



HEARTLAND KIDNEY NETWORK

# **COMPLAINT AND GRIEVANCE PROCEDURE, INFORMATIONAL RESOURCE & WRITTEN PLAN**

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COMMUNITY INFORMATION &  
RESOURCE

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# COMPLAINT AND GRIEVANCE PROCEDURE, INFORMATIONAL RESOURCE & WRITTEN PLAN

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## **ORGANIZATION AND AUTHORS OF PLAN**

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Organization: End-Stage Renal Disease (ESRD) #12 Network Coordinating Council, Inc.  
dba: Heartland Kidney Network

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## **I. HEARTLAND KIDNEY NETWORK INTRODUCTION**

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This document is intended to define the internal procedures by which the Heartland Kidney Network and its Medical Review Board (MRB) address complaints and grievances from patients, facility staff, and other agencies, or problems identified through the Network's Quality Improvement activities.

The purpose of these procedures is:

- To encourage open communication between patients and facility staff.
- To promote the prompt resolution of complaints and grievances at the local level.
- To assure that patients and facility staff may take their concerns, complaints, or problems to an independent Network organization without fear of reprisal if matters cannot be resolved locally.

The purpose of any review conducted by the Network is to determine if, in fact, a problem exists. If a problem does exist, the Network makes recommendations to improve the quality of End-Stage Renal Disease (ESRD) care. References cited at the end of each section are based on Section 7 of the Medicare ESRD Network Organizational Manual. (Revised March 12, 2004).

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## **II. ESRD NETWORK AUTHORITY**

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The Network must implement procedures for evaluating and resolving patient grievances as required in (§1881 (c) (2) (D) March 12, 2004) of the Act and Centers for Medicare & Medicaid Services (CMS) regulations. In addition, the Omnibus Budget Reconciliation Act amended the Act in 1989 to provide ESRD Networks with confidentiality in the medical review process (§ 1160) and a limitation on the Network's liability.

The ESRD Final Regulations of October 14, 2008, (§ 494.70 (V 465,466,467)) states that:

All patients are to be informed and assisted to understand and exercise their rights to file internal grievance or external grievances both without reprisal or denial of services. Patients are to be informed of the external complaints and grievances mechanisms and processes, including how to contact the ESRD Network and the State survey agency. Patient have a right to be informed that he or she may file internal or external grievances, personally,

anonymously or through a representative of the patient's choosing without being afraid that they will be treated differently or denied services.

All complaints and grievances regarding a Medicare-certified facility made by a Medicare beneficiary regarding failure to provide care and services should be addressed to the Network. The Network will act upon those matters that could affect patients' health or safety immediately, and/or referrals may be made to State Agencies (SA) or other appropriate authorities.

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### **III. ROLE OF THE NETWORK IN A COMPLAINT/GRIEVANCE**

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Heartland Kidney Network assumes a proactive role in the prevention, facilitation, and resolution of complaints and grievances, including implementing educational programs that will assist facility staff in handling difficult situations.

The Network's role in resolving a complaint, grievances, or inquiry will vary, depending upon the situation. The following are examples of different roles that the Network may assume:

#### **A. Expert Investigator**

The Network may assume the role of an expert investigator, when the quality of care provided to a patient(s) is an issue, the investigation's focus is the individual complaint and any overall patterns of care within the facility related to the complaint. For example, if a patient complains about the procedures used to initiate dialysis, the Network investigates the complaint by reviewing the techniques used by the facility to initiate dialysis on potentially affected patients.

#### **B. Facilitator**

When communication between the patient and the facility is problematic, the Network's role may be to facilitate communication and the resolution of differences.

#### **C. Advocate**

Networks advocate for individual patient's rights and/or the rights of all patients at a facility, depending on the situation. The Network acts for the greater good when the situation involves a threatening or violent patient.

#### **D. Referral Agent**

Issues that are not specifically ESRD Network issues, such as staff safety, fraud, and compliance with the Conditions for Coverage (CfC), should be handled by State Agency's or other local, State, or Federal agencies. Each Network must maintain a current list of appropriate local, State, and Federal resources to use as referrals for beneficiaries and/or complainants in need of assistance.

#### **E. Coordinator**

Where potentially serious quality of care concerns and/or CfC issues are involved, the Network alerts the appropriate Regional Office and Project Officer immediately and coordinate its investigation with the SA to avoid duplication of effort and conflicting outcomes.

#### **F. Educator**

The Network acts as an educator providing information and/or a referral to an appropriate resource when patients, families or facility staff request or require information/ education about ESRD, treatment of ESRD, or appropriateness of care.

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#### **IV. NETWORK CONFLICT OF INTEREST**

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Heartland Kidney Network staff, Board and Committee members may not participate in a complaint or grievance review if the reviewer:

- Has participated in the care under investigation.
- Has a direct involvement with the complainant or grievant.
- Has a financial interest, directly or indirectly, in that facility.
- Is a staff member of the ESRD facility in question.
- Has any potential conflict of interest.
- Is a governing body member, officer, partner, owner, or managing employee of the facility under review.

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#### **V. DEFINITIONS OF COMPLAINT AND GRIEVANCE**

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“A **complaint** is a verbal or written report of dissatisfaction regarding administrative issues or how a beneficiary or someone on behalf of a beneficiary may feel he or she was treated within the health care/Medicare field.” (NCC/CMS Annual Meeting Presentation February, 2008)

“A **grievance** is a verbal or written report of a health care risk of any kind, or a violation of an obligation which has occurred in one or more instances and presents a risk to the health, safety, or well-being of a patient or places the patient unnecessarily in a high-risk situation.” (NCC/CMS Annual Meeting Presentation February, 2008)

“**Health Care Risk**- A medical situation that if not quickly resolved would have immediate negative impact on the beneficiary’s health, putting the beneficiary’s health in jeopardy. Or it may be a situation that resulted in the death of a patient and is potential risk to the health of other beneficiaries.” (NCC/CMS Annual Meeting Presentation February, 2008)

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#### **VI. MECHANISM FOR RECEIVING COMPLAINTS/GRIEVANCES**

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The Network may receive a written or verbal inquiry, complaint, or grievance from an ESRD patient, a personal representative, a family member, a friend, a facility employee, a physician, a Federal or State agency, a patient advocate, or a concerned individual. In addition, other sources, such as the media, may make the Network aware of quality of ESRD care issues that should prompt an investigation.

