we cannot complete a review of your complaint until we receive your complaint form.

Thank you. For your cooperation as we work toward resolution of this matter. If you have any questions, please call me at _____.

Sincerely,

Director of Operations
Name:_____

Address:_____

City, State, Zip:_____

Attachment C

(Page 1) Impact Medical Services' Complaint form

Please Print Case # _____

Subscriber name: _____

Address: _____

City: _____ state: _____

Zip: _____ phone: (home) _____

Policy#: _____ Group#: _____

Report Taken By: _____

Patient: _____

Relationship: _____

Type of complaint (check one)

_____ physician – related
_____ hospital – related
_____ delays in getting services
_____ delays in getting delivery
_____ telephone problems
_____ other (please explain)

_____ problems with benefits
_____ billing issue
_____ pharmacy issue
_____ health plan personnel problem
_____ HIPAA

Explanation:_____

Description of complaint

1. What date was service provided? _____
2. Who provided service (e.g., name of sales representative, driver, or intake person)? _____
3. Please explain your complaint (use additional sheet if necessary):
   _____
   _____
   _____

Over for More

Impact Medical Services' Complaint Form – 2

4. Have you discussed this complaint with any Impact Medical Services' Staff/personnel?

   ____ Yes ____ No if yes, with whom?

   1. _____ 2. _____ 3. _____

Name Name Name

What did they say?

1. _____

2. _____

3. _____

5. If your complaint involves a denial of a claim payment, have you paid for this care?

____ Yes ____ No if yes, how much? $ _____

6. How would you like your complaint resolved?

_____

_____

_____

7. Other comments:

_____

_____

_____

_____ _____

Signature Date

_____ _____

Print name Relationship to Patient

Please return in 10 days to:

Name:_____

Market Office: _____

Address:_____

Attachment D

Telephone Call Follow-up

This call is just a reminder that Impact Medical Services has not received your complaint form. Please remit the form within five (5) working days. We cannot investigate your complaint without this information. Should you have any questions, please contact use at the following:

Market Office:_____
Address:_____
Telephone number:_____
Date called:_____
Person called:_____
Name of caller:_____

Attachment E

Form Letter: Resolution of Complaint and Notice of Right to Appeal

Re: written compliant ____wc-_____
(Case #1)

Dear _____:

We have investigated the facts surrounding your complaint dated _____ relating to _____. We have made the following decision regarding your complaint:

_____
_____
_____
_____
_____
(Description of finding)

If the resolution of your complaint is unsatisfactory to you, you may appeal this decision to the Impact Medical Services' complaint committee. To appeal, you must notify me in writing within 30 days of the date of this letter.

[You may request that the Director of Operations appoint a staff person to represent you. The staff person shall have no direct involvement in the case.]

We appreciate you utilizing Impact Medical Services and hope that an explanation of our decision resolves your complaint. If you have any questions, please call me at_____ _____.

Sincerely,

Name:_____
Director of Operations

Attachment F

Form Letter: Receipt of Appeal to Committee

Re: Appeal of case # _____

Dear _____

The complaint committee of Impact Medical Services acknowledges receipt of your request for review of the decision in the case referenced above.

[Depending on the complaint, some variations are possible:]

> *"To review your complaint, please provide the committee with the following information within five (5) days."*
>
> *"You may request an informal hearing before the committee to present your complaint. If you desire to present your complaint in person to the committee, please notify me within five (5) days of receipt of this letter."*

The complaint committee will review and make a decision on your complaint by _____ (30 days) provided that you have supplied the committee with all information requested to render a decision.

If you have any questions, please call me at _____.

Thank you.

Sincerely,

Name:_____

Attachment G

Form Letter: Complaint Committee Findings and Notice of Right to Appeal

Re: appeal of case # _____wc-_____

Dear _____:

The complaint committee has reviewed and investigated the decision of the Director of Operations on your complaint.

Our decision is as follows:

[You may appeal this decision to _____, State insurance commissioner or your health plan's grievance manager.]

We appreciate your patience as we have investigated your complaint. It is your goal to be responsive to the needs of our patients and to provide quality healthcare.

Again, thank you and we apologize for any inconvenience this many have caused you.

Sincerely,

Attachment H

Complaint Log

Written Complaint Log

Equipment/Service	Case #	Date Rec'd Compl.	Date Rec'd Office	Rec'd By	Asgn'd To	Serial/Id Number	Patient	Rel	Health Name	Complaint Codes	Date 1st resp By Office	Date Appeal Letter	Decision Code	Appeal	Date Final Disposition