KERN HEALTH SYSTEMS

| KERN HEALTH SYSTEMS<br><br>POLICY AND PROCEDURES | | | | | |
|---|---|---|---|---|---|
| SUBJECT: KHS Member Grievance Process | | | | POLICY #: 5.01-P | |
| DEPARTMENT: Member Services | | | | | |
| Effective Date:<br>2007-07 | Review/Revised Date:<br>07/2022 | DMHC | X | PAC | |
| | | DHCS | X | QI/UM COMMITTEE | |
| | | BOD | | FINANCE COMMITTEE | |

_____ Date _____
Emily Duran
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:**

KHS must establish, implement, maintain and oversee a grievance an appeal system to ensure the receipt, review and resolution of grievance and appeals in accordance with regulatory requirements. This policy will define and communicate a systematic approach to the grievance and appeal process for all members of KHS and to adhere to the guidelines of the Department of Managed Health Care (the DMHC) and the Department of Health Care Services (the DHCS). All members are notified of the plan's grievance system and the procedures for filing and resolving grievances, as well as the telephone number and address for presenting a grievance, in the Member Handbook that

is available to all new members and mailed annually thereafter. The Member Handbook also includes information regarding the DMHC's review process, the Independent Medical Review system and the DMHC's toll-free telephone number and website address.

Grievances and appeals related to services carved out of KHS' scope of coverage will be redirected to the appropriate entity. Pharmacy-related complaints and grievances received by the Plan for Medi-Cal Rx (MRX) services provided on or after the MRX implementation date, must be transferred by the Plan to MRX for resolution. The Plan will continue to process complaints and grievances for pharmacy-related services rendered before the implementation date of MRX. Complaints or grievances received by phone or secure chat by MRX will be appropriately triaged and referred by MRX to the Plan by phone once it is determined to be a KHS complaint or grievance. MRX will make the best efforts to immediately forward complaints and grievances to the Plan for timely and accurate resolution. Complaints and grievance received in writing will be appropriately triaged, mailed and/or faxed to the Plan within three (3) calendar days.

There is no discrimination against a member, including termination of coverage, on the grounds that the complainant filed a grievance or appeal. [3] KHS will not discourage the filing of grievances. A member need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and processed as a grievance by KHS. If a member expressly declines to file a grievance, the complaint must still be categorized as a grievance and not an inquiry

**DEFINITIONS:**

| | |
|---|---|
| **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.<br><br>The reduction, suspension, or termination of a previously authorized service.<br><br>The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ''clean claim'' at 42 CFR section 447.45(b) is not an adverse benefit determination<br><br>The failure to provide services in a timely manner.<br><br>The failure to act within the required timeframes for standard resolution of Grievances and Appeals.<br><br>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. |
| **Appeal** | An "appeal" is federally defined as a review by KHS of an adverse benefit determination. While state regulations do not explicitly define the term "appeal," they do delineate specific requirements for certain types of grievances that would fall under the federal definition of appeal because they involve the delay, modification, or denial of services based on medical necessity or a determination that the requested service is not a covered benefit. KHS must treat these grievances as appeals under federal regulations. |
| **Complainant** | A complainant is the same as grievant, and means the person who filed the grievance, including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee. |
| **Exempt Grievance[5]** | Grievances received over the telephone, facsimile, by e-mail, or online through KHS' internet website, that are not potential quality of care concerns, coverage disputes, disputed health care services involving medical necessity, experimental or investigational therapy, or denial of urgent care or emergency services 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 complainant, 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. |
| **Expedited Grievance or Appeal[6]** | 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 or the normal timeframe for the decision-making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function. Decisions to approve, modify, or deny the requests by providers shall be made within seventy-two (72) hours. |
| **Grievance** | A grievance is any 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 member's right to dispute an extension of time proposed by KHS to make an authorization decision. A complaint is the same as a grievance. If KHS is unable to distinguish between a grievance and an inquiry, it must 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. |
| **Notice of Action (NOA)** | A formal letter from KHS, informing a member of an Adverse Benefit Determination. |
| **Notice of Appeal Resolution** | A "notice of appeal resolution" (NAR) is a formal letter from KHS informing a member of the outcome of the appeal of an adverse benefit determination. The NAR informs the member whether KHS has overturned or upheld its decision on the adverse benefit determination. |
| **Resolved** | Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within KHS' grievance system, including entities with delegated authority. |

