

PROVIDER COMPLAINT REPORTING FORM DEFINITIONS

MN Rule 4685.1110 sub 9A

Access

Inability to obtain referral, Delay in obtaining service, Delays in appointment scheduling, Excessive wait times, Inability to access or obtain medical information, Inadequate geographic options, Lack of availability of special services, Culturally diverse providers

Communication / Behavior (Provider or Staff / Member communication)

Rude or uncaring or disrespectful, Rushed or did not listen or amount of time spend was inadequate, Inadequate education, Failure to provide complete examination, Delay in communicating test results, Inappropriate behavior, Culturally insensitive, Inadequate privacy

Coordination of Care (Provider/Provider communication)

Failure to follow up, Information not provided or available at time of care, Multiple providers/lack of overall coordination of treatment, Treatment delay due to lack of communication between providers, Delay in referral

Technical Competence/Appropriateness

Delay or incorrect diagnosis, Inappropriate treatment, Wrong test ordered or performed, Procedural error, Performing procedures or services outside scope of practice or expertise, Infection control

Facility/ Environment

Facility does not physically accommodate patient needs, Environment not comfortable, Equipment malfunction, Cleanliness, Unsafe physical conditions

This does not include benefit coverage, finance/billing, contractual issues/concerns

Requirement: MN Rules, parts 4685.1110 and 4685.1700 to 4685.1900 require providers to report quality complaints received at the clinic level to the enrollee's health plan. Complaints directed to the medical group are to be investigated and resolved by the medical group.

Definition: Quality complaints are defined as concerns regarding access to service, communication/behavior, coordination of care, technical competence and facility / environment affecting patients safety or comfort.

Frequency: At a minimum, medical groups must provide a written report on a quarterly basis, i.e. January 1 through March 31. Please submit by the second Friday following the end of each quarter. Reporting is required even if no complaints are received during this quarter.

Data Elements

Provider Group: Reporting provider clinic / care system.

Completed by: This is the name of the person that compiles the data on the report.

Date:	This is the date the report was submitted to the payer.
Reporting Period:	This is the quarter that you are reporting data on. Example: If the data you are reporting is for January, February and March, list or check 1 st Quarter on the report.
Send Report to:	This is the health plan that will receive the report. The health plan name and address are provided.
Date Received:	This is the date the clinic received the complaint.
Occurrence date:	This is the date of the event, incident, etc. If the patient or representative of the patient does not specify an exact date, use the date received. Examples of when to use the date received are; patient says “every time, always, last month, some time ago, etc.”
Patient ID:	The member name is not required but can be included at clinic’s discretion or include a complaint specific identifier for follow up questions to clinic. The purpose of the identifier is to allow communication between health plans and the clinic. Other options include member ID #, SSN or clinic assigned identifier.
Member DOB:	Not required but can be included at the clinic’s discretion.
Complaint:	Both verbal and written complaints should be reported. Defining what a complaint is should be up to clinics to use their judgement on what is a complaint. They should consider what is important to their business.
Category:	Clinics should categorize the type of complaint. It is also recommend that clinics use all categories of complaint that apply if multiple complaints are received by one patient. (Example: Access / Communication / Behavior)
Date & summary of resolution:	This is the date the clinic resolved the issue and a narrative summary of the resolution.
Total patients:	This is the total number of patients with complaints in this quarter.
Total complaints:	The total number of all complaint categories assigned to a patient. For example, if 1 patient has multiple complaints count all complaints. There may be more complaints than patients.