Division of Quality Assurance

PROCEDURE SUMMARY

Title		
Acute Care Compliance Section Complaint Management Procedure		
Original Effective Date	Revision Effective Date	Procedure Number
5/12/92	12/02/09	3212
Bureau Responsible for Procedure	Bureau(s) Affected by Procedure	
Health Services Section (BHS)	BHS & BTLE Section	

Providers Affected

Hospitals (including general acute, alcohol, critical access, psychiatric and rehabilitation hospitals and units, and swing beds); home health agencies, hospice agencies, end stage renal disease facilities, ambulatory surgery centers, outpatient physical therapy/speech pathology providers, comprehensive outpatient rehabilitation facilities and rural health clinics.

Purpose of Procedure

To describe and differentiate screening and investigation of complaints.

List of Applicable Rules, Regulations, Statutes, State Operations Manual (SOM) or State Agency Performance Standards (SAPS)

DHS 105, 106, 107, 124, 131, and 133, Chapter 51.64, State Agency Performance Standards (SAPS) #6, Centers for Medicare and Medicaid Services (CMS) State Operations Manual (SOM) Chapter 5, Complaint Procedures.

Reason for Most Recent Revision

To include references to Personal Care Worker (PCW) Agencies, and End State Renal Dialysis (ESRD) involuntary discharge procedures, and to amend information on due dates to align with the CMS requirements.

Summary of Changes

Update to DQA responsibilities for PCW and ESRD. Correct due date calculation information.

Related DQA Procedures

1260, Referrals; 3216, NLTC Citing Guidelines

LIST OF FORMS AND ATTACHMENTS USED IN THIS PROCEDURE
Hyperlink the available forms and attachments noting NC (no change), new or revised.

Name of Form or Attachment	Effective Date	Status
BHS Complaint Processing Desk Instructions	7/1/2005	Revised
Letters acknowledging complaint receipt and outcome	Varies	NC
CMS State Operations Manual, Chapter 5, Complaint Procedures		
Complaint Processing Timelines	5/21/04	Revised
S&C Memo 04-09: Guidelines to Support Management of	7/1/05	Revised
Complaints/Incidents Tracking System (ACTS)	11/13/04	New
S&C Memo 05-27: Interim Timeliness Guidelines to Support the Entry of		
Data into the ACTS & Revisions to Field Definitions in ACTS	5/12/05	New
S&C Memo 04-23: Procedures in the Event of Fire in Medicare/ Medicaid		
Certified Health Care Facility	3/11/04	New
Reportable Death Review Committee forms/procedures		
Region V ACTS NLTC Complaint/Incident Processing Guide	Unknown	Unknown
	12/28/04	Revised

HISTORY OF REVIEWS AND REVISIONS

Review Dates	Revision Dates
Please see history for dates previous dates.	Please see history for dates previous dates.

Signature – Bureau Director	Date Signed	Signature – Deputy Administrator	Date Signed
Alfred C. Johnson /s/	12/22/2009	Jane Walters /s/	01/04/2010
Signature – Bureau Director	Date Signed		
Cremear H. Mims /s/	12/29/2009		

PROCEDURE

I. COMPLAINT OVERVIEW

A complaint is received when the Division of Quality Assurance (DQA) obtains information from a stakeholder who believes regulatory action should be taken regarding a specific allegation(s). A complaint may originate from a variety of sources. These sources include direct telephone calls from complainants; mail including e-mail; referrals (including caregiver incident reports from the Office of Caregiver Quality); results of an unrelated survey; a complainant presenting in person; or from the home health hotline maintained by the Division of Quality Assurance. Allegations may come from the patient, patient's family members, other health care providers, concerned citizens, public agencies, or from media reports. In some cases, the complainant may request anonymity. Complainants may be anonymous, or may give contact data with the understanding that the source of the complaint will not be revealed during the complaint investigation. These complainants shall be informed that, in the rare circumstance of post-survey legal action, their names may be released during the legal proceedings.

The Bureau of Health Services (BHS) complaint coordinator receives and reviews the allegations to determine whether an assertion of regulatory noncompliance has been alleged and whether DQA has jurisdiction or authority to act on the allegation.

The complaint coordinator captures complete information necessary to prioritize and plan investigation of the allegations, including: information about the complainant and other individuals involved; specifics about the allegation, such as the type of incident, time, place, etc.; the frequency and pervasiveness of the allegation; the provider or supplier name and location; how and why the complainant believes the allegation occurred; whether the complainant initiated any other course of action; and what expectations or desires the complainant may have for resolution or remedy. (Suggested questions are listed on the Intake tab in ACTS.)

The complaint coordinator provides a complainant with information that assists in resolving his/her conflicts. Such information includes an explanation of the scope of authority of Bureau; BHS and the Centers for Medicare and Medicaid Services' (CMS) procedures for handling complaints; anticipated time frames and course of action; other appropriate sources of assistance; and BHS contact information for follow up purposes. See CMS Survey & Certification memo 04-09, Guidelines to Support Management of Complaints and Incidents and the National Implementation of the ASPEN Complaints/Incidents Tracking System (ACTS).

For the BHS Complaint/Incident Processing Desk Instructions detailing complaint processing and data entry instructions see Attachment 1.

II. OPENING COMPLAINTS

Screening determines whether an allegation of actual regulatory noncompliance has been made and whether DQA has jurisdiction or authority to act on the allegation. Complaint screening also determines the level of response required per BHS protocols and CMS requirements.