The Network may be requested to investigate certain cases by its Project Officer. The Network may also receive referrals of complaints affecting or made by ESRD patients from Quality Improvement Organization(s) (QIOs), State Agency’s, other ESRD Networks, the Medicare 1-800 Hotline, Medicare Fiscal Intermediaries, and CMS Central Office.

The Network receives and acknowledges all complaints and grievances directed to it. Complaints or grievances may be made anonymously. A complainant's or grievant's identity must remain confidential unless specific permission is given by the complainant or grievant to use or release his/her name.

The Network always asks the complainant/grievant if his/her name can be revealed before the Network begins its investigation. The Network always documents the complainant's position on maintaining confidentiality and when possible obtains a written authorization. The Network should not wait for written authorization before beginning its investigation. When written or verbal complaints/grievances are received, they should be documented by entering them into the electronic format system approved by CMS.

In resolving a complaint involving patient care, the Network gathers information on the telephone, by letter/email, by conducting on-site reviews, or by performing other investigative activities concerning care provided by a facility or a provider as appropriate while maintain confidentiality and meeting HIPAA requirements. In making a determination, the Network utilizes recognized standards of care to assure proper treatment for ESRD patients.

The Network will keep supporting documents and related correspondence in a confidential tracking file system approved by CMS identifying number and date.

There may be occasions when a complaint/grievance recurs, and a closed case needs to be reopened because of a further need for review, investigation, and/or action. When the Network reopens a case, it counts it as a new case, but it should be linked to any previous cases so that patterns of concern can be identified. If a case is linked to another case or there are multiple complainants about the same problem (e.g., threatening staff at a facility or malfunction of dialysis machines in a given area), the Network documents the linkage in the electronic tracking system approved by CMS Contact section until the electronic system is able to automatically link related cases.

When a complainant contacts the Network with a problem, there are three options for handling any given situation:

**1. Confidential Consultation**

In this case, the caller only wants to consult with the Network and does not want the Network to assist or intervene in the situation. The Network staff discusses the situation with the caller and offers support, education, and information. Technically, confidential consultation is a component of the informal complaint process which is also considered as an inquiry.

**2. Complaint Process**

A complaint process allows the Network to communicate with the facility/practitioner by phone, letter, fax, email, or in person. This process does not require a formal written report to the complainant. The Network will work with the involved parties to shepherd a workable solution.

**3. Grievance Process**

A grievance process is usually a longer process. This involves a CMS-specified investigation process, a grievance determination, due process for the involved parties, and a final written report in a letter to the beneficiary.

**4. Referral**

A referral to an appropriate agency or entity is made when the issue falls under that agency's or entity's authority (e.g., failure to meet a Condition for Coverage would be referred to the State survey agency for action.)

The Network can recommend one of the above options to the complainant, but it must present all options. The Network uses the complaint handling option that the complainant prefers. A grievance automatically initiates the formal process. Regardless of whether a formal or informal process is used initially, the process used may be changed later.

Within five days of receipt, the Network acknowledges all written complaints either in writing or by phone. The Network writes a letter to a complainant that states the Complaint, explains the options for handling the situation, and provides a Network contact person and a toll-free phone number. All grievances should be acknowledged in writing within five working days of receipt. In responding to a grievance or a written complaint, the Network explains in writing the disclosure provisions that will govern Network activities. It also explains that the final grievance response letter will include as much information as the Network is permitted to disclose under those provisions.

1. The Network advises that in a grievance/complaint it will not reveal the grievant or complainant's identity during its investigation/review process without his/her consent. However, explain that because of the small patient population in dialysis facilities, identification by the provider/involved practitioner may occur, even when confidentiality is maintained.
2. The Network advises anonymous grievant or complainant's that their complaints/grievances will be investigated but the Network will be unable to report back to them without their name and address. Explain that because of the small patient population in dialysis facilities, identification by the provider/involved practitioner may occur, even when anonymity is maintained.
3. The Network advises that the complainant or grievant needs to inform the Network, either by telephone or in writing, of his/her decision regarding the use of his/her name in the investigation/resolution process.
4. The Network advises the grievant only that once its review is completed, the Network is required to advise the provider/involved practitioner of its determination and solicit comments prior to the release of the Network's response to the grievant. Thirty days are allowed for the submission of comments.
5. The Network advises the grievant that information which explicitly or implicitly identifies the practitioner is confidential and cannot be disclosed without the practitioner's consent and that the confidential information in the grievance response letter pertaining to the grievant may be disclosed by the grievant in any context, including litigation, provided no other patient or provider is identified. If a physician consents to have his/her name released in the grievance letter that information is confidential and may not be re-released without the physician's consent.
6. The Network assures the complainant/grievant that regardless of whether his/her name remains confidential; the Network will investigate the complaint/grievance and will act on the findings. If the case is investigated as an anonymous grievance, and there is no contact information, the Network will be unable to provide him/her with a final report letter.

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## VII. NETWORK STAFF RESPONSIBILITIES

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### **Patient Services Coordinator (PSC)**

The Patient Services Coordinator (PSC) is the primary point of contact for complaints and grievances at the Network. The PSC also coordinates the Network's process and response to any grievance or complaint. Medical findings will be determined by the grievance committee.

### **Quality Improvement Coordinator (QIC)**

The Quality Improvement Coordinator (QIC) provides coverage for complaints and grievances when the PSC is not available. The QIC may also assist the PSC in following up on specific cases as requested.

### **Quality Improvement Director (QID)**

The Quality Improvement Director (QID) provides coverage for complaints and grievances only when the PSC and QIC are not available. The QID participates in the review of all complaints and grievances involving areas of medical and clinical practice. The QID may direct the PSC to obtain medical records and other information as necessary to investigate the concerns.

### **Executive Director (ED)**

The Executive Director (ED) is kept abreast of current issues on a weekly basis or as necessary. In certain instances the ED may provide technical assistance or become directly involved in a complaint or grievance.

### **Project Officer (PO)**

On occasion, the Network office will contact the Project Officer (PO) to alert him /her of significant situations or request expert assistance. Complaint and Grievance data, trending and tracking is provided to the PO through the monthly calls and Quarterly Report four times per year.

### **CMS Ombudsman**

On occasion, the Network office will contact the Ombudsman to request expert assistance.

