IPA Guidelines for HMO
Member Complaints Inquiries
Appeals and Grievances **HMO Policy and Procedure**

BLUE CROSS AND BLUE SHIELD OF ILLINOIS
PROCEDURE

DEPARTMENT: Network Provider Performance	**POLICY NUMBER: Administrative 22A**	**ORIGINAL EFFECTIVE DATE: 4/1/2019**
POLICY TITLE: IPA Guidelines for Member Complaints, Inquiries, Appeals and Grievances		**EFFECTIVE DATE:04/01/2023**
		LAST REVISION DATE: 04/01/2023
EXECUTIVE OWNER: DSVP, IL Health Care Delivery	**BUSINESS OWNER: Executive Director, Network Performance**	**LAST REVIEW DATE: 04/01/2023**

I. SCOPE

This Procedure applies to the following lines of business and products:

Line of Business / Product Scope / Plan Scope/Contract Number (if applicable)	In Scope [x]
HMO Commercial	x
HMO Exchange	x
Health Care Delivery QI HMO Commercial	
Health Care Delivery QI PPO Commercial	
Health Care Delivery QI HMO Exchange	
Health Care Delivery QI PPO Exchange	

II. POLICIES IMPLEMENTED BY PROCEDURE

This Procedure implements the following Policies:

1. Quality Improvement 26 – Quality of Care Complaints and Occurrences

III. PROCEDURE

All supporting Complaint process documents are located on the BCBSIL IPA Access portal at:

Population Health Management > Commercial and Exchange > Population Health Management CE > Utilization Management > HMO UM Plan Supporting Documents > **yyyy**

The documents include:

- Definitions of Complaints, Inquiries, Appeals and Grievances
- Examples of types of Complaints, Inquiries, Appeals and Grievances
- Frequently Asked Questions for Complaints, Inquiries, Appeals and Grievances
- Flow Chart for Complaints, Inquiries, Appeals and Grievances

- IPA Complaint check list for required documents

General Member Complaints:
BCBSIL HMO retains full responsibility for resolution of member complaints within 30 calendar days of receipt. HMO members are provided with detailed instructions advising them to send all complaints to HMO for resolution. If a member voices complaint to their assigned IPA, the IPA is required to contact the HMO per the following process.

Examples of member complaints include but are not limited to the following:

- Attitude and service: member was dissatisfied with attitude of provider or office staff
- Quality of Office Site: Member was dissatisfied with office cleanliness
- Potential Quality of Care: Member was never notified of misdiagnosed test results
- Billing: Member has received two bills for services that should have been covered and this is the third call regarding the bill

1. Upon receipt of a member complaint, the IPA must complete and upload an IPA Member Complaint Form within one (1) business day of receipt to the BCBSIL IPA Access Portal at Population Health Management > Commercial and Exchange > Complaint Form.

2. For HMO to adhere to the 30-calendar day resolution timeline, the IPA is required to email the following information to HMOCAUUnit@bcbsil.com within 14 calendar days from the initial day of completing and uploading the IPA Complaint Form:

    - Copy of authorization related to the complaint for dependents over 18
    - All supporting documentation regarding the complaint issue
    - Explanation of complaint
    - IPA Medical Director and Administrator Recommendations
    - Primary Care Physician (PCP) statement related to complaint
    - If PCP is unaware of the issue, PCP's recommendation is required
    - Copy of referrals related to complaint
    - Copy of authorization related to complaint
    - Claim payment information (if applicable) including:
        - Date paid
        - Check number, and
        - Paid amount

3. During the fourteen-day period, the HMO Customer Assistant Unit (CAU) Health Service Assistant (HSA) verifies that the appropriate documents have been submitted.

    - If a document(s) is missing, the HSA will email the Member Complaint Check List to the IPA requesting the missing information. The IPA is required to email the missing document(s) to HMOCAUUnit@bcbsil.com within 2 days from the date the HSA emailed the IPA. See Guidelines for location of IPA check list.