BHS complaints are promptly screened by the complaint coordinator, or by BHS management staff. Once it is determined that the allegation(s) falls within DQA's authority, the complaint coordinator triages the intake to determine the severity and urgency of the allegations, so that appropriate and timely action can be pursued in accordance with the State Operations Manual (SOM).
Priority categories from the federal data system are:

A – IJ (Immediate Jeopardy)
B - Non-IJ High

C - Non-IJ Medium
D - Non-IJ Low
E - Non-IJ Admin Review/Offsite Investigation
F - Referral-Immediately
G - Referral-Other
H - No Action Necessary

The priority category assigned to an allegation determines if a complaint will be investigated and how quickly it will be investigated. See CMS S&C memo 04-09, Guidelines to Support Management of Complaints and Incidents and the National Implementation of the ASPEN Complaints/Incidents Tracking System (ACTS) for a full description of the priority categories.

A. IJ (Immediate Jeopardy) is defined as, "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." Intakes are assigned this priority if the intake information indicates immediate corrective action is necessary because a provider's or supplier's alleged noncompliance may have caused, or is likely to cause, serious injury, harm, impairment or death to a patient. Such complaints must be investigated within 2 working days of receipt of complaint for non-deemed providers/suppliers, and within two working days of receipt of regional office (RO) authorization for deemed providers/suppliers. IJ also includes all EMTALA allegations. Federally authorized EMTALA investigations and federally mandated reports of death due to restraint/seclusion must be completed within 5 working days after authorization. Death alleged to be due to uncorrected defects in the physical environment or abuse causing serious injury by staff remaining in direct patient care are examples of IJ priorities. (See S&C Memo 04-23, regarding reporting deaths or serious injury from fire.) DQA must initiate onsite survey within two working days of receipt of information about fires resulting in serious injury or death.

B. Non-IJ High is defined as harm that impairs mental, physical and/or psychosocial status of such consequence to the person's well being that a rapid response is indicated. This level of complaint is represented by specific rather than general information, such as, descriptive identifiers, individual names, date/time/location of occurrence, description of harm, etc. This category includes the death investigations mandated under Wis. Stats. 50.04(2t) and 51.64(1) (deaths in psychiatric treatment areas caused by suicide, restraint, or psychotropic medications). State mandated death reports are assigned a due date within 14 days from the date of receipt of the report of the death. Other Non-IJ High complaints are assigned a due date for completion between 10 and 30 calendar days after receipt of the complaint, depending on the urgency and credibility (e.g., specific information) of the complaint. An isolated death alleged to be due to provider noncompliance, a pattern of nosocomial infection, and a pattern of development of severe pressure ulcers during hospitalization are examples of Non-IJ High priorities.

C. Non-IJ Medium is defined as noncompliance that has caused or may cause harm that is limited in consequence and, although not causing actual harm, may impact the care and treatment of patients. Non-immediate jeopardy complaints for providers with deemed status that are authorized by CMS require an onsite survey within 45 calendar days after approval by the RO. Examples of Non-IJ Medium priorities include: inadequate pain control following surgery; medication errors without serious effect; lengthy waits in the ER for persons with urgent though not EMTALA level medical problems; failure of nursing to notify the physician of a change in condition (without serious negative outcome); and discharge of a patient needing home health follow-up without adequate referral.

D. Non-IJ Low is defined as situations that may have caused physical, mental and/or psychosocial discomfort. An onsite survey may be scheduled within 120 calendar days. Examples of this priority include allegations that

the call light was not answered timely causing discomfort and irritation to the patient, allegations that visitors were improperly restricted, or allegations that a dietary consult was not obtained timely (with absence of serious negative outcome).

E. Administrative Review/Offsite Investigation is the priority used for complaints/incidents that are triaged as not needing an onsite investigation, but are investigated by an off-site, desk review to ensure compliance with the Federal requirements. The additional information is adequate in scope and depth to determine that an onsite investigation is not necessary; however, BHS has discretion to review the information at the next onsite survey. These allegations are potential regulatory violations with a low probability of resulting in actual harm or complaints with no allegation of actual harm. An on-site desk review consists of phone calls and/or letters to the provider and a summary of provider's actions in relation to the complainant's concerns. The provider may be asked to submit written documentation addressing the concern raised.

F. Referral - Immediately is the priority used for complaints/incidents so serious as to require referral or reporting to another agency, board or network immediately for investigation. Serious caregiver abuse reported by the provider who has already taken steps to protect the patients is an example of this priority. (See DQA Procedure Summary #1260, Referrals; DQA Memo # 04-004, Referrals to the Office of Caregiver Quality; BHS Memo # 01-004, BHS Caregiver Complaint Management Procedures; and the worksheet instructions titled, Attachment 2, Referrals From BHS, 3/5/04, updated 7/1/05.)

G. Referral - Other is the priority used for complaints/incidents that will be referred to another agency, board or network for investigation, or for informational purposes.

H. No action necessary is the priority used when adequate information about the incident/complaint yields the conclusion that BHS can determine with certainty that no further investigation, analysis, or action is deemed necessary. For all cases except EMTALA, that do not allege immediate jeopardy, and at BHS's discretion an intake may not require a new onsite investigation, if at a previously completed survey, the same events were investigated; the previously completed survey evaluated the appropriate individuals, including those identified in the intake; and the situation did not worsen. These types of intakes should be linked to the appropriate survey that has already reviewed the issue. Samples in this category may include:

- complaints that represent an isolated incident with minor negative outcome or low probability of resulting in harm;
- complaints in which the complaint incident occurred over one year from the date of receipt of the complaint, except in extraordinary circumstances;
- complaints about subjects outside the regulatory authority of DQA, such as billing issues;
- referrals to or from other agencies or DQA sections which lack substantial probability of provider noncompliance with regulations enforced by DQA;
- complaints alleging violation of Federal regulations in deemed providers that CMS has not authorized for investigation for which there is no allegation of violation of State regulations. This includes EMTALA allegations, most Discharge Planning allegations, some Patient Rights allegations such as allegations of failure to evaluate seclusion/restraint done for behavioral control within one hour, or restraint complaints that are medical only.

