univera HEALTHCARE

SUBJECT: ONGOING MONITORING: MEMBER COMPLAINTS and ADVERSE EVENTS SECTION: CREDENTIALING/RECREDENTIALING POLICY NUMBER: CR-10A	EFFECTIVE DATE: 7/1/25
Applies to all products administered by the Plan	

Policy Statement: The Health Plan has a process in place to identify and, when appropriate, refer to a Health Plan Medical Director, cases requiring action on important quality, service, and safety issues. The Health Plan reviews data on a regular basis for evidence of patterns suggestive of quality, service, or safety issues, including reviewing for adverse events monthly. The Health Plan addresses instances of poor quality in the intervals between recredentialing cycles. A practitioner monitoring report is developed every six months for any practitioners who fall within the scope of credentialing. The monitoring reports may include, but are not limited to, clinical review, member complaint review, medical record review, and sanctions/litigations. The information reported assists with identifying opportunities for practitioner improvement, assures practitioner performance monitoring is ongoing, and conducted prior to the practitioner re-credentialing date.

Definitions:

Member Complaint: A member's expression of dissatisfaction with the action(s) of network practitioner(s)
Adverse Event: An injury that occurs while a member is receiving health care services from a practitioner (Severity level 2 or higher)
Practitioner: A licensed or certified professional who provides medical care or behavioral healthcare services

Data Sources:

Clinical Quality of Care Concerns: Advocacy records quality of clinical care concerns and coordinates case reviews. Quality of Care concerns with a severity level of 2 or higher, are considered "Adverse Events", and are also reported separately. A Medical Director reviews each individual concern along with any previous history on the physician in review to determine if there are any patterns and trends identified. The Medical Director determines when additional review and/or action are required.

Member Complaints: Health Plan staff record member complaints received by phone, in person, or in writing. Complaints are categorized as they are received, and the data analyzed and reported quarterly. The Medical Director may take action based on regular review of practitioner complaints or upon identification of patterns or trends.

In addition to the above sources, the following data sources may be used, when available, to monitor

providers:
Member Satisfaction: Member satisfaction with PCP, for example collected by Clinical & Group CAHPS surveys, is included as available. The plan may also conduct periodic patient satisfaction surveys.

Access/Availability: The Plan routinely measures access and availability of PCPs. OB/GYNs and Behavioral Health practitioners (See policy QI/BH-01A and QI/BH-01B).

Process:

The Credentialing Department gathers complaints and Quality of Care Concerns reported to the Customer Advocacy Unit (CAU), Medicare Advocacy Unit (MAU) or Customer Care monthly. Findings are reported to the Corporate Credentialing Committee. Should an adverse event be identified, the finding is reported to the next Corporate Credentialing Committee (CCC) meeting. The CCC will recommend appropriate interventions to address quality and safety issues.

Every six months, Practitioners with complaints from three or more members in a three-year period are identified as a "Provider Outlier". Duplicate complaints filed from the same member, or multiple family members are counted as one complaint. A Provider Monitoring report is created and shared with the Medical Director. This report includes trended adverse event volumes, newly identified Provider Outliers, and a report on follow up complaints from previously identified Provider Outliers. The Medical Director reviews the cases, and feedback occurs as needed.

During the review, "themes" within the complaints will be identified.

The Medical Director may initiate a range of actions including, but not limited to:

- Initiate additional research such as peer review of selected medical records, initiation of Special Investigations Unit (SIU) inquiry, or survey of a sample of patients
- Decision to track and trend the case
- Outreach to the identified provider directly or through the appropriate Provider Relations Representative.

Outlier cases and themes are then brought to the CCC for discussion.

Once a final determination is made, all related documents and research are placed in the practitioner's credentialing file. In addition, a remark will be added to the notes section of the practitioner's file in the credentialing system to alert recredentialing staff there is a monitoring
report on file. This information is made available for the Medical Director at the time of recredentialing. A list of newly identified outliers is additionally sent to the Special Investigations Unit for review.

Committee Approvals:
Corporate Credentialing Committee: New policy 6/18/2025;