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## VIII. REFERRING COMPLAINTS AND GRIEVANCES

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The Network is responsible for reviewing the issue(s) raised by a complaint or grievance and determining the action required (e.g., investigation or referral). If there is a question about how to handle a complaint or grievance, the Network seeks direction from its Project Officer (PO). If the Network and its PO determine that a complaint or grievance concerns an issue that would more appropriately be handled by another agency, organization, or licensing board, the Network advises the complainant/grievant and either provides the referral information to the complainant/grievant or makes the referral to:

- 1. Carrier, Fiscal Intermediary (FI), and Centers for Medicare & Medicaid Services Regional Office (RO) Medicare Coordinator**

If the grievance concerns a payment or denial of services, the Network refers the complainant to the appropriate carrier or intermediary or to the RO representative who works with carriers or intermediaries.

**2. State Survey Agency (SA)**

Life threatening situations should be referred immediately to the State Agency (SA) . If the complaint/grievance is not life threatening but involves Conditions for Coverage (CfC), the Network coordinates its activities with the SA and/or refers the complaint. The Network may provide quality improvement (QI) assistance whether or not the complaint has been referred to the SA. The Network may also provide QI assistance when the facility requests it as a result of a SA investigation or survey.

**3. Quality Improvement Organization (QIO)**

The Network refers complaints or grievances involving hospital inpatient stays, nursing homes, and ambulatory surgical centers or any other setting that is outside of the Network's scope of authority to the QIO for peer review in the State where the hospital or service provider is located whether or not the complaint/grievance is specifically related to ESRD treatment or services. The complaint may involve care or services for co-morbid conditions.

**4. Centers for Medicare & Medicaid Services (CMS) Regional Office**

The Network refers complaints/grievances that indicate a facility's unwillingness to meet any of the Conditions for Coverage, or failure to participate in Network activities and to meet Network goals, to the CMS Regional Office (RO). Any complaint or grievance that is potentially an immediate and serious threat to patient health and safety should be referred immediately to the appropriate SA and the appropriate RO. The Network should refer to the CMS Web site for the most recent Associate Regional Administrator (ARA) list.

**5. State Licensing Boards**

The Network refers complaints/grievances about a physician or other provider services furnished in private offices, clinics or other ambulatory settings to the appropriate QIO for review, investigation and a determination as to whether the complaint/grievance should be referred to an accreditation, licensing, or certification agency.

**6. Managed Care Organization (MCO)**

If the patient is a known managed care patient, the Network should refer complaints/grievances about services furnished contractually for the MCO to the MCO's department for patient complaints. If the complaint is about the MCO itself, the Network should refer the complaint to the CMS RO responsible for the state in which the MCO is located.

**7. Federal or State Agencies**

If the Network determines that a complaint or grievance raises a potential or alleged fraud or abuse issue, the Network may refer a complaint or grievance to Federal or State fraud and abuse enforcement agencies responsible for the investigation of fraud or abuse of the Medicare or Medicaid program without a request.

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## **IX. PROVIDER IMPROVEMENT PLAN (IP) PROCESS**

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An Improvement Plan (IP) will be requested if it has been determined that a single problem or a pattern of substandard care exists which has, or may have, an impact on the health or well being on one or more Medicare beneficiaries. The designated intervention should correct the problem(s) identified. The facility or provider develops the intervention and the Network approves it. The Network (if requested) will assist the facility in the development of the intervention.

A facility's Improvement Plan should include the following in content:

- Identify reasons why improvement is necessary
- Develop and describe implementation of an intervention activity to correct the problem
- Describe the staff and material resources that will be used in the intervention
- Provide an expeditious timetable including all interim steps that will taken to resolve the problem
- Propose a methodology that will allow the Network to periodically monitor the intervention activities and outcome in order to ensure that the problem has been corrected and that it does not recur
- Provide a final completion date

### **Timetable for Improvement Plan**

The facility has 15 calendar days to submit an Improvement Plan (IP) after it is requested. The Network has up to 30 days to accept or reject the IP. An IP must be finalized and implemented within 60 calendar days of notification. If possible, the IP should be completed within a 1-3 month period.

### **Tracking/Monitoring**

The Network will track/monitor the Improvement Plan (IP) to ensure adherence to the IP scope and time line. The Network will contact the facility on a monthly basis to offer assistance and support.

### **Determination of Compliance**

At the conclusion of the approved time period, the Network will determine whether the facility has complied with the plan and if the problem has been adequately addressed. The determination may be made by either onsite inspection or off-site review of material provided by the facility, or conference call with involved parties, or any combination of the above.

### **Determination of Noncompliance**

If it has been determined that the facility has not complied with the Improvement Plan (IP) after timely Network reviews, a decision will be made by the Network as to whether to amend the existing IP, recommend a sanction to the Regional Office, and/or refer the situation to the State Agency. The Project Officer will be informed of any/all outcomes of the Improvement Plan.