DQA/BHS enforces State regulations in hospital, home health, and hospice. The priority definitions above apply to the decision as to whether State only investigations are conducted. If another agency, such as MetaStar or the Office of Caregiver Quality, has or plans to investigate a complaint that is also referred to DQA/BHS/ACCS, investigation will be conducted only if:

- the allegations rise to medium or high priority, and
- actions of the other agency are not predicted to result in correction of provider deficient practice.

DQA/BHS and CMS Region V follow the procedures outlined in the CMS State Operations Manual (SOM). CMS Region V determines whether a complaint against a deemed provider alleges one or more Condition-level(s) of noncompliance. DQA/BHS conducts investigation of deemed hospitals, home health agencies, and ambulatory surgery centers under federal authority after it receives authorization via ACTS. Complaints alleging substantial noncompliance by deemed providers and suppliers that are authorized by CMS are investigated in accordance with CMS deadlines. Complaints alleging noncompliance by non-accredited providers and suppliers are investigated per the SOM.

The BHS complaint coordinator initiates data entry of the complaint record into ACTS and assigns a surveyor to an on-site or desk investigation as appropriate to the designated priority. See the BHS Complaint Processing Desk Instructions.

III. COMPLAINTS NOT OPENED

Assess written or telephone complaints using priorities described in Sections II.

Enter the complaint in ACTS.

No action necessary complaints are summarized in ACTS for future reference. Surveyors are expected to review the ACTS summary for these allegations prior to future surveys for subsequent investigations or other survey activities at the provider.

End State Renal Dialysis (ESRD) providers are required to report to DQA when a patient is involuntarily discharged. These reports should be entered in ACTS as an unopened entity-reported incident. See attachment 1.

IV. INVESTIGATION & CLOSURE

The surveyor investigates all assigned complaints in accordance with the State Operations Manual. See the online SOM at: http://www.cms.hhs.gov/manuals/downloads/som107c05.pdf

The surveyor follows the guidance of Region V ACTS NLTC Complaint/Incident Processing Guide, System Instructions for Deemed NLTC Complaints and Incidents. The surveyor chooses the Findings Text box on the Allegation Tab, then describes survey tasks and summarizes the investigative process and results. The Guide describes linking the investigation to the complaint/incident intake(s) via the "Full Investigation Properties" button or the investigation tab. If the investigation is not linked to the complaint/incident, linking the deficiencies is not possible. The surveyor links deficiencies to allegations by clicking the link deficiencies button below the list of allegations after citing the deficiencies. If deficiencies were cited that were unrelated to the allegations, they should not be linked to any allegations. In accordance with the Guide (quoted below), the surveyor enters allegation findings, substantiated vs. unsubstantiated, and reasons why.

A substantiated allegation is an allegation that did occur and is verified by evidence. An allegation is considered substantiated based on the finding about the individual or specific situation named by the complainant in his or her allegation; or, other residents or patients reviewed or similar situations, even if the noncompliance was corrected for the specific individual(s) named by the complainant in the allegation.

A. Federal deficiencies related to the allegation are cited.
B. State deficiencies related to the allegation are cited

C. No deficiencies related to the allegation are cited The SA determined that the allegation did occur. However, at the time of the investigation, the provider had taken action necessary to prevent the deficient practice, and/or the allegation was not serious enough to warrant citing deficiencies. (This is not applicable for EMTALA; for EMTALA see the State Operations Manual at §3410.)
D. Referral to appropriate agency After investigation, the complaint/incident was forwarded to the appropriate agency.

An unsubstantiated allegation is an allegation where evidence cannot support that the allegation did occur.

A. Allegation did not occur Evidence indicates that the allegation did not occur.
B. Lack of sufficient evidence The SA is unable to verify that the allegation did occur because of insufficient evidence. e evidence is inconclusive.
C. Referral to appropriate agency After investigation, the complaint/incident was referred to the appropriate agency.

If the investigation (EMTALA or deemed) was not authorized by the RO and is not going to be investigated under State regulations, the BHS complaint coordinator will change the priority to "no action necessary" and close the complaint/incident on the actions/close tab. If the complaint is not authorized but will be investigated under State regulations, the BHS complaint coordinator will change the intake subtype on the Intake Tab to "state licensure."

For on-site investigations see the Non-Long Term Care Citing Guidelines document. The surveyor should contact the complainant prior to the on-site visit to verify the allegations and determine it the complainant has further information. The surveyor should also phone the complainant when the on-site investigation is completed, and explain the tasks completed and the findings, and advise the complainant that they will be receiving a letter of response. If there are unusual circumstances affecting the post-survey phone call, the surveyor should consult with the supervisor.

For desk investigations, the assigned surveyor completes desk investigation survey by the date due. Surveyor refers survey packet (investigation form, supporting documents, and surveyor notes) to the office operations associate for entry in Aspen Central Office and then forward to BTLE.

