Grievance, and Appeal Report: Member Issues Log INSTRUCTIONS

- Report OPEN cases for this file. (You report CLOSED cases in a separate submission.)

- Report ALL grievances and appeals for your MO HealthNet membership. Review the contract to be clear on the contractual definitions for grievances and appeals. ALL of these need to be reported on this log.

- Report ONLY activity that occurred during the designated quarter. For example, if a grievance was opened on March 28 and closed on April 3, it should be reported as an "OPEN" case for Mar, and as a "CLOSED" case for Apr. NO reported dates should fall AFTER the end of the designated quarter. These will be flagged and returned to you.
- For fields with an Acceptable Values list, include ONLY items from that list. Be sure they are spelled EXACTLY as given in the specifications. Even minor deviations in spelling may result in your submission being rejected.

- Submit report in a pipe-delimited ASCII (or DOS) file format. DO NOT save as a Unicode file format. Your IT people will understand the distinction.

- The first row of the pipe-delimited file MUST contain the field names, EXACTLY as indicated in the specifications. Do NOT change spelling or add spaces to field names.

- DO NOT INCLUDE THE PIPE CHARACTER ("|") IN YOUR ACTUAL DATA. The pipe character is ONLY to be used as a delimiter between fields. If you include pipes in your descriptions of events or elsewhere in your data, your file will not import properly and will need to be corrected and resubmitted.

- It's a good idea to search your data for pipes and replace any that are found BEFORE saving your data as a pipe-delimited file. Good replacement characters for pipes are dashes, underscores, backslashes, and forward-slashes. (But it's a better idea to simply not use them in your data in the first place!)

- DO NOT USE COMMAS in your number values. For example, report 1234 and NOT 1,234.
- All Date fields must use a 4-digit year.

FIELD NAMES	DATA TYPE	ACCEPTABLE VALUES	NOTES
CalYear	Number		The year that the issue was resolved (or the year of the current reporting quarter, if an issue is still open at the end of the reporting quarter). Report the 4-digit calendar year.
CalMonth	Text	Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Report the current reporting month in which the case is still open. For example, if you're reporting for June, and the case still still open at the end of June, use 'Jun'. Use only the Acceptable Values.
HealthPlanName	Text	HealthyBlue HomeState UnitedHealthcare	Report the Health Plan Name using only the Acceptable Values. NOTE that there are NO SPACES in the plan names in the Acceptable Values list.
HealthPlanRegion	Text	Eastern Central Western Southwestern	Report the Health Plan Region using only the Acceptable Values.
DCN	Text		The Health Plan member's 8-digit MHD identification number. Format as text to retain any leading zeros.
OpenOrClosed	Text	Open	The only acceptable value that should appear in this field is 'Open'. Closed cases should be sent in a separate file.
InitiatedBy	Text	Member Provider Parent/Guardian Ombudsman Other	Report InitiatedBy using only the Acceptable Values.

FIELD NAMES	DATA TYPE	ACCEPTABLE VALUES	NOTES
InitiatedBy_ExplanationOfOther	Text		A description of who initiated the issue for any 'InitiatedBy' value of 'Other'.
IssueType	Text	Appeal Grievance	Report the IssueType using only the Acceptable Values.
IssueID	Text		This is the internal tracking ID assigned to the appeal or complaint by your Health Plan. To allow for plans that include letters in their Issue ID, this field has a "Text" data type.
InitiatedHow	Text	Email Fax Letter Phone Provider on behalf of member Referral from Care Manager Referral from MO HealthNet Verbal	Report InitiatedHow using only the Acceptable Values.
PlaceOfService	Text	Ambulatory Surgery Center Clinic Emergency Room FQHC Hospital Member's Home RHC Other	Report PlaceOfService using on the Acceptable Values. Use 'Clinic' for clinics other than FQHC or RHC, which have their own separate category.
PlaceOfService_ExplanationOfOther	Text		A description of the place of service for any 'PlaceOfService' value of 'Other'.