**X. NETWORK COMPLAINTS AND GRIEVANCES PROCESSES**

**Time Table for Complaints and Grievances**

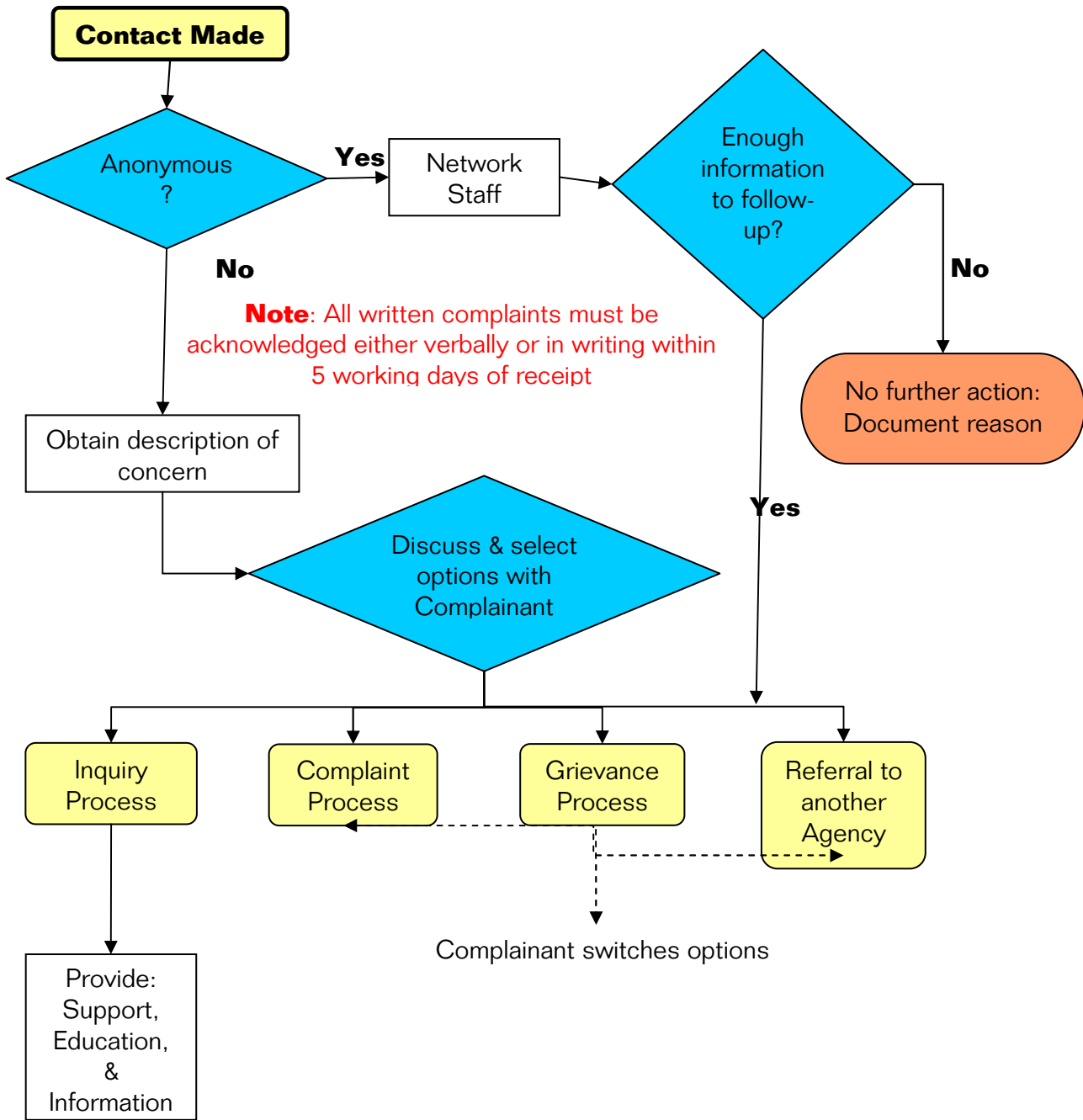
<b>Contact Type</b>	<b>Acknowledge Complaint</b>	<b>Investigation, Review, and Make Initial Determination</b>	<b>Determination Letter to Provider &amp; Request for Provider Comment</b>	<b>Final Report/ Letter</b>	<b>Total Days</b>
<b>Complaint (Verbal)</b>	Acknowledge complaint & describe complaint/grievance process during first contact	Gather information & try to resolve the complaint as quickly as possible	Letter <b>not</b> required.	Follow-up by phone or letter as appropriate	Usually 1-90 calendar days plus follow-up as necessary
<b>Complaint (Written)</b>	Letter or call of acknowledgement sent within 5 working days from receipt of complaint letter	Gather information & try to resolve the complaint as quickly as possible	Letter <b>not</b> required.	Follow-up by phone or letter as appropriate	Usually 1-90 calendar days plus follow-up as needed
<b>Complaint becomes a Grievance</b>	Letter of acknowledgement sent within 5 working days from the time a complaint becomes a grievance	Up to 50 calendar days for intake and resolution	30 calendar days (includes response time from the provider)	Within 5 working days after 30 day response time, letter is sent to grievant	Up to 90 calendar days plus follow-up as needed
<b>Grievance</b>	Letter of acknowledgement sent within 5 working days from receipt of grievance	Up to 50 calendar days for intake and resolution	30 calendar days (includes response time from the provider)	Within 5 working days after 30 day response time, letter is sent to grievant	Up to 90 calendar days plus follow-up as needed
<b>Life Threatening Situation</b>	Forward to SSA within 24 hours of receipt or determination and notify complainant/grievant	If unsure of complaint validity, gather information and make referral if appropriate	N/A	N/A	24 hours

A COMPLAINT/GRIEVANCE MUST BE HANDLED AS QUICKLY AS POSSIBLE.

IN HANDLING A GRIEVANCE, THE 90 CALENDAR DAYS TIMEFRAME MAY BE SHORTENED, WITH THE EXCEPTION OF THE TIME ALLOWED FOR THE NOTICE OF DETERMINATION TO AND RESPONSE FROM THE PROVIDER.

	<b>Plan Submission</b>	<b>Network Approval</b>	<b>Plan Implementation</b>	<b>IP Completed &amp; Evaluated</b>	<b>Follow-up</b>
<b>Quality Improvement Plan</b>	15 calendar days from determination of need	Up to 30 calendar days	Within 15 calendar days of approval	Usually 30 calendar days after implementation	1-3 calendar months as appropriate