At periodic scheduling meetings utilizing reports from ACTS, supervisors monitor complaint investigation progress. At the conclusion of a complaint investigation, supervisors review complaint materials and the Statement of Deficiencies using the Principles of Documentation. The complaint packet includes a packet checklist specific to provider type to assure that all required documents are completed and a survey record to assure that processing and follow-up are congruent with requirements including timeliness. Attachment 3 describes the internal checklist and survey record forms per provider types, which include complaint surveys. Supervisors sign appropriate documents and forward to the office operations associate.

The BHS office operations associate (OOA) sends the complaint investigation survey to BTLE if the complaint was federally authorized (a deemed provider or EMTALA) or has condition level cites. If a complaint is substantiated with cites or unsubstantiated with cites, the OOA enters survey information in ASO (670 time, dates in survey properties, plan of correction dates in "properties"). If a complaint is unsubstantiated or substantiated with no cites, the OOA will enter 670 time in ASO, print the 2567, and forward the packet to BTLE. The BTLE section processes the documents and sends to CMS RO V as required.

If the complaint was investigated under DHS 124 only or in a hospital that is either non-accredited or has lost deemed status, and has cites below the condition level, the BHS OOA processes the complaint. The OOA

serves the Statement of Deficiencies, prepares applicable follow up notes, begins ACO data entry, and sends the packet to the BTLE section for processing and data entry into the federal complaint subsystem as required.

Any complaint for any non-long term care (LTC) facility that has a Medicare number must come to BTLE for complaint processing. The BTLE staff person completes ACTS data entry, uploads and then closes the complaint. If the complaint concerns a facility that is state-licensed only, the complaint can go directly to the DQA File Center.

For a table of which staff is responsible for complaint closures according to complaint type, see Attachment 4.

BTLE staff will assure that the following ACTS fields are completed:

- Investigated by (required for priorities IJ through IJ Low)
- Check the "Forward to RO/MSA" box: only check this box when the following conditions are met: all SA required fields, as defined by the Guide and S&C Memorandum 04-09, have been completed including the CMS-670 and CMS-2567; the completed package has been sent in the mail (see NOTE below); a narrative is available for viewing (see section II-C, subsection iii)
- NOTE: In addition to the forms and information obtained in ACTS by the RO, i.e., the CMS-2567, CMS-670, allegation findings/narrative report, etc, there are several forms still required to be mailed to RO for completion of the complaint/incident review process. These forms are detailed in Appendix D of the Region V ACTS NLTC Complaint/Incident Processing Guide–under "Forms to be Mailed to the RO."

If an authorized complaint is referred to the SA from the RO, then the RO will complete the following field. Otherwise, BTLE completes the following field:

- Acknowledgement date (will reflect on the CMS-562 and will be uploaded to OSCAR, the SA should complete this field at the time they acknowledge the complaint/incident in accordance with SOM 3260). No acknowledgement date is required for an entity-reported incident or an anonymous complainant.

BTLE also completes the following fields:

- Proposed Actions-Federal: Can only be entered if an onsite investigation is scheduled. Will appear as #12 on the CMS-562;
- Proposed Date-Federal: According to S & C Memorandum 04-09, attachment 3, this is the date of the notice sent to the provider/supplier informing the provider/supplier of actions that may be taken as a result of the investigation findings. If the provider/supplier is in compliance, the proposed action date is the date the provider/supplier is notified that it is in compliance. (The date of the exit conference can be entered here.)
- Overall findings: this field will populate from the findings entry on the allegation tab.
- "Forward to RO/MSA" Check box and date: this check box and date will carry forward from the investigation tab; see the section J for instructions on this field.

If the investigation was of a death, reportable under Wisconsin Statutes Chapter 51.64, the OOA sends two copies of the complaint investigation summary, the Statement of Deficiencies if any, and the state death report forms to the BHS Reportable Death Review Committee member.

For guidance on ACTS data entry timeframes, see Attachment 5.

For guidance on ACTS required fields, see Attachment 6.

ATTACHMENT 1: BHS COMPLAINT/INCIDENT PROCESSING DESK INSTRUCTIONS

After assessing and determining a priority level, the complaint coordinator records the complaint in the federal complaint system, ACTS.

NOTE: Adjust the due date to reflect the priority of the complaint. State mandated entity reports of deaths resulting from suicide or use of psychotropic medications should be assigned an investigation due date within 14 days of the receipt date. Complaints prioritized as non-IJ Medium should be given a due date of 45 calendar day (ACTS will calculate either working or calendar days), entered on the Intake Tab. Complaints prioritized as IJ, non-IJ high, deaths resulting from use of restraint or seclusion, or EMTALA will have shorter due dates: 5 days from CMS authorization for EMTALA, 2 days from CMS authorization for IJ, and 10 to 30 calendar days for non-IJ High A change in due date of up to six months from the date of intake may be made if the complaint is prioritized as non-IJ low, is being investigated under State authority only, or when an extension of due date is made by supervisors or CMS due to unique circumstances. Due dates may be extended to coincide with a scheduled recertification survey in the interests of efficiency, or when required by unit scheduling needs.

For complaints in category E, desk reviews only, the complaint coordinator assigns a surveyor who may be the lead worker. For complaints that will not be investigated, no data is entered in the CMS complaint system. In ACTS, use the "findings/text" box on the Allegations Tab to describe what action was taken (such as referring the caller to MetaStar, Department of Regulation and Licensing) and to describe rationale (i.e., allegations do not describe a regulatory violation). Close the complaint in the Actions/Close Tab by checking the flagged Finalized checkbox and reason closed checkbox (usually, "no jurisdiction"). The date field auto-dates.

ACTS Data Entry:
Open ACTS and use the Find field or the provider on the alphabetic list of the drop down to locate the provider/supplier. Highlight the provider and left click to the menu. Choose New Intake.

