



Just Ask...we can help to resolve your health care concerns

IFMC is the Medicare Quality Improvement Organization for Iowa. If you have a concern about the quality of care you or a family member received, you can request we review your case.

Examples of quality concerns IFMC can address are:

- ♦ Medication errors
- ♦ Unnecessary or inappropriate surgery
- ♦ Change(s) in condition not treated
- ♦ Discharged from the hospital too soon
- ♦ Incomplete discharge instructions and/or arrangements

Examples of concerns IFMC cannot address include:

- ♦ Items of comfort, such as the temperature of your room
- ♦ Inadequate housekeeping
- ♦ Communication problems
- ♦ Questions about your bill or what Medicare covers

The purpose of our review is to work with the health care providers and doctors to improve current and the future care they give. When a concern is found, IFMC takes steps to find out what may have caused the concern so it can be prevented from happening again.

Our review is based on what is written in the medical record. Our staff will not conduct formal interviews or go on-site at any of the facilities you may have concerns with. Based on the medical record, we will tell you if the care you received met professionally recognized standards of health care. Federal law limits what we can tell you.

If you decide to make a formal complaint your concerns must be put in writing. You can print and complete the following Medicare Beneficiary Complaint Form and return it to us or you can call us to help you with this process.

Mail: IFMC
Attn: Medicare Beneficiary Protection Team
1776 West Lakes Parkway
West Des Moines, IA 50266-7771

Fax: 515-223-2141

Phone: 800-752-7014

Once IFMC receives the written complaint, a formal quality of care review begins. Please keep in mind the entire process is lengthy, and may take up to 120 days to complete.

An IFMC case manager will:

- ◆ Serve as your point of contact throughout the process
- ◆ Work with you to keep you informed of the progress of the case
- ◆ Request the necessary medical information from the health care facility and/or doctor's office
- ◆ Forward your written quality of care concern(s) and the medical record to an independent physician

An independent physician who is licensed and in active practice in the state of Iowa will:

- ◆ Review all of the available medical record(s)
- ◆ Evaluate all aspects of care surrounding the complaint
- ◆ Make a quality of care determination on whether the services provided met professionally recognized standards of health care

Thank you for your interest in the Medicare beneficiary complaint process. Every time a consumer voices a concern, it enhances our health care system by increasing provider sensitivity and awareness.

Please contact us at 1-800-752-7014 if you have any questions or need help in filing a complaint. For questions unrelated to quality of care issues you may call 1-800-Medicare (800-633-4227).

INSTRUCTIONS FOR THE MEDICARE QUALITY OF CARE COMPLAINT FORM

Medicare contracts with Quality Improvement Organizations (QIOs) to review complaints from people with Medicare about the quality of health care services. Follow the instructions below to describe your complaint.

If you need help with this form or if you need help with your complaint call your QIO. Their phone number is _____. If your complaint isn't about the quality of care you got, the QIO will refer your complaint to the right organization.

Follow the directions below and complete each line of the form. If your personal information is already included on the form, please make sure it's correct.

Line 1: Print the name of the person with Medicare who got the services related to the complaint.

Line 2: Include this person's Medicare (HICN) number, if known.

Line 3: Check the box next to this person's sex. Write this person's age in the blank space.

Line 4: Check the box or boxes that show this person's race or ethnicity. Please note that this information is **strictly voluntary** and **won't** impact your complaint.

Line 5: If the person with Medicare **won't** be the primary contact during the complaint process, print the name of the person's authorized representative.

Line 6: Print the contact information for the person who will be the primary contact during the complaint process—either the person with Medicare or the authorized representative.

Line 7: Check the box indicating whether you would like the doctor or provider who was involved in your complaint to know your name. If you check "No," the QIO **won't** reveal your name.

Line 8: Describe what happened. Include any information you believe would help the reviewer, including dates and times; names and addresses of doctors, staff and providers; information from witnesses, if available. If you need more space, you can attach additional sheets of paper. You can also include any documents you believe support your complaint.

Line 9: By signing the form, you are authorizing the QIO to review your complaint and give you a formal decision. The QIO may need to request your medical records related to the complaint.

Once you've finished the form, do the following:

- Keep these instructions (page 1) for your information.
- Make a copy of the form (page 2). Keep a copy for yourself and mail a copy to the QIO.

The QIO will send you a decision on your complaint within ____ days of getting the signed complaint form.

MEDICARE QUALITY OF CARE COMPLAINT FORM

1. NAME

2. MEDICARE NUMBER (HICN)

3. SEX

 Male Female

DATE OF BIRTH

4. RACE/ETHNICITY (*This section is voluntary*):A. Are you Hispanic or Latino? Yes No

B. How would you describe your race? Please mark one or more boxes.

 American Indian or Alaska Native Native Hawaiian or Other Pacific Islander White Asian Black or African American5. AUTHORIZED REPRESENTATIVE'S NAME (*if primary contact for the complaint*)

6. CONTACT INFORMATION FOR PRIMARY CONTACT:

STREET/APT.

CITY

STATE

ZIP

PHONE

ALTERNATE PHONE

7. During the review of your complaint, do you want the doctor or provider staff involved in the complaint to know your name?

 Yes No

8. Briefly describe the incident or your concerns: Include names, addresses, dates, and times involved. You can attach additional sheets of paper or other documents.

9. BY SIGNING THIS FORM, I AM REQUESTING THAT THE QIO REVIEW MY COMPLAINT.

SIGNATURE OF BENEFICIARY OR REPRESENTATIVE

DATE

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1102. The time required to prepare and distribute this collection is 10 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850