    - If the IPA has not submitted the missing documentation by calendar day thirteen, the HSA will send a reminder email to the IPA.

4. If the IPA has not submitted the missing documentation by calendar day fifteen, the HSA may issue an Administrative Complaint and enlist the appropriate HMO Provider Network Consultant (PNC) for assistance to obtain an IPA response. See policy- Administrative 39- HMO Administered Complaints

Expedited Member Complaints
IPAs may identify a member complaint requiring an escalated review.

1. Upon receipt of the escalated member complaint, the IPA must complete the following within one (1) business day of receipt:
    a. Complete and upload the IPA Member Complaint Form to the BCBSIL IPA Access Portal
    b. Complete IPA Complaint Check List for Required Documentation and email to HMOCAUUnit@bcbsil.com

2. BCBSIL HMO CAU team responds to the escalated member complaint by the end of the third business day.

Note: If an IPA or HMO CAU determines that a general or expedited member complaint is a Quality of Care Complaint, CAU forwards the case to Quality of Care within twenty-four hours of receipt for follow up. See policy, Quality Improvement 26 – Quality of Care Complaints and Occurrences

Inquiries
If an IPA receives a member inquiry, the IPA is not required to send the case to HMO and responds to the member via phone, email or fax.

Examples of Inquiries include but are not limited to the following:

- Billing: Member questioning their copay or other billing matters that can be remedied at the time of the inquiry
- Office Procedures: Member needs to know how to change PCP and/or how to obtain a referral
- Access to PCP/PSP: Member inquiring if PCP offers early morning or evening hours

If the member inquiry is regarding an appeal, the member is either directed to follow the Appeal process or if the IPA cannot resolve the appeal inquiry, the IPA follows the Complaint process.

Appeals
All member appeals are investigated and finalized by BCBSIL. If a member contacts the IPA regarding an appeal, the IPA directs the member to follow the appeal process outlined in the member denial letter.

Examples of Appeals include but not limited to the following:

- Denials (Ambulatory/Preservice): Member appealing denial to see an out of network specialist
- Denials: Member appealing denial of requested Durable Medical Equipment

Grievances:

If an IPA determines a member has a grievance, the IPA follows the Complaint process described above.

Examples of Member Grievances include but are not limited to the following:

- **Benefits**: Member dissatisfied with **HMO benefits**
- Policies: Member dissatisfied with PCP Offices' twenty-four-hour cancelation policy
- Guidelines: Member wants to be admitted for upcoming outpatient procedure

IV. CONTROLS/MONITORING

Line of Business and/or Area	Control Requirements
HMO	Controls are detailed in the Policy itself

V. AUTHORITY AND RESPONSIBILITY

BCBSIL HMO entities including HMO CAU, HMO Clinical Programs Strategy and Oversight and HMO Service Centers maintain and coordination IPA compliance to regarding HMO member complaints, inquiries, appeals and grievances.

VI. RELATED DOCUMENTS

Quality Improvement 26 – Quality of Care Complaints and Occurrences

VII. IMPACTED BUSINESS AREAS

HMO Customer Assistant Unit
HMO Clinical Programs Strategy and Oversight
HMO Network Operations/Provider Performance
HMO Service Centers

VIII. IMPACTED EXTERNAL ENTITIES

HMO Medical Groups

IX. PROCEDURE REVIEWERS

Person Responsible for Review	Title	Date of Review
Mary Ellen Merbeth	HMO Provider Network Consultant	March 2, 2022
Danielle Washington	Manager Provider Performance	March 21, 2023

X. PROCEDURE REVISION HISTORY

Description of Changes	Revision Date
Removed TOB language	March 2, 2022
Update grievance example to mirror the policy	March 21, 2023
Updated year to yyyy	March 21, 2023

XI. PROCEDURE APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
BCBSIL P&P			3/24/2022
BCBSIL P&P			3/23/2023