FIELD NAMES	DATA TYPE	ACCEPTABLE VALUES	NOTES
ServiceType	Text	Behavioral Health - Inpatient Behavioral Health - Outpatient Dental DME Emergency Room Services Health Plan Home Health Laboratory, Radiology, and Other Diagnostic Services Medical Inpatient Medical Outpatient (Primary Care Physician/Clinic/Urgent Care) Optical Personal Care Pharmacy Rehab Services (OT, PT, ST) Specialist Care Transportation Other	Report the ServiceType the issue pertains to, using only the Acceptable Values.
ServiceType_ExplanationOfOther	Text		A description of the service type for any ServiceType value of 'Other'.
MHDIssueCode	Number	100 Health Plan/Provider Policy 110 Provider Staff Behavior 120 Health Plan Staff Behavior 135 Appointment Standards 145 Network Adequacy 155 Waiting Times (Office/Timeliness of Service) 165 Quality of Office Setting/Safety 170 Treatment Plan/Diagnosis 180 Provider Competency 190 Interpreter 200 Fraud and Abuse of Services 210 Recipient receiving bills/ provider requests payment before rendering services 220 Health Plan Information 230 Provider Communication 240 Member Rights 300 Service Denial 310 Service Reduction, suspension or termination 320 Payment Denial 345 Transportation 350 Other	Report the MHDIssueCode using only the Acceptable Values. For this field, we will accept the 3-digit number alone, or the 3-digit number in combination with the description. The description alone is NOT acceptable. See 'Definitions' for additional detail on these categories.

FIELD NAMES	DATA TYPE	ACCEPTABLE VALUES	NOTES
MHDIssueCode_ExplanationOfOther	Text		A brief description of the Issue for any 'MHDIssueCode' value of '350 (Appeal Code) Other'.
DateReceived	Date		The date the grievance or appeal was received (either orally or in writing) by the health plan. Format date as mm/dd/yyyy.
DateAcknowledgementLetterSent	Date		The date of the written acknowledgement of the grievance or appeal sent to the member. Format date as mm/dd/yyyy.
ExpeditedReview	Text	Y N N/A	Report ExpiditedReview using only the Acceptable Values.
SummaryOfIssue	Text		Provide a short summary of the issue, including a clear understanding of why the member brought forward the issue.
ExtendedReviewRequested	Text	Y – Health Plan Requested Y – Member Requested N	Report the ExtendedReviewRequested using only the Acceptable Values.
ExtendedReviewRequestDate	Date		Indicate the date of any request to extend the grievance or appeal review period. Format date as mm/dd/yyyy. Leave blank if no extension was requested.

DEFINITIONS

Field Name	Acceptable Values	Acceptable Value Definition
InitiatedHow	Email	An email is received.
	Fax	A fax is received.
	Letter	A written letter is received.
	Phone	A telephone call is received.
	Provider on behalf of member	A provider is filing a grievance or appeal on behalf of the member.
	Referral from Care Manager	Health plan's Care Manager referred the grievance or appeal.
	Referral from MO HealthNet	Notification is received from MO HealthNet and contact is made with member which results in a grievance or appeal.
	Verbal	Verbal; In-person notification of a grievance or appeal.
PlaceOfService	Ambulatory Surgery Center	Service being billed took place in an ambulatory surgery center.
	Clinic	Service being billed took place in any clinic, other than an FQHC or RHC.
	Emergency Room	Service being billed took place in an emergency room.
	FQHC	Service being billed took place in an FQHC.
	Hospital	Service being billed took place in a hospital.
	Member's Home	Service being billed took place in the members home.
	RHC	Service being billed took place in an RHC.
	Other	
ServiceType	Behavioral Health - Inpatient	Medical necessity denial of IP Psychiatric Svc. Dissatisfaction with customer service/billing; dissatisfaction of care (IP, therapy, SUD).
	Behavioral Health - Outpatient	Dissatisfaction with/denial of outpatient services related to therapy, day program, or SUD.
	Dental	Dissatisfaction with/denial of authorization for services (dental tx and orthodontics); provider refuse to see members for i.e. lack of tx time span, member BH issues, and refusal to provide braces - authorization on file for 9 mos). Wait period for service 30-60 days. No notification from provider advising no longer accepting health plan. Cancellation of scheduled surgery without parent/member notification.
	DME	Dissatisfaction with/denial of authorization for services/items; member unaware of breast pump program/process.
	Emergency Room Services	ER wait time and lack of care; dissatisfaction with bill received; pay a deposit at ER.
	Health Plan	Issue with health plan customer service; member incentive rewards.
	Home Health	Dissatisfaction with/denial of in home services.
	Laboratory, Radiology, and Other Diagnostic Services	Dissatisfaction with/denial of services using NIA Clinical Guideline; Record Keeping and Documentation Standards; dissatisfaction with billing; dissatisfaction of denial of authorization for services; dissatisfaction with attitude of service provider, health plan personnel, or customer service received.
	Medical Inpatient	Dissatisfaction with/denial of services using NIA Clinical Guideline; Record Keeping and Documentation Standards; request for services not medically needed. Dissatisfaction with customer service/billing; dissatisfaction with/denial of care (IP, therapy).
	Medical Outpatient (Primary Care Physician/Clinic/Urgent Care)	Dissatisfaction with customer service/billing; amount of time waiting to be seen. Dissatisfaction with attitude of service provider or health plan personnel. Also includes Chiropractic services, and accupuncture.
	Optical	Dissatisfaction with customer service/billing; members received bills for services not seen at billing provider.
	Personal Care	Request medical PCA vs nurses; possible harassment and fraud of in home services.
	Pharmacy	Dissatisfaction with attitude of service provider, health plan personnel, or customer service received. Dissatisfaction with billing; services covered/not covered.
	Rehab Services (OT, PT, ST)	Dissatisfaction with customer service/billing; dissatisfaction with/denial of authorization for services; dissatisfaction with care.

