	Section: 1	Number: Q102K
		Category: A
Last Review Date: 12/17/08, 7/31/09, 4/27/10, 1/25/11	Page 1 of 9	Original Date of Issue: 04/24/07
Functional Area: Quality Department	Date(s) Revised: 8/27/07, 7/21/09, 1/25/11	
Prepared by: VO-Kansas QI		
Service Center/Operating Unit: Kansas Service Center, Public Sector Division	Subject: Provider and Stakeholder Grievances	
Approval Signatures: <i>Brian Baker</i>	<i>Sheree Marzka</i>	
Brian Baker Director of Clinical Operations	Sheree Marzka Director of Quality Improvement	


I. Purpose: To establish the ValueOptions Kansas (VO-KS) policy and procedures for handling provider and stakeholder grievances. It is VO-KS's policy to assure all providers that they have a right to file a grievance and that their resolutions are received within the required timeframes.

II. Department(s) and Committee(s) Affected:


- A. Kansas Service Center Clinical Quality Committee and all Subcommittees
- B. All Kansas Service Center Departments and employees
- C. ValueOptions Company Quality Council (CQC) and Subcommittees

III. Policy: It is the policy of VO-KS that the Grievance Coordinator, or designee, responds in a timely manner to grievances filed by a provider.

- A. At no time does VO-KS retaliate or take discriminatory action against an individual because he/she filed a grievance.
- B. Grievances may be filed verbally or in writing. Customer Service Representatives and/or the Grievance Coordinator assist the grievant in filing a grievance as necessary.
- C. Grievances must be filed within 180 calendar days of the date the dissatisfaction or event occurred.
- D. VO-KS provides a written notice that the grievance was received and the expected date of resolution within 5 business days of receipt of the grievance.
- E. The investigation and resolution process for grievances is completed within 14 calendar days of receipt of all required documentation. All decisions are issued in writing and all resolution letters contain the reasons and/or rationale for the resolution. The grievance decision is the final step in the grievance process.

 VALUEOPTIONS	Section: 1	Number: Q102K
		Category: A
Last Review Date: 12/17/08, 7/31/09, 4/27/10, 1/25/11	Page 2 of 9	Original Date of Issue: 04/24/07
Functional Area: Quality Department	Date(s) Revised: 8/27/07, 7/21/09, 1/25/11	
Prepared by: VO-Kansas QI		
Service Center/Operating Unit: Kansas Service Center, Public Sector Division	Subject: Provider and Stakeholder Grievances	
Approval Signatures: <i>Brian Baker</i>	<i>Sheree Marzka</i>	
Brian Baker Director of Clinical Operations	Sheree Marzka Director of Quality Improvement	


- F. VO-KS may extend the 14 day timeframe by 14 calendar days if the provider requests the extension or VO-KS demonstrates that there is a need for additional information and the extension is in the provider’s best interest. For any extension not requested by the provider, VO-KS shall obtain SRS approval and give the provider written notice of the reason for the extension within 2 working days of the decision to extend the timeframe.
- G. VO-KS ensures that health care professionals with appropriate clinical expertise make decisions if the grievance involves clinical issues.
- H. Documentation regarding the grievance shall be made available to the grievant, if requested.
- I. All information gathered or learned during the investigation, research, or resolution of a grievance is held in a confidential manner in accordance with federal and state regulations.
- J. Documents are maintained in accordance with ValueOptions Policy LC305, “Storage of Records” and LC306 “Destruction of Records.” Documentation is filed in a secure manner and is accessible to SRS, upon request, for review. Records are retained for 10 years following the final decision, or closure of a file, whichever occurs later.
- K. The Director of Quality Improvement, in conjunction with the Clinical Director and Chief Medical Officer, is responsible for the oversight of all quality of care issues (See ValueOptions Policy and Procedure Q 314 Identification and Monitoring of Quality of Care Issues and Trends).
- L. The Director of Quality Improvement, or designee, is responsible for tracking, trending, and reporting grievance resolution timelines and issues.
- M. It is the policy of ValueOptions that communications are in plain language for all members and their designated representative that request language services. ValueOptions provides services in the requested language through:

	Section: 1	Number: Q102K
		Category: A
Last Review Date: 12/17/08, 7/31/09, 4/27/10, 1/25/11	Page 3 of 9	Original Date of Issue: 04/24/07
Functional Area: Quality Department	Date(s) Revised: 8/27/07, 7/21/09, 1/25/11	
Prepared by: VO-Kansas QI		
Service Center/Operating Unit: Kansas Service Center, Public Sector Division	Subject: Provider and Stakeholder Grievances	
Approval Signatures: <i>Brian Baker</i>	<i>Sheree Marzka</i>	
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1. Language Line interpretation services available to help members register oral complaints, grievances and appeals.
2. Orally interpret an English document into a member's preferred language.
3. Translation of written documents upon request.