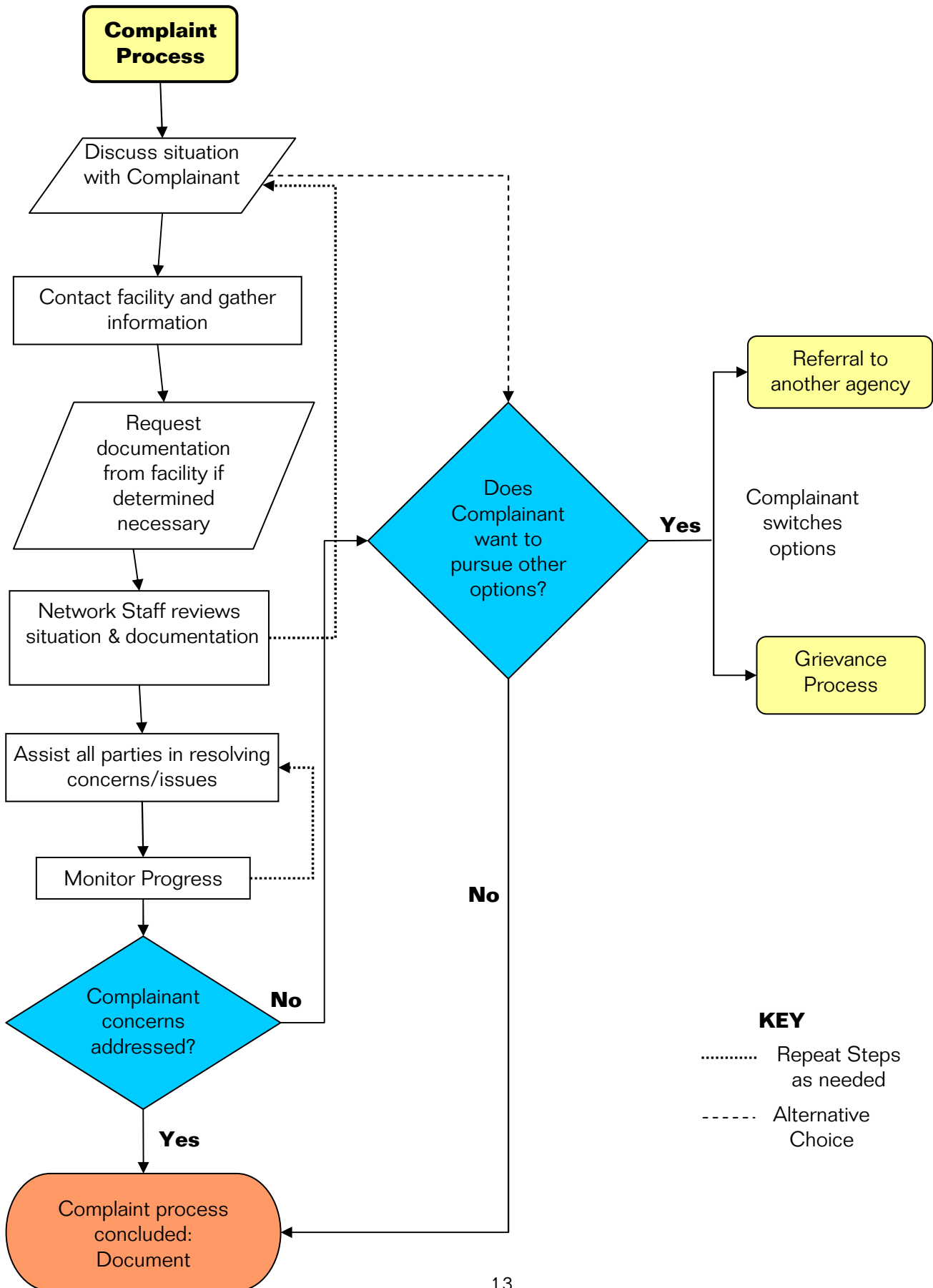
# ESRD Network Initial Contact



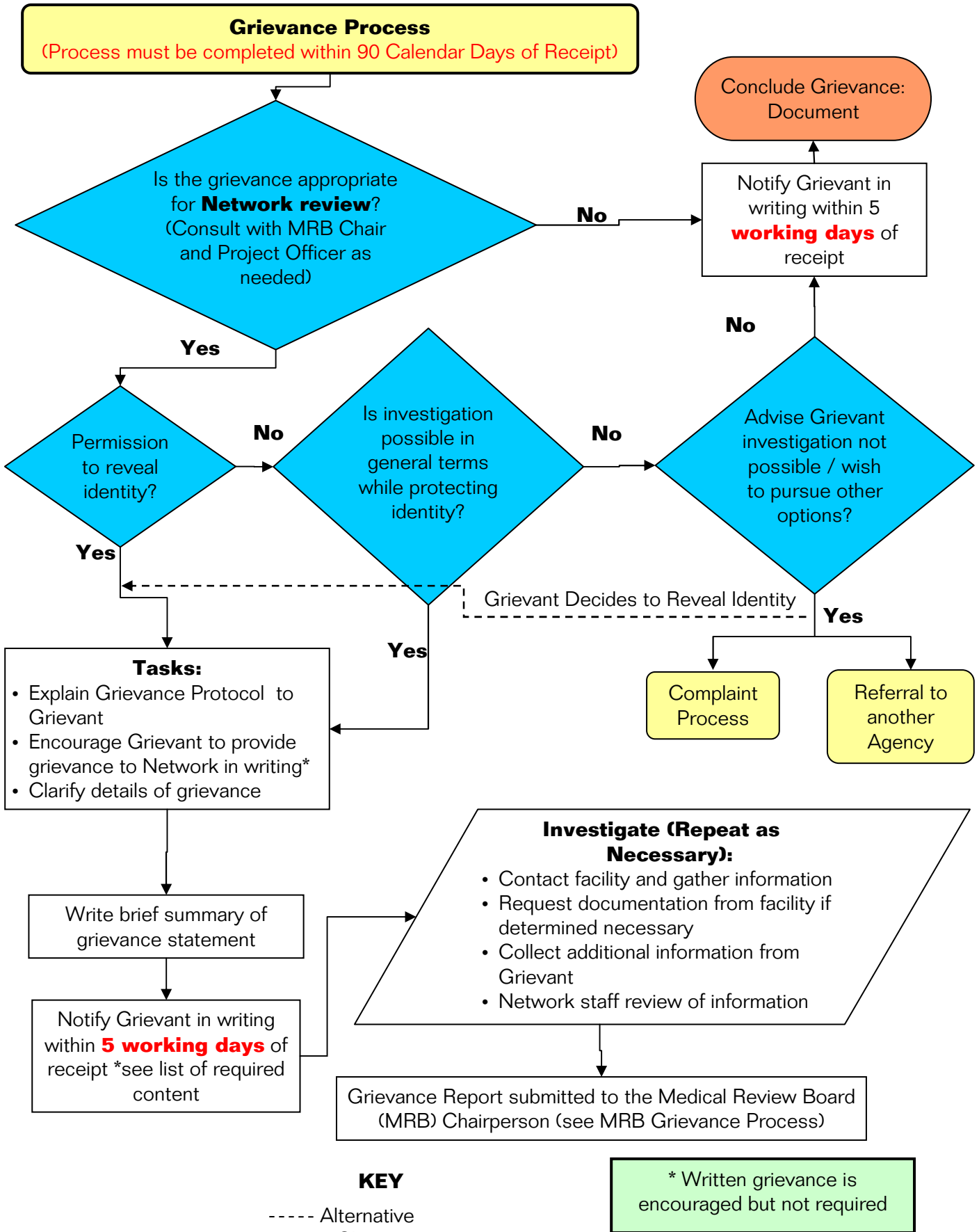
In the event of a life-threatening event, the Network will contact the State Agency immediately and contact the CMS Project Officer. The Project Officer will contact the Regional Office's Associate Regional Administrator.  
 (Timeline: within 24 hours of receipt or determination).