On the **Intake** top tab screen enter appropriate data into the following fields:

- Intake staff section: the State Agency and your name are defaults. Change this if that is not accurate.
- Assignment section:
  - Intake Type: choose Complaint or Entity Reported Incident from the dropdown.
  - Intake Subtype: choose appropriate subtype from drop-down menu. Choose A, federal, for complaints that will be investigated in non-accredited providers and for complaints in deemed providers that will be submitted to CMS. Choose B, state licensure, for investigations that will be conducted under State authority only. After a complaint categorized as A is disapproved by CMS, change the subtype to B if a State only investigation is planned. If no investigation will be conducted, choose C, No State or Federal compliance issue.
  - Received by: choose from the drop down the method of receipt, i.e., Email, Telephone, etc. Complaints received via the online complaint system are considered "Email."
  - Location received: default is the region where the provider is located; if the provider is not in the Madison region but the complaint was received in Madison, change to BHS-MADISON.
  - Responsible parties: click the + Add S.A. and choose Cremear Mims, Marsha Musillami, Jan Heimbruch, and Mark Andrews under S.A. Click the + Add R.O. and choose Michael Potjeau and Heather Lang for deemed and accredited hospital, home health, hospice or ASC complaints.
  - Responsible team: defaults to the region where the provider is located. Change to the region where the surveyor assigned to do the complaint investigation is located. For EMTALA, federal only complaints, or no investigation complaints, scroll to the bottom of the regional office choices in the drop down and make it blank.

Complainants, Residents/Patients, Alleged Perpetrators section:

- Enter the last and first name of the complainant and click the + Add button. If the complainant's name is already in ACTS, ACTS will display the entry. If the complainant is the same person, select the existing entry. If it is not, click NEW (lower left corner) to add this name as a new entry. To change the address phone number etc., as necessary, click "Modify" by the existing name. If the complaint is anonymous, click the button labeled "Add Anonymous." (Required)
- Enter the last and first name of the patient and click the + Find/Add button. If the patient's name is already in ACTS, ACTS will display the entry. If the patient is the same person, select the existing entry. If it is not, click NEW (lower left corner) to add this name as a new entry. Enter the patient's gender.

Source section:

- Scroll down to this section and check the applicable box describing the source of the complaint. (Required)

Response Information section:
Check the box describing the priority of the complaint (required). If the complaint is a federal only complaint that is not authorized by CMS, the priority must be changed to H, no action necessary, before the complaint can be closed in ACTS. For complaints in deemed facilities that are not authorized by CMS and that the State does not plan to investigate under state authority only, the complaint coordinator completes this action at the time the federal decision is received and the complaint is closed.

The "investigate within" box is below the box of priority choices (required). Assign a date derived from the priority of the complaint. For Non-IJ Medium complaints, enter 45 calendar days, using the ACTS calculator.

If CMS authorizes an investigation in an accredited provider, change the due date to 45 calendar days from CMS authorization.

The beginning and end dates of the intake will fill in automatically. Type over these dates if correction is required.

State only complaints generally have a lower priority than complaints that have a federal component, and the time frame may be extended up to six months. This includes providers that have a state license, but no Medicare certification in Wisconsin (such as HHA branches in Wisconsin whose home agency is Medicare certified in a bordering state), and when implemented, Personal Care Worker agency complaints. If the complaint is prioritized as "A-IJ" or "B-Non-IJ High," the complaint will be investigated within ten, 30, or 45 calendar days depending on the severity of the allegations.

Attachments:
For complaints received by mail:
The original letter and any supporting documentation goes to the OOA, who makes a copy and forwards to the assigned surveyor for inclusion in the packet. Original documents may also be scanned into a pdf format and attached to ACTS via the "Attach" button at the bottom of the Intake tab page. The OOA faxes material to CMS as needed by CMS.

Complaints about home health and hospice providers received via the Home Health Hotline are begun in ACTS by BTLE section staff. Review the ACTS entries, prioritize the complaint, assign a due date, and fill out the "Activities" tab in ACTS for surveyor assignment and response letter assignment.

On the **Allegation** top tab screen enter appropriate data into the following fields:
Allegations section:
For complaints other than EMTALA, go to the allegations tab, click on the Add icon, and choose the category that applies to the allegation. There may be more than one category. Click OK. Enter the content of the allegation in the appropriate category. Start with a "key:" patients are assigned numbers, and everyone else is assigned letters. An explanatory sentence above the key, especially for "other" (i.e., "This part of the complaint alleges that the medical record was not made available when requested by the patient.") may be helpful.

If the complaint was received via e-mail, cut and paste the e-mail into the appropriate allegation category.
For complaints or entity reported incidents involving patient death in a hospital due to restraints or seclusion, after the Allegation is completed, a box will appear on the Allegations tab titled Deaths Associated with the Use of Restraints/Seclusion. This box will auto populate with the patient name and death type. Fill in the fields for Reported, Date of Death, and Setting. CMS will fill in the fields for AO Notify, To P&A, RO Notify, CO Notify. These fields must be completed before the complaint can be closed.

On the **EMTALA** top tab screen section:

Go to this tab if the allegation is EMTALA. Check the boxes for "create EMTALA allegation" and "request RO approval." These allegations will open automatically on the allegations tab. Check the box indicating the type of emergency alleged. Then go to the Allegations tab and enter the content of the allegation(s).

On the **Deemed** top tab screen section:

Check the box by the flag requesting RO approval. Check the deemed box if it is not auto-checked for deemed providers.