IV. Definitions:

- A. Access to Services – The extent to which a provider can obtain available clinical care for the member at the time the care is needed, including access to ValueOptions' clinical referral services.
- B. Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of an MCO or PIHP to act within timeframes provided in §438.408(b).
- C. Care Disruptions – Issues related to the disruption of care for reasons other than an action (e.g. exhaustion of benefits, provider terminates treatment against the wishes of the patient).
- D. Claims/Invoice Issues – Issues related to the payment of claims/invoices for services.
- E. Clinical Issues – Issues related to the authorization or delivery of clinical services.
- G. Grievance: an expression of dissatisfaction for which the provider/stakeholder wants to receive a formal response about (see Procedure section V) any matter other than an action

	Section: 1	Number: Q102K
		Category: A
Last Review Date: 12/17/08, 7/31/09, 4/27/10, 1/25/11	Page 4 of 9	Original Date of Issue: 04/24/07
Functional Area: Quality Department	Date(s) Revised: 8/27/07, 7/21/09, 1/25/11	
Prepared by: VO-Kansas QI		
Service Center/Operating Unit: Kansas Service Center, Public Sector Division	Subject: Provider and Stakeholder Grievances	
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- H. Grievance Coordinator: Designated staff with the authority to administer the policies and procedures for resolution of grievance. The Grievance Coordinator is an individual not involved in any previous level of review.
- I. Plain Language: Communication that uses short words and sentences, common terms instead of (medical) jargon, and focuses on the essential information recipients need to understand.
- J. Quality of Care Issue - Any issue that decreases the likelihood of desired health outcomes and is inconsistent with current professional knowledge. Examples of quality of care issues may include, but are not limited to:
1. Any major deviation from established structures, policies and procedures that may be viewed as contributing to unexpected outcomes
 - a) Treatment and/or discharge planning issues
 - b) Medication management issues
 - c) Access to appropriate treatment
 - d) Inappropriate or unprofessional behavior
 - e) Member safety issues
 2. Performance outside established parameters for:
 - a) Over- and under-utilization
 - b) Quality of care indicators
 - c) Clinical guideline adherence
 3. Fraud and abuse
 4. Adverse Incidents
- K. Service Issues - Issues related to ValueOptions' processes or the services provided by ValueOptions non-direct care staff (for tracking purposes grievances regarding ValueOptions direct care staff would be classified under "Clinical Issues"; grievances related to access to ValueOptions clinical authorization and/or referral services would be classified under "Access to Services").
- L. Stakeholder – Anyone other than a member or in network provider. Examples


	Section: 1	Number: Q102K
		Category: A
Last Review Date: 12/17/08, 7/31/09, 4/27/10, 1/25/11	Page 5 of 9	Original Date of Issue: 04/24/07
Functional Area: Quality Department	Date(s) Revised: 8/27/07, 7/21/09, 1/25/11	
Prepared by: VO-Kansas QI		
Service Center/Operating Unit: Kansas Service Center, Public Sector Division	Subject: Provider and Stakeholder Grievances	
Approval Signatures: <i>Brian Baker</i>	<i>Sheree Marzka</i>	
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include advocates, State employees or other state or privately funded agencies.

V. Procedure:

A. Receipt of Grievance

1. The Grievance Coordinator receives the grievance orally or in writing. Upon receipt of the grievance and verification that the grievance was filed timely the issue is entered into the VO-KS database. VO-KS makes available reasonable assistance for the provider with completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
2. The Grievance Coordinator logs the grievance in the database documenting the date received, name of the grievant and nature of the grievance.
3. The Grievance Coordinator acknowledges all written or verbal grievances with an acknowledgement letter within five (5) business days of receipt. The acknowledgement letter includes the VO-KS address and phone number and the expected date of resolution.
4. The Grievance Coordinator works toward resolution with other VO-KS staff as necessary, such as:
 - a. Provider Relations
 - b. Claims Department
 - c. Clinical Operations Department
 - d. Regional Offices
5. If a potential Quality of Care issue is identified, the case is forwarded to the Director of Quality Improvement, or designee, for oversight and investigation.


	Section: 1	Number: Q102K
		Category: A
Last Review Date: 12/17/08, 7/31/09, 4/27/10, 1/25/11	Page 6 of 9	Original Date of Issue: 04/24/07
Functional Area: Quality Department	Date(s) Revised: 8/27/07, 7/21/09, 1/25/11	
Prepared by: VO-Kansas QI		
Service Center/Operating Unit: Kansas Service Center, Public Sector Division	Subject: Provider and Stakeholder Grievances	
Approval Signatures: <i>Brian Baker</i>	<i>Sheree Marzka</i>	
Brian Baker Director of Clinical Operations	Sheree Marzka Director of Quality Improvement	

6. If a resolution cannot be completed within 14 calendar days, the grievant is contacted either telephonically or in writing prior to the 14th day and is advised of the status of the grievance.
 - a. The resolution timeframe may be extended up to 14 calendar days if the provider requests the extension or if VO-KS demonstrates that there is need for additional information and the extension is in the provider's interest.
 - b. For any extension not requested by the provider, VO-KS shall give the provider written notice of the reason for the extension within 2 working days of the decision to extend the timeframe.

