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