KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: KHS Member Grievance Process				POLICY #: 5.01-P	
DEPARTMENT: Member Services					
Effective Date: 2007-07	Review/Revised Date: 06/16/2020	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Director of Compliance and Regulatory Affairs

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Member Services

POLICY:

Member grievances and appeals are documented, investigated, and resolved within thirty (30) calendar days. There is no discrimination against a member on the grounds that the member filed a grievance or appeal. A copy of this policy and procedure which includes a description of the grievance and appeal processes, and copies of grievance forms is available at KHS headquarters and at each KHS practitioner/provider office. Practitioner/providers must make this policy and procedure available to KHS members upon request.

All KHS member grievances must be directed to KHS for review and resolution.

Members and practitioner/providers may contact Member Services and request a copy of the KHS internal policy and procedure relating to grievances.

DEFINITIONS:

Appeal	An Appeal is a review by KHS of an Adverse Benefit Determination upon request by a member, or by a provider on behalf of a member.
Exempt Grievance[i]	Grievances received over the telephone that are not potential quality of care concerns, coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the close of the next business day are exempt from the requirement to send a written acknowledgment and response. KHS shall maintain a log of all such Grievances containing the date of the call, the name of the member, beneficiary identification number, nature of the Grievance, nature of the resolution, and the representative's name who took the call and resolved the Grievance. The information contained in this log shall be periodically reviewed by KHS.
Grievance	A member's verbal or written expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by KHS to make an authorization decision. A complaint is the same as a Grievance. When KHS is unable to distinguish between a Grievance and inquiry, it shall be considered a Grievance.
Inquiry	An inquiry is a request for information that does not include an expression of dissatisfaction. Inquires may include, but are not limited to, questions pertaining to eligibility, benefits, or the KHS processes.
Expedited Grievance or Appeal[ii]	A Grievance or Appeal involving an imminent and serious threat to the health of the member, including, but not limited to, severe pain and/or potential loss of life, limb, or major bodily function.
Adverse Benefit Determination	The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service.

	The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner. The failure to act within the required timeframes for standard resolution of Grievances and Appeals. For a resident of a rural area with only one Managed Care Plan (MCP), the denial of the beneficiary's request to obtain services outside the network. The denial of a beneficiary's request to dispute financial liability.
Notice of Adverse Benefit Determination (NOA)	A formal letter, informing a member of an Adverse Benefit Determination.
Access to Care	Issues involving possible violations of KHS Policy 4.30-P.
Covered Services	Services set forth in Title 22 CCR Chapter 3, Chapter 4, Subchapter 13, beginning with Section 6840, unless specifically excluded under the terms of the DHCS Contract 03-76165.
Coverage Dispute	An appeal for a service that is not a covered benefit or that is not covered due to a specified restriction that does not pertain to a medical necessity guideline.
Difficulty with Accessing Specialists	Issues involving possible violations of KHS Policy 4.30-P, specifically involving a specialty provider.
Issues related to Cultural and Linguistic Sensitivity	Issues involving, but not limited to, possible violations of KHS Policy 11.01-P.
Medical Necessity	A determination of prior authorization for a covered service based on plan guidelines that include professionally recognized evidence-based clinical standards of health care and in accordance with KHS guidelines.
Quality of Care	Issues pertaining to the health care services of a member including, but not limited to any service involving professionally recognized standards of health care practices; whether appropriate health care services have been provided and whether the services have been provided in appropriate settings.
Quality of Service	Issues of service involving non-medical services.
Other Issue	An issue that is outside of all other issue codes.

Subcontracted Entity	A KHS contracted entity for which the oversight of member's healthcare is delegated to the group or vendor; i.e., vision, behavioral health, 24 hour advice nurse, etc.
Timely Assignment to Provider	Issues involving the member's assignment to a PCP by the Plan.

PROCEDURES:

1.0 FILING OF GRIEVANCE

A grievance or appeal from a member or a member's representative may be submitted either verbally or in writing at the following address, phone number, or website:

KHS Member Services
2900 Buck Owens Boulevard
Bakersfield, CA 93308
661-632-1590 (Bakersfield)
1-800-391-2000 (outside of Bakersfield)
www.kernfamilyhealthcare.com

If the member is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the member, as appropriate, may submit the grievance or appeal as the agent of the member. The provider may join with or otherwise assist the member in submitting a grievance or appeal, and may advocate on behalf of the member. Following the submission of the grievance or appeal, the member or member's agent may authorize the provider to assist, including advocating on behalf of the member.

Members are encouraged but not required to submit their grievance or appeal in writing, utilizing the *Member Report of Complaint Grievance* form which is available by contacting Member Services or at any of the provider's offices. (See Attachment A). Member Services staff may be contacted for assistance in filling out the form or filing the grievance or appeal over the telephone.[iii] Members or their designated representative may also file a grievance or appeal in writing or verbally at any of the plan's provider offices.