## 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**

Written instructions on the use of the grievance process is in the Member Handbook (also called the Combined Evidence of Coverage and Disclosure Statement), on page 53; section 6, *Reporting and Solving Problems*. The handbook is sent to the member within 7 days of the date of enrollment and annually thereafter. [ix]

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. A "patient advocate" or ombudsperson may also be used for assistance with submitting a grievance.[iii] 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). KHS provides grievance forms to members who wish to file written grievances promptly upon request. [x] Member Services staff may be contacted for assistance in filling out the form or filing the

grievance or appeal over the telephone.[i] 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.

As per outlined in KHS policy and procedure 3.43-P, Hospice Services, section 8.1 Denials to Terminally Ill Members, KHS is required to provide members and providers with notification of denial for a prior authorization request for services within five (5) business days or less. The notification to the member will provide all of the following information: a statement setting forth the specific medical and scientific reasons for denying coverage, a description of alternative treatment, services or supplies covered by KHS, if any, and copies of KHS' grievance procedures or complaint form, or both. Upon receiving an appeal from a member with a terminal illness, which for the purposes of this section refers to an incurable or irreversible condition that has a high probability causing death within six months or less, for treatment, services or supplies deemed experimental, as recommended by a participating plan provider, KHS shall provide the member an opportunity to attend a conference in person to review the information within thirty (30) calendar days. KHS allows attendance in person by the member, a designee of the member, or both, or if the member is a minor or incompetent, the parent, guardian, or conservator of the member, as appropriate. However, the conference shall be held within five (5) business days if the treating participating physician determines, after consultation with the health plan medical director or his or her designee, based on standard medical practice, that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by the plan, would be materially reduced if not provided at the earliest possible date[xvii].

### 1.1 Grievances Filed in the Provider's Office[ii]

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 within five (5) calendar days from receipt, informing them that their grievance or appeal has been received and is in process. The grievance or appeal shall be resolved within thirty (30) calendar days. Upon the grievance resolution, a written response will be mailed to the member within thirty (30) calendar days. [xi]

### 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 (5) calendar days of receipt of the grievance or appeal.

Acknowledgements include the following information: [xiv]

A. Notice that the grievance or appeal has been received
B. Date of receipt
C. Name, telephone number, and address of the Grievance Coordinator.

## 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 or the normal timeframe for the decision making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function are immediately classified as expedited grievances or appeals.[ii] When KHS has notice of a case requiring expedited review, KHS will immediately inform members in writing of their right to notify DMHC of the grievance. 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 and provide the department's phone number, **1-888-466-2219**.[iii] 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.[iv]

### 3.1 Contacts for Expedited Grievances and Appeals[ii]

KHS has staff on call twenty four (24) hours a day, seven (7) days a week to respond to DMHC inquiries/requests regarding expedited grievances and appeals. During business hours, KHS staff responds to the department within thirty (30) minutes after initial contact from the Department. During non-work hours, the plan shall respond to the Department within one (1) hour after initial contact from the Department.

Staff that is designated as on call has the authority to resolve expedited grievances or appeals and authorize related services and expenses without further approval.

KHS shall notify DMHC at least thirty (30) days in advance of implementing any revisions to the grievance system.

## 4.0 Grievance Review Process

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

Upon receiving an appeal requesting a conference from a member with a terminal illness, which for the purposes of this section refers to an incurable or irreversible condition that has a high probability causing death within six months or less, for treatment, services or supplies deemed experimental, as recommended by a participating plan provider, KHS shall provide the member a statement setting fort the specific medical and scientific reasons for denying coverage, a description of alternative treatment, services or supplies covered by KHS, if any, and copies of KHS' grievance procedures or complaint form, or both. KHS shall also provide an opportunity to attend a conference in person to review the information within thirty (30) calendar days. KHS allows attendance in person by the member, a designee of the member, or both, or if the member is a minor or incompetent, the parent, guardian, or conservator of the member, as appropriate. However, the conference shall be held within five (5) business days if the treating participating physician determines, after consultation with the health plan medical director or his or her designee, based on standard medical practice, that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by the plan, would be materially reduced if not provided at the earliest possible date.[xvii]