On the **Activities** top tab screen section:

Go to "Activities" tab in ACTS and fill in "letter to complainant" and "schedule onsite investigation" assignments with staff names if the complaint is being opened. First, click "add" and pick the type of action ("letter to complainant" and "schedule onsite investigation"). Click SA and add the name of the staff responsible, then click OK at the bottom of the box. Each task must be assigned separately. Click "add" to assign the next task and repeat choosing the task, assigning specific staff, and clicking "OK." Do not assign a surveyor to EMTALA or "federal only" until CMS decides the approval status of the complaint.

The complaint coordinator assigns a surveyor, using criteria of geographical proximity, workload balance, training needs, other surveyor responsibilities, and special competencies. Supervisors communicate needs for change of assigned surveyor to the complaint coordinator. Complaint assignments are reviewed in bimonthly surveyor meetings to maximize efficient use of surveyor time and resources.

Next Steps:
When complaint intake is completed, send an e-mail with facility name, ACTS # in the subject line to CMS if the complaint is EMTALA, an accredited facility, or a potential IJ. Using the Outlook resend function, resend the e-mail, and for non-accredited and State authority only complaints, send an original e-mail, to:

- Office operations associate(OOA) responsible for the letter of acknowledgment;
- assigned surveyor;
- both supervisors.

Add the due date in bold in the subject line.

The OOA sends an acknowledgement letter to complainant, if applicable, and starts a document file consisting of a copy of the letter, and any supporting documentation.

Save these e-mails in the shared Outlook folders.

For ESRD complaints, notify Network #11 by e-mail of the provider and content of the complaint (see the worksheet, Attachment 7, Collaboration With ESRD Network # 11). For reports of involuntary discharge of patients from an ESRD, the DQA staff receiving the report asks, or asks the provider to e-mail with specific responses that can be cut and pasted into the ACTS "Allegations" section, (1) reason for involuntary discharge, (2) summary of provider efforts to solve the problem causing the discharge, and (3) actions the provider has taken to assure that the patient continues to receive dialysis. The report is entered in ACTS as an entity reported incident, and closed at the same time unless the content of the report suggests that onside investigation is warranted.

When PCW regulation is implemented, a section for PCW complaints should be added to the binder.

<u>On-line complaints processing:</u>
BHS complaint intake staff will check the BHS/OCQ email box (DHFSDQABHSACCS) at least twice a day or set up an email box rule to forward received emails to their personal email box.

If the complaint is not going to be opened, cut and paste the online form into an Outlook e-mail, title it with the name of the complainant and the facility (i.e. "Brewster re Psych Co Hospital), and send it to the complaint coordinator. These e-mails will be saved in an Outlook folder that will track all online complaints received.

If the complaint is going to be opened, or if it may be opened, cut and paste the complaint into a Word document; do a "save as" using complainant name and provider name and save at O:\BQA\BHS\BHS. Complaints\Online complaints\.doc. Example: O:\BQA\BHSBHS. Complaints\Online complaints\Brewster re Rock Co Psych.doc

Answer the complainant via e-mail. Attach the Word document that is a copy of the online information. Blind copy yourself, complaint coordinator, and ACCS OPA. If the complaint is being opened, this e-mail will be the acknowledgment letter. If further information is needed, request it in the e-mail. If complaint coordinator is only away for a day, direct the complainant to respond to complaint coordinator and give complaint coordinator the e-mail address and phone number. If complaint coordinator is away for more than a day, direct the complainant's response to the back-up staff.

Move your e-mail response into the Shared Folder in Outlook that is labeled "Online Complaints" If the complaint concerns solely an ACCS provider, this folder should have an e-mail that tells the complainant whether or not the complaint is being opened. If the complaint concerns allegations of abuse, neglect, or misconduct by a licensed professional, respond back to OCQ for OCQ investigation only for referral to another agency.

From this point forward, for complaints being opened, process according to Procedure 3212, including ACTS data entry. The WORD document should be attached in ACTS.

<u>Hotline Complaint Processing</u>
BHS complaint intake staff will check the 1-800-642-6552 number twice a day. For home health, hospice, hospital, and ESRD, call the access number 1-8020. Upon the system answering, press **, 608-300-5203.

When prompted, enter passcode 300-5203. The AODA/MH mail box is accessed at 1-8020, then ** 608-300-5204, passcode 300-5204.

Complaints will be triaged using the established process described above.

Section Chiefs will be notified of opened or pending complaints.

ATTACHMENT 2: REFERRALS FROM BHS

If call concerns disputed billing, Consumer Hotline: 1-800-422-7128., Wisconsin Department of Agriculture, Trade, & Consumer Protection

Physician practice issue when patient was a Medicare beneficiary: MetaStar, Inc. 1-800-362-2320, or write 2909 Landmark Place, Madison, WI 53713.

Personal Care Worker agencies, Medicaid program contacts include:

- Helen Derrickson at (608)261-7782
- Kerry Cantwell at (608)266-3142
- Cindy Zander (608) 261-4955

If the provider is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the person may file a complaint with JCAHO by writing to:

JCAHO
1 Renaissance Boulevard
Oakbrook Terrace, IL 60181

Or contact JCAHO by calling 1-800-994-6610, or by e-mail to complaint@jcaho.org

Complaints about individual providers licensed by the Department of Regulation &Licensing: (608) 266-7482.