There is no time frame for a member to file a grievance regarding an incident or action that caused dissatisfaction and may be filed at any time.

For appeals pertaining to an Adverse Benefit Determination, where a requested medical service is denied, deferred, or modified as communicated through a formal Notice of Adverse Benefit Termination (NOA) letter, the member has sixty (60) calendar days from the date on the notice to file an appeal with KHS.

1.1 Grievances Filed in the Provider's Office[iv]

If a member requests to file a grievance or appeal in the provider's office, the provider must supply the member with a *Member Report of Complaint/Grievance* form. The provider must then inform the member of the following options for filing the grievance:

A. The member may submit the grievance verbally by speaking to a KHS representative. If the member chooses this option, provider office staff should allow the member to use the office phone to contact KHS and should dial the phone number for the member (661-632-1590) or (1-800-391-2000).

B. The member may submit the grievance in writing utilizing the *Member Report of Complaint/Grievance* form. If the member chooses this option, provider office staff should inform the member that he/she may use the office phone to contact KHS for assistance with filling out the form. The provider must fax the form to KHS on the day of receipt (661-664-5179).

2.0 RESPONSE TO GRIEVANCE

Where applicable, KHS is required to send an acknowledgement to the member, informing them that their grievance or appeal has been received and is in process,

2.1 Exempt Grievance

If possible, the grievance is resolved over the phone before the close of the next business day. If such grievances meet the definition of "Exempt Grievance", the grievance is then logged and periodically reviewed by KHS.

2.2 Routine Grievances and Appeals

An acknowledgement is mailed to the member within five calendar days of receipt of the grievance.

3.0 Expedited/Urgent Grievance and Appeals

Grievances or appeals involving an imminent and serious threat to the health of the member, including but not limited to, severe pain and/or potential loss of life, limb, or major bodily function are immediately classified as expedited grievances or appeals. If a grievance or appeal qualifies as an "expedited grievance", the member is notified immediately of the classification and of his/her right to notify the Department of Managed Health Care (DMHC) of the grievance.[v] An acknowledgement along with a written statement on the disposition or pending status of the grievance is submitted to both DMHC and the member within seventy two (72) hours of receipt.[vi]

4.0 Grievance Review Process

Members are given a reasonable opportunity to present, in writing or in person before the Grievance Review Team, evidence, facts, and law in support of their grievance.[vii]

The grievance or appeal is reviewed by the *Grievance Review Team*, and a resolution is provided to the member within 30 calendar days of receipt. In cases of expedited grievances, consideration is given to the member's medical condition when determining response time.[viii] In such cases, Member Services attempts to contact the member by telephone on the same day as the determination of the resolution and provide the member with oral notice of the resolution.

If a grievance is unable to be resolved within 30 calendar days, the member is provided notice of the status of the grievance and estimated completion date of resolution.

The action/decision included in the Grievance Resolution Form is the conclusion of the Plan's

grievance resolution process. No further appeal is considered.

5.0 PRACTITIONER/PROVIDER COOPERATION

Providers are required to submit medical records and, if requested, a written response to the KHS Grievance Coordinator within ten (10) business days of the date of their receipt of the request, per their contract with KHS. Providers who do not comply with contract requirements may be subject to disciplinary action.

5.1 Provider Response

For complaints pertaining to Quality of Care or Services, the Grievance Coordinator shall submit a request for a written response. For Quality of Services issues only, the Grievance Coordinator may elect to use the KFHC Request for Provider Response Form (see Attachment B). If the requested response is not received by the Grievance Coordinator by the 10th business day, the provider shall be sent a request for Provider Response 5 Day Notice (see Attachment C). If the requested response is not received by the 5th business day, the grievance may be resolved in favor of the member due to no response received from the provider.

ATTACHMENTS:

- Attachment A: *Member Report of Complaint/Grievance form*
- Attachment B: *Request for Provider Response*
- Attachment C: *Provider Response 5 Day Notice*

REFERENCE:

Revision 2020-04: Revision 2019-08: Policy reviewed and revision provided by Member Services Department. **Revision 2017-08:** Policy revised to reflect timeframes for filing grievances. **Revision 2012-11:** Policy revised at the request of KHS's Chief Operating Officer. Responses from providers are required in writing and are due within 10 business days from the Grievance Coordinators request. Routine Revision 2006-11: Revised per Member Services Manager Request. Revision 2005-12: Revised per DHS Workplan Comments 14a, b, and c (8/23/05). Revision 2005-06: Routine revision. Reviewed against DHS Contract 03-76165 (Effective 05/01/04). Revision 2004-04: Although this is a new procedure, changes made to text that was moved from policy #5.01 into this policy is shown in redline format.