**4.1 Grievance Review Timeframe**

The grievance or appeal is reviewed by the *Grievance Review Committee*, and a resolution is provided to the member within thirty (30) calendar days of receipt. The management or supervisory staff responsible for the services or operations which are the subject of the grievance are included in the Grievance Review Committee which provides for a prompt review of the grievances.[xii] In cases of expedited grievances, consideration is given to the member's medical condition when determining response time.[vi] 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 thirty (30) calendar days, the member is provided notice of the status of the grievance and estimated completion date of resolution.

**4.2 Grievance and Appeal Resolution**

The action/decision included in the Grievance Resolution Form is the conclusion of the Plan's grievance resolution process. Upon the grievance resolution, the Grievance Coordinator completes a written Grievance Resolution Form which shall contain a clear and concise explanation of the plan's decision.[xi] No further appeal is considered.

For resolutions involving an appeal of an Adverse Benefit Determination, a separate Notice of Adverse Benefit Resolution form is completed which shall contain a clear and concise explanation of the plan's decision. The decision of the appeal is the final level of appeal for members within KHS.
The NAR includes:[xv]

A. The results of the resolution and the date it was completed.
B. If KHS determines that the appeal was denied in whole or part on medical necessity, the written response shall contain a clear and concise explanation of the plan's

decision and shall include in its written response the reasons for its determination including, clearly stating the criteria, clinical guidelines, or medical policies used in reaching the determination.

C. Knox-Keene licensed MCPs must also include the IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC. Knox-Keene licensed MCPs are required to check the DMHC website periodically to ensure use of the most current form.

D. If KHS determines that the appeal was denied of coverage for experimental or investigation therapy, or denial of urgent care or emergency services, KHS shall notify the member in writing of the ability to request an Independent Medical Review within five business days of the decision to deny coverage. The response shall include an application for Independent Medical Review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814. See *KHS Policy and Procedure #14.51-P Independent Medical Review* for additional information.

E. If KHS determines the requested service is not a covered benefit, KHS shall include in its written response the provision in the DHCS Contract, Evidence of Coverage (EOC), or Member Handbook that this service is excluded. The response shall either identify the document and page where the provision is found, direct the member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applied to the service or benefit requested.

## 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.

## 6.0 Cultural and Linguistic Requirements [xvi]

Members will be informed of the availability of linguistic services through new member orientations and the member handbook. KHS provides vital documents in threshold languages which includes, but is not limited to, notices containing information regarding their rights to file a grievance or appeal and to seek an Independent Medical Review and through oral interpretation. [xvi] KHS will include the Notice of Non-Discrimination, the Non-Discrimination Statement, and the language assistance Taglines as required by Section 1557 of the Americans

with Disabilities Act (ADA) and as prescribed in All Plan Letter 17-011 on all required publications and communications. Grievances are processed in accordance with cultural and linguistic requirements. KHS currently translates all grievance resolution and appeal NARs, including the clinical rationale for the decision, into the member's threshold language before mailing. Members with visual impairment may also receive their grievance and appeal correspondence in the alternative format of their choice, including Braille, audio cd or data cd.
.

### 6.1 Notice of Non-Discrimination

The Notice of Non-Discrimination includes the seven required elements as indicated in the ACA 1557 example for the Notice of Non-Discrimination. The elements convey language pertinent for non-discrimination and accessibility requirements and conveys KHS' compliance with those requirements. The Notice of Non-Discrimination will be posted in a conspicuously visible font size (minimum of 12-point font) and be included in significant publications and significant communications except those publications and communications that are small in size, such as postcards and tri-fold brochures. For small-size publications and communication, the Non-Discrimination Statement and language assistance taglines are included in Spanish and Chinese which are the top two non-English languages spoken by individuals with Limited English Proficiency (LEP) in California.

#### 6.1.2 Taglines

Taglines provide information about the availability of language assistance services and must be posted in a conspicuously visible font size (minimum 12-point font) in English and at least the top 16 non-English languages spoken by individuals with LEP.