Complaints about Family Care:

- Contact member rights specialist at the CMO. This is usually by county; get more information from Monica Deignan. CMO phone numbers at http://dhfs.wisconsin.gov/Medicaid2/handbooks/familycare/index.htm
- Milwaukee is: CMS Quality Improvement Coordinator at (866)229-9695
- Monica Deignan, 1 West Wilson, Madison WI, Rm 518, phone 608 261-7807

Persons possibly eligible for services from Aging and Disability Resource Centers contact: http://dhfs.wisconsin.gov/medicaid6/handboooks/familycare/pdfs/appendix2.pdf except, LaCrosse RC is (608) 785-6050 and Milwaukee RC is (414)289-5950.

Mental Health and AODA consumers: each provider is required under HFS 94 to have a grievance system, the results of which can be appealed.

Ambulance complaints: Bureau of Emergency Medical Services & Injury Prevention, Emergency Medical Services Section is (608) 266-1568 in the old phone book. EMS phone # on the intranet is 608/ 266-9781. This is in the Division of Public Health.

Privacy complaints: HIPAA, Region V - U.S. Department of Health & Human Services
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX
http://www.hhs.gov/ocr/hipaa/
Medicare Fraud: 1(800) 447-8477
Medicaid Recipient Hotline: 1(800) 362-3002

Medicaid Fraud: Alan White, Division of Healthcare Access and Accountability, (608) 266-7436

Medical Mediation Panels
Randy Sproule, Director
110 East Main Street, Suite 710
Madison, WI 53703-3356
Phone: (608) 266-7711
Fax: (608) 261-2352

Additional resources may be found through the nearest county Aging and Disability Resource Center. A Directory is found at: http://dhs.wisconsin.gov/LTCare/Generalinfo/adrccontactlist.pdf

ATTACHMENT 3: PACKET CHECKLIST AND SURVEY RECORD FORMS

Hospital, F62516, Hospital Survey Packet Checklist: Checklist of forms and documents for each category of hospital survey, i.e., accredited federal random sample, non-accredited T-18 full survey; accredited hospital federal complaint validation, non-accredited T-18 hospital complaint; accredited hospital validation verification visit; non-accredited T-18 validation visit; federal EMTALA, HFS 124 only initial, HFS 124 only verification visit, HFS 124 only complaint.

Hospital, F62068, Health and Life Safety Code Survey Record: History of survey actions and reviews. Includes survey type, COPs out, existing and initial waivers, IJ status, SOD information, dates of data entry.

HH & Hospice Survey Packet Checklist, F62314: Checklist of forms and documents for HH recertification surveys, home visits, verification visits, and complaint investigations; and checklist of forms and documents for hospice recertification surveys, verification visits, and complaint investigations.

HH & Hospice, F62278, Home Health or Hospice Survey Record: History of survey actions and reviews, including tracking for HH Master Survey Schedule and recommendations for type and timing of verification visits.

Swingbed, CORF, and OPT, F62632, Survey Packet Checklist: Checklist of forms and documents for each provider type, including verification visits.

CAH, ESRD, ASC, and RHC, F62631, Survey Packet Checklist: Checklist of forms and documents for each provider type, including verification visits.

ATTACHMENT 4: CLOSING OF COMPLAINTS

Provider & Survey Type	ACTS Closure	**Notes**
State only investigation completed	Hospital/Other OOA	
State only no investigation	BHS Complaint Coordinator	
Deemed investigation completed	CMS	See page 14 of ROV ACTS Hospital Complaint Incident Processing Guide
Deemed no investigation	BHS Complaint Coordinator	
Non-accredited investigation completed	BTLE ODIE/OSCAR DE OOA	See page 13 of ROV ACTS Hospital Complaint Incident Processing Guide
Non-accredited no investigation	BHS Complaint Coordinator	
State only investigation completed	HHA/Hospice OOA	
State only no investigation	BHS Complaint Coordinator	
Deemed investigation completed	CMS	To parallel hospital procedures in ROV ACTS Hospital Complaint Inci-dent Processing Guide see page 13
Deemed no investigation	BHS Complaint Coordinator	
Non-deemed no investigation	BHS Complaint Coordinator	
Non-deemed investigation completed	BTLE ODIE/OSCAR DE OOA	
No investigation required	BHS Complaint Coordinator	
Investigation completed	BTLE ODIE/OSCAR DE OOA	

ATTACHMENT 5: ACTS--DATA ENTRY TIMELINES

With respect to complaints and self-reported incidents, state agencies are required to enter the following intakes into ACTS:

- Complaints that allege noncompliance with the Federal condition(s) of participation (COPs), condition(s) for coverage (CFCs), or requirement(s) for participation (RFPs).
- Incidents that lead to an onsite survey of the Federal COPs, CFCs, or RFPs.

Unless there are extenuating circumstances, the following table describes the general timeframes in which SAs must enter data:

Timeframe in which to enter data	Required ACTS fields to which the timeframes apply
Within 5 working days of the date the intake is triaged (Received End date)	Intake Type Intake Subtype Complainant Name Source Received Start Date Received End Date Complaint Priority Investigate within X Days Investigation Due By Allegation Category
If the intake is linked to an onsite survey - Within 15 working days of the survey exit date.	Allegation Findings Category Allegation Findings Subcategory Whether the Intake is Linked to a Survey Whether the Allegation is Linked to a Deficiency
If an onsite survey is conducted - Within 30 working days of the survey exit date.	Intakes linked to an onsite survey Investigated by Investigation Completed Notifications: Type, Party, Method, Notification Date Proposed Action Proposed Action Date Reason Closed Date Closed
If an onsite survey is not conducted - Within 30 working days of the date the intake is received (Received End date).	Notifications: Type, Party, Method, Notification Date Proposed Action Proposed Action Date Reason Closed Date Closed

