DMS Inquiries and Complaints - Quick Reference Guide

WHY

- ✓ **To provide exceptional service to the Department for Medicaid Services (DMS), providers, and members.**
- ✓ **To be accountable for our role in the process and to each other.**
- ✓ **To avoid fines and penalties when we miss DMS deadlines.**
- ✓ **To decrease unnecessary e-mails**

Acknowledgement

- ✓ <u>If you are on the Compliance e-mail</u>, immediately acknowledge via email to the group that you are reviewing the inquiry, indicate if you have a role in the response or if you do not have a role. Identify yourself as a response owner (if appropriate). All subsequent responses should be provided by the lead/response owner (e.g. <u>if you are cc'd on the initial request</u>, coordinate with your lead/response owner who will submit information regarding the response).

Questions/Clarifications

- ✓ If you have questions about the request, send them to Compliance as soon as possible. It shines an unfavorable light on Passport when we wait days or until near the due date to ask for clarifications.

Response Owner

- ✓ All response owners must provide a **complete response** and answer every component of the inquiry. This includes completing the **DMS Provider Inquiry/Complaint Form** in its entirety (sample attached), if it is attached to the original e-mail.
- ✓ Response owners depending on information from subcontractors are strongly encouraged to request the response several hours prior to the Compliance deadline to give some cushion.

Resolution/Response Summary

- ✓ Ensure your response is DMS ready. Pretend your e-mail will be sent to DMS. Make sure it
    - 1) is clear and concise,
    - 2) is grammatically correct and free of spelling errors,
    - 3) includes the detail needed from your area (see below) and
    - 4) can be understood by <u>someone who is not familiar with the issue</u>.

- ✓ In your response summary, identify:
    - **Complaint/Issue**
    - **Root-Cause**
    - **Resolution & steps being taken to prevent or reduce the issues from recurring**

- ✓ If you are providing data, conduct a quality check to make sure it is accurate and complete. For example, look for, investigate and correct:
    - Inaccurate or questionable calculations
    - Invalid negative numbers
    - Missing or conflicting data
    - Formatting errors
    - Variation from historical trending
    - Data does not support previous reports
    - Totals are missing

Provider Outreach (required for ALL inquiries and complaints)

- ✓ Indicate PNM team member who will conduct outreach
- ✓ A minimum of 2 contacts to the provider:
    - 1st outreach upon receipt of the e-mail to inform provider the complaint is in review
    - 2nd outreach upon resolution of the issue to explain the resolution
    - If there were claims reprocessed, provide spreadsheet with remit detail. If remit detail not yet available, communicate date on which detail will be available and send it to Compliance
- ✓ Document outreach for the response. Include
    - Number of outreach attempts **(DMS best practice is 3 attempts)**
    - Date and time of each outreach
    - Name of person contacted
    - Type of contact
        - Email
        - Phone call (indicate if voicemail left)
    - Summary of the discussion (prior discussions with the provider regarding the issue, description of the issue as described by the provider, how you assisted, if the issue is resolved, the next steps including timeframes you shared with the provider, etc.)

Member Outreach(member specific/related complaints)

- ✓ Indicate who will conduct outreach
- ✓ A minimum of 2 contacts to the member:
    - 1st outreach upon receipt of the e-mail to inform the member the complaint is in review
    - 2nd outreach upon resolution of the issue to explain the resolution
- ✓ Document outreach for the response. Include
    - Number of outreach attempts (DMS best practice is 3)
    - Date and time of each outreach
    - Type of contact
        - Email
        - Phone call (indicate if voicemail left)
    - Summary of the discussion (prior discussions with the member regarding the issue, description of the issue as described by the member, how you assisted, if the issue is resolved, the next steps including timeframes you shared with the member, etc.)

Claims and Reworks

- ✓ If claims will be reprocessed, indicate the estimated date of completion for claims reprocessing & adjudication
- ✓ All claims detail must have:
    - Payment Date
    - Payment Amount
    - Check #/EFT Transaction #

Reimbursement

- ✓ Description of root cause
- ✓ Description of resolution/fix
- ✓ Planned claims re-processing activity.

Extensions

- ✓ Request at least 24 hours before the due date and include the rationale for the extension.

Follow-Up Requests

Complete and accurate responses decrease both internal and DMS requests for additional information! In some instances, our response to DMS requires follow-up to close the inquiry (e.g., re-processing of claims, provider enrollment). Flag these cases and send the follow-up to Compliance as noted in your response.