**KEY**  
 ..... Repeat steps as Alternative choice  
 - - - - - Alternative choice

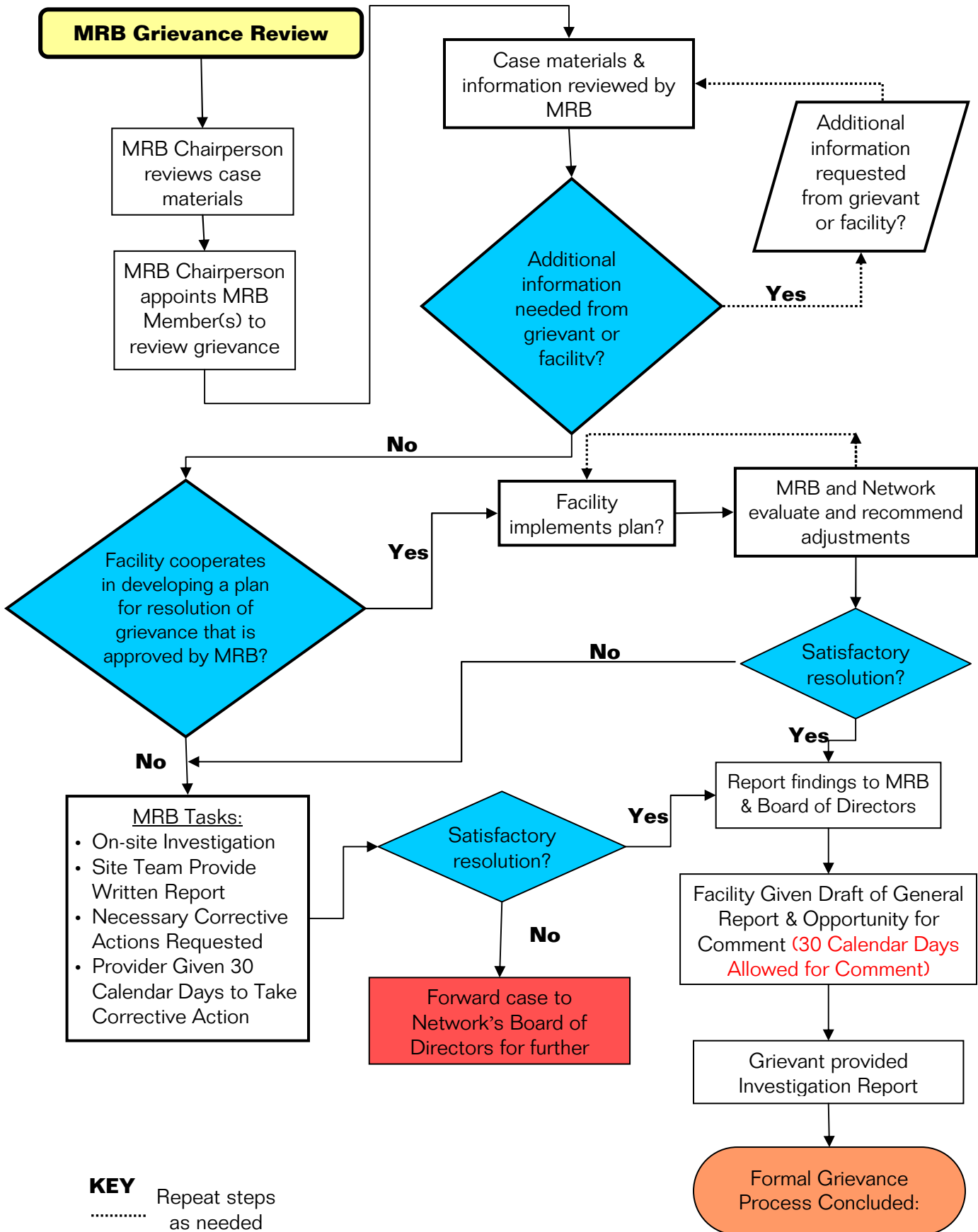
# ESRD Network Complaint Process



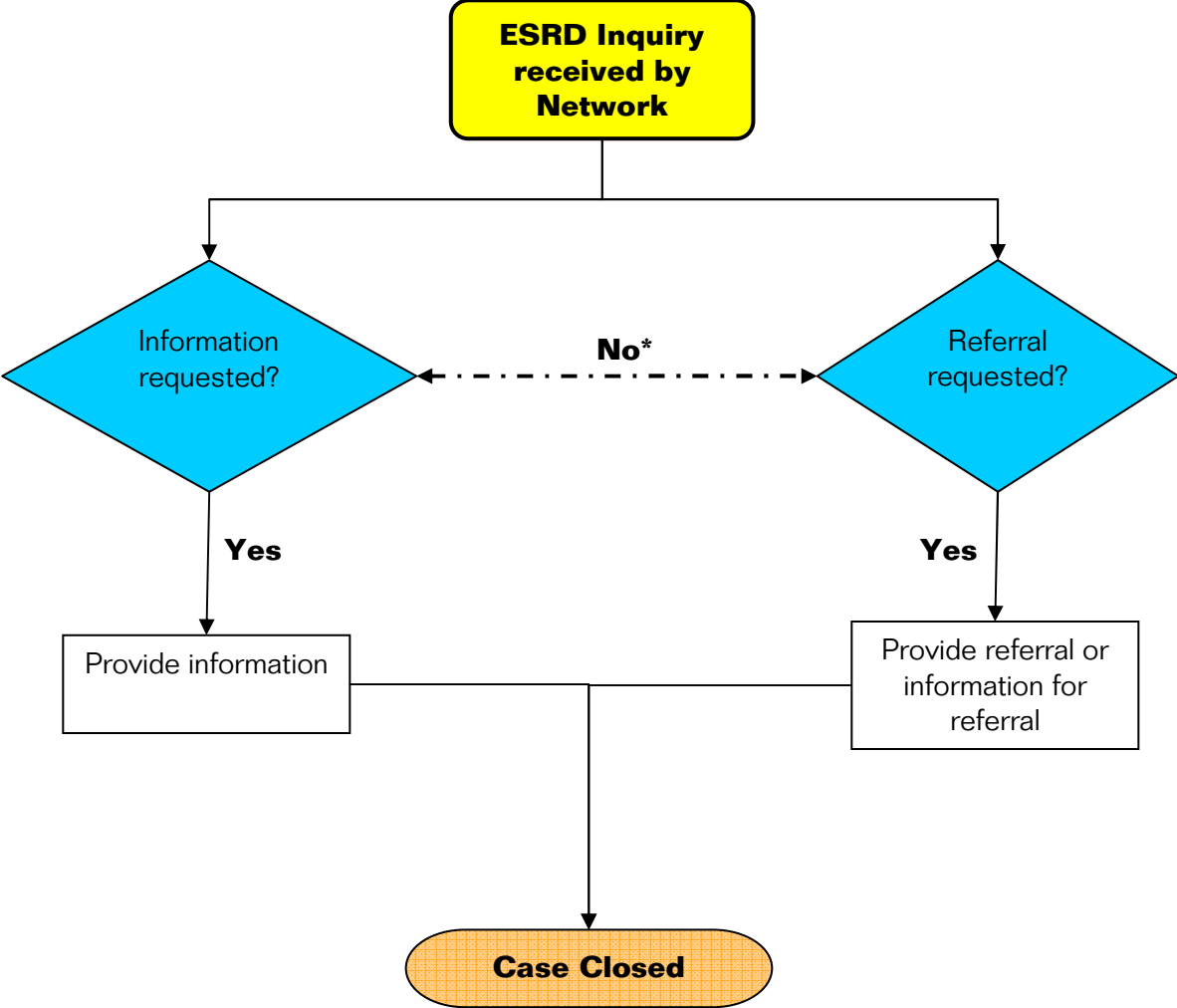
# ESRD Network Grievance Process



# ESRD Network MRB Grievance Review Process



ESRD Network Inquiry Process



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## XI. RESOURCES

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### Contents of Letter to Grievant

When a grievance is received, the Network's written acknowledgement should be provided to the grievant within five (5) business days. The letter of acknowledgement must include:

- A statement of the grievance
- An advisement that the Network will look into the issues raised by the grievant
- An explanation of the disclosure provisions that will govern the final response (Section 130.15)
- An explanation of the review process, approximate timeframes, and notification to grievant of any delays
- An advisement that additional information or documentation can be submitted at any time
- An advisement that if the grievance can be more appropriately handled by another agency, a referral will be made and that the contact person name, address, and phone number of the agency will be provided
- The contact information of the Network staff handling the grievance for the grievant (name, address, and toll-free number), should additional information about the grievance or the process of investigation be needed

### Timetable

The Network should conclude the formal complaints and grievances within 90 calendar days of the receipt of complaint or grievance.

In those instances where **more than 90 days** are required for the determination to be made and the complaint or grievance process to be completed, notification will be made to all parties including the RO PO of the reason for the delay and the anticipated conclusion date of complaint or grievance.

### Final Investigation Report to Grievant

The written report to the complainant or grievant will include the following:

- A brief description of the complaint or grievance and the investigation
- The extent to which the problem described in the complaint or grievance was verified
- Whether the situation resulted in Network recommendations to the facility
- Whether the situation has been or is being corrected by the facility
- Whether the facility is implementing an Improvement Plan (IP), and monitoring to assure correction or improvement is being made

If the Network facilitated a resolution of the complaint or grievance, then a list of agreed-upon actions, information on how to contact the Network, and the name of facility staff person who will be in charge of implementing the facility's actions will be provided.