[i] CCR Title 28 §1300.68(d)(8)
[ii] CCR Title 28 §1300.68.01(a); HSC 1368.01(b)
[iii] CCR Title 28 §1300.68 (b)(6)
[iv] CCR Title 22 §53858 (a)(2)(c)
[v] CCR Title 28 §1300.68.01 (a)(1); HSC 1368.01 (b)
[vi] HSC 1368.01 (b); CCR Title 28 §1300.68.01 (a)(2)
[vii] DHS Contract A-14 2(G)
[viii] CCR Title 28 §1300.68.01(a)(3)

MEMBER REPORT OF COMPLAINT/GRIEVANCE

In order to file a complaint (also known as a grievance), you may call Kern Family Health Care, complete the following form and return it to the Kern Family Health Care Member Services Department, or use our website (www.kernhealthsystems.com). Following receipt of your complaint (also known as a grievance), Kern Family Health Care will send you additional information within (5) calendar days. **The Member Services Department can be reached at (661) 632-1590 or (800) 391-2000 if you need assistance.**

Member's Name: _____ Date: _____

Member's I.D.#: _____Effective Date of Coverage:_____

Address: _____
(Street)

_____ _____ _____
(City) (State) (Zip)

Phone: _____ _____
(Home) (Work)

Name of Person Making/ Filing Complaint: _____
Relationship to Patient: _____
Phone Number (if different): _____
Complaint Summary: _____

Desired Outcome/Resolution:

Please see the back of this form for additional important information.

Member's Signature: _____ Date: _____

Si usted necesita esta carta en Español, por favor llame al Departamento de Servicios de Miembros al (800) 391-2000

You can contact Kern Family Health Care at the following address, phone number, and/or website:

2900 Buck Owens Boulevard
Bakersfield, CA 93308
661-632-1590 (Bakersfield)
1-800-391-2000 (outside of Bakersfield)
www.kernfamilyhealthcare.com

Kern Family Health Care resolves grievances within 30 days.

If your case involves an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, it will be classified as an expedited grievance. We will send you a written statement on the disposition or pending status of an expedited grievance within 3 days of receipt.

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **661-632-1590 or 1-800-391-2000** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions online.

Kern Family Health Care
The Friendly Face
Of Kern Health Systems

REQUEST FOR PROVIDER RESPONSE

<Insert Provider/Clinic Name>

<Insert Provider/Clinic Address>

<Insert Provider/Clinic FAX#>

<Insert Date>

Re:	**Member Name:**	**Member ID#:**	**Member DOB:**
	<insert>	**<insert>**	**<insert>**

Dear Clinic Manager:

On <insert date of grievance>, we received a complaint from the above named member. We realize that member complaints are based upon his or her perception of the events and may not be reflective of the actual circumstances; however, Kern Family Health Care has an obligation to investigate and respond to all member complaints. We require your assistance in the form of a response for your interpretation of the encounter stated by the member below:

<manual insert issue/concern here>.

Please complete, sign and fax this form to <insert GC fax number> within **10 business days** of your receipt of this fax so that I can respond to this member. Thank you in advance for your cooperation and support.

<insert GC name>
Grievance Coordinator

To be completed by the Clinic Manager or Designee

I (Clinic Manager) have reviewed this complaint and (please check all that apply):

☐ I have determined it was unique to a particular day/provider due to unusual or unforeseen circumstances *(please explain in the space below).*

☐ I have addressed this issue with the appropriate office/clinic staff.

☐ I will make the appropriate service improvements and/or adjustments to our policies/procedures.

☐ I have determined this issue requires further analysis and will follow-up, accordingly.

☐ I acknowledge this member was dissatisfied with the clinic/office service. It has been determined that no action to remedy this complaint is necessary at this time.

☐ I would like to inform you of the following: _____

_____

_____

_____

Sign Name *Title* *Date*

☐ Please check here if you would like a cc of the member's resolution letter.

Kern Family Health Care
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Request for Provider Response
5 Day Notice

<Date>

<Provider/clinic name>
<Provider/clinic address>
<Provider/clinic FAX#>

Re:	Member Name:	Member ID#:	Member DOB:
	<insert>	**<insert>**	**<insert>**

Dear <contact name>

This notice is to inform you that we have not received your written response for the request submitted to you on <Date sent>, for the above named member's complaint. As member grievances are time sensitive, it is imperative that we receive your response in a timely manner in order to complete the investigation of the member's complaint and provide a response to the member. The initial request provides a 10 business day response time. This notice will allow you 5 more business days to respond. If we do not receive your response by <Date of 5th business day> we will consider this complaint to be resolved in favor of the member.

Please contact me if you have any questions.

<GC contact information>