Member Grievance Policy and Procedure

Definition per CMS.gov: Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken.

An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Purpose: To assure the quality and continuity of care given to patient/members. To monitor and resolve all quality of care issues and administrative issues through an internal grievance process.

Grievance procedure: at initial enrollment, upon involuntary disenrollment initiated by the Medicare health plan, upon denial of an enrollee's request for expedited review of an organization determination or appeal, upon an enrollee's request, and annually thereafter;

Procedure to file a grievance:

1. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility.
2. Grievances may be filed by enrollee or their representative either orally or in writing no later than 60 days after the triggering event or incident precipitating the grievance.
3. Whether grievance is filed in person, telephonic or by correspondence, the office personnel must document the grievance on a grievance report form and submit a copy to the member's Health Plan.
4. Grievance form must be completed in its entirety with as much detail as possible.
5. If grievance is solvable by the physician and/or office personnel, the documentation of the grievance must be kept on file and recorded on the grievance log and copy submitted to member's Health Plan.
6. If grievance is no solvable by the physician and/or office personnel, then a copy of the grievance form and any supporting documents must be sent to the member's Medical Group/IPA. Member must be offered the opportunity to file a grievance with their Health Plan.

NOTE: All grievance forms, grievance logs and supporting documents must be kept in a separate folder, not in the patient's medical records.

GRIEVANCE REPORT FORM

Date: _____

Patient Name: _____ **Date of Birth:** _____

Grievance filed by (Check those that apply:

_____ Administration _____ Back office staff _____ Front office staff
_____ Laboratory _____ Medical Assistant (MA) _____ Medical Records
_____ Nursing Staff (RN/LVN) _____ Physician/Physician Assistant(MD/PA)_____ X-Ray

Employee involved:

1. _____ (Name/Title/Department)
2. _____ (Name/Title/Department)
3. _____ (Name/Title/Department)
4. _____ (Name/Title/Department)
5. _____ (Name/Title/Department)

Reason for grievance/complaint:

_____

_____

_____

_____

_____

Investigative report:

_____

_____

_____

_____

_____

Action take: _____ Referred to physician: _____ Referred to HealthPlan/IPA: _____ Other: _____

Resolution:

_____

_____

Any supporting documents submitted? _____ Yes ____ No

If no, attach original documents(s) to the grievance form.

_____ _____

Patient signature and date Office staff signature and date

SECTION	Approval date:	
Office Management	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Member Grievances/Complaints	Revision date:	

POLICY:

The site has an established process for member grievances and complaints.

DEFINITION:

A “grievance” is defined as any written or oral expression of dissatisfaction that involves coverage dispute, healthcare medical necessity, experimental or investigational treatment. The health plan does not delegate the resolution of grievances to contracted medical groups.

A “complaint” is any expression of dissatisfaction regarding the quality of service (excluding quality of care) which can be resolved in the initial contact. A “complaint” is self-limiting (e.g., service complaints, appointment wait times) that can be resolved to the member’s satisfaction, such as they do not ask for additional assistance

PROCEDURE:

A. The staff shall ensure that any member who expresses a grievance or complaint is informed of the right for a State Fair Hearing and offered the following numbers:

- The California Department of managed health Care: 1-888-HMO-2219
- For Hearing and Speech impaired persons call: 1-800-735-2929
- State Fair Hearing: 1-800-952-5253

B. Staff shall ensure that grievance forms (in threshold languages) for each participating health plan shall be provided to members promptly upon request.
    - The grievance form must be submitted to the health plan within one (1) business day

C. The staff shall ensure that all complaints (e.g., service complaints, appointment wait times) are tracked and submitted to the health plan after each occurrence.

- These complaints may be resolved at the point of service
- Log the complaint to include the following information:
    a. Date of complaint
    b. Name of complainant and ID#
    c. Nature of the complaint
    d. Resolution/action taken (include information communicated to health plan, as appropriate)
    e. Date of resolution/action
    f. Date log submitted to health plan