The report to the complainant or grievant will be of a general nature and should not detail all the specifics of the investigation. The Network may disclose facility-specific information concerning the complaint or grievance, but may **not** identify a physician or practitioner or the name of another patient without consent. In addition, the letter may include a detailed explanation of other options and contacts, such as referral to the SA or RO, which the complainant or grievant may pursue if not satisfied with the complaint or grievance process or the outcome.

## Complaint or Grievance Statement Form

Write a brief statement of the complaint or grievance as you see it. Where appropriate, specify times, dates, and the facility staff involved. Use additional sheets of paper if you need to. Sign the form and send it to Heartland Kidney Network office. **Your identity will be kept confidential unless you agree to have it released by checking the box below.**

I **give permission** to Heartland Kidney Network to release my identity.

Name (please print) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Number (\_\_\_\_\_) \_\_\_\_\_

Work Number (\_\_\_\_\_) \_\_\_\_\_

Cell Number (\_\_\_\_\_) \_\_\_\_\_

Name of Your Facility \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Have you talked about this complaint or grievance with your facility? Yes No

Who did you speak with? \_\_\_\_\_ When? \_\_\_\_\_

What did he/she suggest? \_\_\_\_\_

Have you followed the grievance procedure at your facility? Yes No

Description of Problem: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What would resolve this situation for you? \_\_\_\_\_

**Personal Representative.** If you wish to have someone act on your behalf, please provide their name, address, and phone number.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Your signature \_\_\_\_\_ Date \_\_\_\_\_

## Letter to Personal Representative

(Date)

(Name of Representative)  
(Address)  
(City, State, and Zip Code)

Dear (Name of Representative):

If you are acting as a personal representative of a living beneficiary and wish to file a complaint or grievance on behalf of that beneficiary, Heartland Kidney Network must receive written authorization from the beneficiary appointing you as his/her personal representative or you may provide a copy of a court order designating you as Guardian or a Representative Payee.

Personal Representative Consent Form

I, \_\_\_\_\_ designate \_\_\_\_\_  
(Beneficiary's Name – Print) (Personal Representative's Name – Print)

who is my \_\_\_\_\_, (State Relationship to Beneficiary) to represent me in the matter stated below.

I understand that once I designate a personal representative he/she will communicate with the Network and will act on my behalf in regards to the complaint/grievance that I have made concerning:

(State the complaint/grievance)

I understand that if I file a complaint and use the informal process that the Network will communicate with my personal representative. If I file a grievance, the outcome letter written in response to my grievance will be sent to my personal representative. It will be the responsibility of my personal representative to share the outcome letter with me.