ATTACHMENT 5: ACTS-EMTALA--DATA ENTRY TIMELINES

SAs are required to enter all intakes that allege a violation with EMTALA. Unless there are extenuating circumstances, the following table describes the general timeframes in which SAs must enter data:

Timeframe in which to enter data	ACTS fields to which the timeframes apply
Immediately (Within 2 working days of the Received Start date).	Intake Type Intake Subtype Complainant Name Source Received Start Date Received End Date Allegation Category EMTALA Request for RO Approval Checkbox EMTALA Request for RO Approval Date
If an alleged EMTALA violation is found - Within 10 working days of the survey exit date.	Allegation Findings Category Allegation Findings Subcategory Whether the Intake is Linked to a Survey Whether the Allegation is Linked to a Deficiency, if applicable
If no alleged EMTALA violation is found - Within 15 working days of the survey exit date.	Allegation Findings Category Allegation Findings Subcategory Whether the Intake is Linked to a Survey Whether the Allegation is Linked to a Deficiency, if applicable

ATTACHMENT 6: ACTS REQUIRED INTAKE FIELDS

TAB	FIELD(s)	DEFINITION
Intake	Intake Type	1) Complaint - A complaint is a report made to the SA or RO by anyone other than the administrator or authorized official for a provider or supplier that alleges noncompliance with Federal and/or State laws and regulations. 2) Incident - An incident is an official notification to the SA or RO from a self-reporting provider or supplier (i.e., the administrator or authorized official for the provider or supplier).
	Intake Subtype (for Complaints)	Federal COPs, CFCs, RFPs, EMTALA: The allegation relates to noncompliance with the Federal condition(s) of participation (COPs), condition(s) for coverage (CFCs), requirement(s) for participation (RFPs), or EMTALA requirement(s). This would include allegations of noncompliance with Federal requirements only or both Federal and State requirements. (SAs and ROs are required to enter these cases into ACTS.) State-only, licensure: The allegation is related to noncompliance with State licensure requirements only. (SAs have the option to enter these cases into ACTS.) No State or Federal provider compliance issue involved: The allegation does not relate to noncompliance with Federal or State survey and certification requirements. (SAs have the option to enter these cases into ACTS.)
	Intake Subtype (for Incidents)	Federally required, entity-reported: A provider or supplier is required by Federal law, regulation, or policy to report this type of incident, which includes the following: 42 C.F.R. §482.13(f)- Standard: Seclusion and restraint for behavior management. The hospital must report to CMS any death that occurs while a patient is restrained or in seclusion, or where it is reasonable to assume that a patient's death is a result of restraint or seclusion. (SAs and ROs are required to enter into ACTS all incidents that lead to an onsite survey of Federal requirements or conditions.) State-required, may result in Federal noncompliance, entity-reported: A provider or supplier is required by State law, regulation, or policy to report this type of incident to the SA. This type of incident may result in noncompliance with a Federal condition(s) of participation, condition(s) for coverage, requirement(s) for participation, or EMTALA requirement(s). For incidents of this type, the SA must follow CMS policies and procedures to investigate Medicare/Medicaid complaints, no matter the source of information. (SAs and ROs are required to enter into ACTS all incidents that lead to an onsite survey of Federal requirements or conditions.) State-required, all other, entity-reported: A provider or supplier is required by State law, regulation, or policy to report this type of incident to the SA. This type of incident does not imply noncompliance with Federal conditions or requirements. (SAs and ROs are required to enter into ACTS all incidents that lead to an onsite survey of Federal requirements or conditions.) Reported by other agencies: As defined by the State. None of the above: A provider or supplier is not required by Federal or State laws, regulations, or policies to report this type of incident. (SAs and ROs are required to enter into ACTS all incidents that lead to an onsite survey of Federal requirements or conditions.)

ATTACHMENT 7: DQA COLLABORATION WITH ESRD NETWORK #11

To implement the Agreement for Collaboration between Renal Network of the Upper Midwest, INC (ESRD Network #11) and Wisconsin Department of Health Services, finalized 6/15/04, the Division of Quality Assurance will undertake the following measures:

1. BTLE staff will forward to the Network #11 Director of Quality Improvement and Consumer Services copies of all Statements of Deficiency from recertification and complaint surveys. BTLE will also forward facility plans of correction for incidents voluntarily sent by the facility. BTLE will keep documentation of accomplishment of these tasks.

2. BHS supervisor will notify the Network by phone of any findings of Immediate Jeopardy. This notification will be followed up by an e-mail. The e-mail will cc'd to the BHS supervisor, and saved in the Outlook shared folder titled "Network 11" for purpose of documentation.

3. BHS will consult any information provided by the Network, including facility rankings, in the development of the annual recertification schedule. Documentation will be in the form of a column reflecting Network rankings on the annual recertification schedule.

4. The BHS complaint coordinator will send an e-mail with the substance of all complaint allegations scheduled for investigation under Medicare certification regulations to the Network. These e-mails will be saved in a Outlook Shared Folder entitled "Network 11" for purpose of documentation.

5. The BHS complaint coordinator will refer complaints received that do not represent a violation of Medicare regulations to Network #11. These referrals will be documented in the BHS Uninvestigated Complaints log.

6. As many BHS ESRD surveyors as practically possible will attend the Network's annual meeting and Network educational offerings. DQA training coordinator's files will document these attendances.

7. Informal phone contacts between ESRD surveyors and Network staff will continue as is past practice. Surveyors will summarize these phone calls in an e-mail to the Complaint Coordinator to save in the Outlook Shared Folder entitled "Network 11"