Field Name	Acceptable Values	Acceptable Value Definition
	Specialist Care	Dissatisfaction with/denial of authorization for services/billing; dissatisfaction of no follow-up from doctor office after test completed for further evaluation and treatment; denial of incentive rewards.
	Transportation	Denied reimbursement for transportation; appointment availability issues; access to service/care denied; no access to or dissatisfaction with transportation.
	Other	
MHDIssueCode	100 - Health Plan/Provider Policy	Use when a member is unsatisfied with the policy of the health plan (i.e. does not like the PA process, referral process, etc.) or is not happy with the provider's policy.
	110 - Provider Staff Behavior	Use when a member is not happy with how a provider or their staff has treated them.
	120 - Health Plan Staff Behavior	Use when a member is not happy with how the health plan or their staff has treated them.
	135 - Appointment Standards	Use when a member is unable to get an appointment within the timeframes outlined in the Appointment Standards section of the MC Managed Care contract. (Record issues regarding office wait times under 150)
	145 - Network Adequacy	Use when a member cannot find a provider/specialist in the health plan's network.
	155 - Waiting Times (Office/Timeliness of Service)	Use when a member feels the wait times in a provider's office is excessive or the timeliness of a service is disputed (i.e., DME scheduled to be delivered but is late, glasses are delayed).
	165 - Quality of Office Setting/Safety	Use when a member feels the conditions of the provider's office is in poor condition (i.e., unclean, not handicap accessible, etc.).
	170 - Treatment Plan/Diagnosis	Use when a member has an issue with the treatment plan/diagnosis of the provider. If this issue involves a denial of a service and rises to the level of an appeal, use Service Denial code.
	180 - Provider Competency	Use when a member has an issue with competency of the provider.
	190 - Interpreter	Use for all interpreter issues, including dissatisfaction with the language used on member notices.
	200 - Fraud and Abuse of Services	Use when a member feels there is a reason to believe a provider is being fraudulent in rendering services and/or billing issues.
	210 - Recipient receiving bills/provider requests payment before rendering services	Use when a member has received a bill from a provider/collection agency or when a member is billed at the time of service or is told payment must be received before services are rendered.
	220 - Health Plan Information	Use when a member has not received membership cards, provider directory, etc. from health plan or that information is not up-to-date.
	230 - Provider Communication	Use when a member is an established patient of a provider and the provider, or his/her staff, does not return calls or will not talk to the member.
	240 - Member Rights	Use when a member feels a provider or health plan has violated his/her rights as stated in Section 2.6.2 j 2) of the MC+ Managed Care contract (Dignity and privacy, Receive information on available treatment options, Participate in decisions, Free from restraint or seclusion, etc.).
	300 - Service Denial	Use when a requested service has been denied by the health plan.
	310 - Service Reduction, Suspension or Termination	Use when a member receives a reduction, suspension or termination of a previously authorized service based on a decision from the health plan.
	320 - Payment Denial	Use when the health plan has denied, in whole or in part, payment for a service.
	345 - Transportation	Used when a member feels the transportation provider is late, does not show up, leaves them at an appointment, acts inappropriately, does not have adequate safety restraints, or is not handicapped accessible.
	350 - Other	