\_\_\_\_\_  
(Beneficiary's Signature) and (Date)

\_\_\_\_\_  
(Witness' Name) and (Date)

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## DEFINITIONS FOR ESRD COMPLAINTS AND GRIEVANCES PROCESS

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1. **Closed** – A complaint or grievance where no further action can be taken by or required of the Network.
2. **Complaint** – is a verbal or written report of dissatisfaction regarding administrative issues or how a beneficiary or someone on behalf of a beneficiary may feel he or she was treated within the health care/Medicare field.
3. **Complainant** – An individual who expresses a concern by filing a complaint.
4. **Grievance** – is a verbal or written report of a health care risk of any kind, or a violation of an obligation, which has occurred in one or more instances and presents a risk to the health, safety, or well being of a patient or places the patient unnecessarily in a high-risk situation.
5. **Grievant** – An individual who expresses a concern through a formal process by filing a grievance.
6. **Health Care Risk**- A medical situation that if not quickly resolved would have immediate negative impact on the beneficiary's health, putting the beneficiary's health in jeopardy. Or it may be a situation that resulted in the death of a patient and is potential risk to the health of other beneficiaries.
7. **Inquiry** – any contact made to a resolving entity by a Medicare beneficiary or beneficiary representative via phone, fax, e-mail, or white mail (U.S. Postal Service) that does not fall into the category of being a complaint or grievance.
8. **Medicare Beneficiary** – An individual, who due to age, disability, or end stage renal disease, is entitled to receive benefits under Medicare.
9. **Personal Representative** – An individual designated to represent another individual for a designated reason and a specific length of time.
10. **Referred** – The information provided by the complainant or grievant has been sent to the agency or individual that can most appropriately respond to the complaint or grievance. Alternatively the complainant/grievant has been given the appropriate contact information for the best agency or individual to assist him/her with the concern and will make the contact himself/herself.
11. **Reopened** – A previously closed inquiry, complaint, or grievance that has reoccurred and assistance was requested.
12. **Resolved** – The Network has worked with the facility and the complainant/grievant to adequately address or correct the problem to the extent that the complainant/ is in agreement with the determination and /or the outcome.

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## **WRITTEN PROCESS STEPS**

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### **A. ESRD Network Initial Contact**

1. Network is contacted
2. Is the call anonymous?
  - a) YES
3. Network Staff reviews call to gather information
4. Network Staff obtains description of the concern or situation
5. Is there enough information to proceed as a complaint?
  - a) NO – Call is only informational in nature. No further action and reason is documented in the electronic format system approved by CMS
  - b) YES
6. Discuss and select concern options with complainant
  - a) Inquiry Process -YES
  - b) Complaint Process
  - c) Grievance Process
  - d) Referral to another Agency
7. Provide support to caller, education and information
8. If it is a complaint, grievance or referral to another agency, provide caller with alternative options
9. Offer mediation on the callers behalf
10. Contact documentation is entered into the electronic format system approved by CMS

### **B. ESRD Network Complaint Contact**

1. Network is contacted with a complaint
2. Discuss situation with complainant
3. Contact facility and gather information
4. Request documentation from facility if determined necessary
5. Network staff reviews situation and documentation
6. Assist all parties in resolving concerns/issues
7. Monitor progress
8. Is complainant satisfied with resolution?
  - a) Yes - Complaint process concluded
  - b) No
9. Does complainant want to pursue other options? Yes
10. Formal grievance process begins and/or referral to another agency
11. Complainant switches options
12. Repeat steps as needed
13. Offer alternative choices
14. Contact documentation is entered into the electronic format system approved by CMS

### **C. ESRD Network Grievance Contact**

Grievance process must be completed within 90 calendar days of receipt.  
Note when initial acknowledgement needs to be sent as well.

1. Is the grievance appropriate for Network review? (Consult with MRB chair and PO as needed)
  - a) Yes
  - b) No - Notify grievant in writing within 5 working days of receipt and conclude grievance by documenting into the electronic format system approved by CMS
2. Obtain permission to reveal callers identity
3. Is investigation possible in general terms while protecting callers' identity? No
  - a) Advise grievant investigation not possible /wish to pursue other options?
  - b) Alternative choice is complaint process or referral to another agency
5. Explain grievance protocol to grievant
6. Encourage grievant to provide grievance to Network in writing (encouraged but not required)
7. Clarify details of grievance
8. Write a brief summary of the grievance statement
9. Notify grievant in writing within 5 working days of receipt
10. Investigate (repeat as necessary)
  - a) Contact facility and gather information
  - b) Request documentation from facility if determined necessary
  - c) Collect additional information from grievant
  - d) Network staff reviews information
11. Grievance report is submitted to the medical Review Board (MRB) Chairperson (See MRB grievance process)
12. Contact documentation is entered into the electronic format system approved by CMS

### **D. ESRD Network Inquiry Contact**

#### Process Steps

1. Network is contacted with an inquiry
2. Information requested?
  - a) Yes
3. Network Provides Information
4. Network Referral requested?
  - a) Yes
5. Provide caller with referral or information for referral to appropriate agency
6. Contact is entered into the electronic format system approved by CMS
7. Inquiry case is considered closed

## **Network Grievance Process**

The following is a general overview of Heartland Kidney Network's Grievance Procedure, many of these steps of which are provided through the CMS contract:

- A grievance is received at the Network office.
- The Network staff notifies the grievant through certified mail acknowledging receipt of grievance.
- Network staff ascertains what steps the patient has taken previously to resolve the problem and the patient's goal(s).
- Network staff notifies the ESRD provider or physician's office of the grievance and request a response to the concern that may include a request for specific records. Notification is sent via certified return receipt, requested mailing.
- Network staff reviews documents and removes all identifiers from information provided by all parties.
- The Grievance Committee reviews the case and either makes a determination regarding patient care, asks for additional information, or refers the case to the Medical Review Board.
- Network staff drafts a response to the grievant, which is sent to the facility or physician for review and comment.
- The grievant is notified of the Grievance Committee's decision including facility or physician comments and their appeal rights.

A facility visit may be necessary at any time during this process due to the nature of the complaint. Matters serious enough to be an immediate threat to the patient's or other patients' health and safety are referred immediately to the appropriate State Survey Agency.

If care problems are found, the Medical Review Board may request an improvement plan from the facility. If the facility is not successful in correcting the identified problem within the time frame of the improvement plan, the MRB with support of the Executive Committee may recommend that CMS sanction the facility. There is an appeal process available if a grievant is not satisfied with the findings of the Network.

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## **SOURCES**

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1. Medicare ESRD Network Organizational Manual. Section 7 (Revised, March 12,2004)
2. Conditions for Coverage – CMS/ ESRD Final Regulations Released October 14, 2008
3. NCC/CMS Annual Meeting Presentation (Baltimore, MD) February, 2008