7. When a grievance is received involving a member in urgent care, or when the grievant indicates that a delay in resolving the grievance might endanger the life or health of the member, the staff member designated to process the grievance immediately undertakes a "warm transfer" of the call to the Clinical Director or designee. Investigation and resolution of a grievance involving urgent care, including notification to the grievant, occurs as soon as possible taking into account the exigencies of the situation, but not later than 48 hours after receipt of the grievance. There are no extensions for attempted resolution of grievances involving urgent care.

8. The written resolution response to the provider contains all required information including but not limited to:
 - a. All information considered in the investigation of the grievance;
 - b. Findings and conclusions based on the investigation; and
 - c. The disposition of the grievance.

9. The Grievance Coordinator updates the grievance database to include the resolution date of the grievance and the disposition.


	Section: 1	Number: Q102K
		Category: A
Last Review Date: 12/17/08, 7/31/09, 4/27/10, 1/25/11	Page 7 of 9	Original Date of Issue: 04/24/07
Functional Area: Quality Department	Date(s) Revised: 8/27/07, 7/21/09, 1/25/11	
Prepared by: VO-Kansas QI		
Service Center/Operating Unit: Kansas Service Center, Public Sector Division	Subject: Provider and Stakeholder Grievances	
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10. Fair Hearing – At any time during the grievance process the provider may request a State Fair Hearing. State Fair Hearing procedures are included in the receipt of grievance letter sent to the provider and is also posted on the VO-Kansas website. The Grievance Coordinator receives the request orally or in writing. Upon receipt of the Fair Hearing request and verification that the request was filed timely the issue is entered into the VO-KS database. VO-KS makes available reasonable assistance for the provider with completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

1. Providers may file a request for a State Fair Hearing at any stage of the grievance process and are not required to first file a grievance in order to access the State Fair Hearing process.
2. The State Fair Hearing can be requested up to 180 calendar days of the date the dissatisfaction or event occurred. Furthermore, a Provider may seek a State Fair Hearing if not satisfied with ValueOptions' decision in response to a grievance.
3. A State Fair Hearing request must be made in writing, signed, and sent to the **Office of Administrative Hearings, 1020 S Kansas Avenue, Topeka, KS 66612-1311**. Fair Hearing Request forms can be accessed at <http://www.oah.ks.gov/request.htm>


B. Reporting, Tracking, and Trending

1. The Director of Quality Improvement, or designee, is responsible for ensuring the timely resolution of grievances through regular review of the tracking database.
2. Grievances are tracked according to the following categories:
 - a) Access to Services Issues
 - b) Clinical Issues (includes Quality of Care issues)
 - c) Care Disruption Issues
 - d) Claims/invoice Issues

	Section: 1	Number: Q102K
		Category: A
Last Review Date: 12/17/08, 7/31/09, 4/27/10, 1/25/11	Page 8 of 9	Original Date of Issue: 04/24/07
Functional Area: Quality Department	Date(s) Revised: 8/27/07, 7/21/09, 1/25/11	
Prepared by: VO-Kansas QI		
Service Center/Operating Unit: Kansas Service Center, Public Sector Division	Subject: Provider and Stakeholder Grievances	
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e) Service Issues

3. The Director of Quality Improvement, or designee, reviews all grievances on a monthly basis to identify patterns.
 - a. Action plans are developed as issues are identified.
 - b. Patterns of poor quality are forwarded to the VO-KS Clinical Quality Committee as necessary.
 4. The Grievance Coordinator provides the VO-KS Clinical Quality Committee with monthly summary reports for review and recommendation.
 5. The Director of Quality Improvement submits grievance reports to the SRS, as required by contract.
- C. All documentation related to the grievance is maintained through the grievance file in accordance with confidentiality and document retention requirements.
1. VO-KS documents the following information, (but not limited to):
 - a. Date of filing of grievance;
 - b. Name, identifier, and nature of the grievance;
 - c. Date of the acknowledgment letter;
 - d. Dates of decision to extend the timeframe as well as SRS approval and provider notification;
 - e. The determination made including the date of the resolution, the title(s) of the personnel and credentials of any clinical personnel who participated in each determination;
 - f. Date the resolution letter is mailed to the grievant;

	Section: 1	Number: Q102K
		Category: A
Last Review Date: 12/17/08, 7/31/09, 4/27/10, 1/25/11	Page 9 of 9	Original Date of Issue: 04/24/07
Functional Area: Quality Department	Date(s) Revised: 8/27/07, 7/21/09, 1/25/11	
Prepared by: VO-Kansas QI		
Service Center/Operating Unit: Kansas Service Center, Public Sector Division	Subject: Provider and Stakeholder Grievances	
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- g. All correspondence between VO-KS and the grievant, including notices of final resolution and all other pertinent information.
2. The grievance file is released to the provider (or their representative) upon request as permitted by federal and state confidentiality laws and regulations.

VI. References:

42 CFR 438 Subpart F

VII. Attachments:

Grievance Resolution Workflow

VO-KS Staff Grievance Training Presentation