KHS addresses cultural and linguistic member needs as well as regulatory requirements as outlined in the following *KHS Policies and Procedures*:

- *#11.23-I: Cultural and Linguistic Services*
- *#11.22-P: Linguistic Services*
- *#11.11-I: Cultural Competency*
- *#11.26-I: Translation of Written Member Materials*

## 7.0 State Fair Hearing Requests

A member has the right to request a State Hearing when a claim for medical assistance is denied or is not acted upon with reasonable promptness. Members may request a State Fair Hearing to resolve an appeal only after the completion of the KHS grievance resolution process. A member has one hundred and twenty (120) days from the date on the Notice of Appeal Resolution (NAR), informing the member that the Adverse Benefit Decision has been upheld, to file a State Fair Hearing. The State Department of Social Services is responsible to coordinate the processing of all State Fair Hearing Requests submitted by Medi-Cal beneficiaries who are enrolled in a managed care plan.

Upon notification from DHCS that a member qualifies for medical assistance pending the fair hearing decision, KHS will authorize and provide services in accordance with California Code of Regulations Title 22 Section 51014.2.54

Upon receipt of a routine State Fair Hearing Notification, the Grievance Coordinator will

notify the Grievance Review Committee of the notification and provide a brief summary of the issue being appealed. The Grievance Review Committee will determine who will provide the Statement of Position. The plan has two (2) weeks from the date of the emailed or faxed notification to submit the signed Statement of Position to the Fair Hearing Coordinator as instructed on the Notification. The plan will mail a copy of the Statement of Position with any other documentation submitted to the Fair Hearing Coordinator to the Plan Member to provide the member access to a this information at least two working days prior to the scheduled date of the hearing as set forth in the Welfare and Institutions Code, Section 10925.5.

Upon receipt of notification of the State-Fair Hearing, the Grievance Coordinator logs the information of the hearing and forwards the information to the appropriate department head. The Grievance Coordinator opens and logs as a new entry the date of receipt of the hearing notification and the DHCS case number.

Within two working days of being notified by DHCS that a member has filed a request for fair hearing which meets the criteria for expedited resolution, the GC submits the plan's documents to the Administrative Law Judge (ALJ). The documents submitted include the Statement of Position as prepared by the Medical Director or Associate Medical Director and can include attachments as applicable such as: Treatment Authorization Request, NOA Letters, and Resolution documents from the internal grievance process. If the documents are not in English, the fully translated documents are also included with the submittal. The hearing request and response action is documented in QNXT with a brief summary of the case. The Grievance Coordinator opens and retains a State-Fair Hearing Case file in the member's name. One or more of the plan representatives with knowledge of the case are available by phone during the scheduled fair hearing55.

KHS will notify members the ALJ has ninety (90) calendar days from the date of a standard request and three (3) working days for and expedited State Fair Hearing request, to issue a final a decision. Upon receipt of the Hearing Officer's decision, the final disposition of the case is logged in QNXT and the decision retained in the member's State Hearing file. If the decision is overturned, KHS has seventy-two (72) hours to authorize the requested service. KHS will attempt to verbally inform the member of the overturned decision and document each attempt. The State Fair Hearing Process flowchart provides an overview of the KHS Grievance Process (See Attachment N).

In the event of deemed exhaustion due to untimely or insufficient notice, the member can file a State Fair Hearing within 120 days from: 1) the expiration date of the timeframe in which the MCP should have sent a NAR to the member; 2) the expiration date of the timeframe in which the MCP should have sent a NOA to the member; 3) the date of the member's receipt of the MCP's deficient written NAR/NOA..

## 8.0 DMHC Grievance [xiv]

A member may submit a grievance to the Department if they have completed or participated in the KHS grievance process for at least thirty (30) days. In any case determined by the department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily

function, cancellations, rescissions, or the nonrenewal of a health care service plan contract, or in any other case where the department determines that an earlier review is warranted, the member is not required to complete the grievance process or to participate in the process for at least thirty (30) days before submitting a grievance to the department for review. If an appeal was denied in whole or part on medical necessity, the department shall have the final authority to determine whether the grievance is more properly resolved pursuant to an Independent Medical Review. See *KHS Policy and Procedure #14.51-P Independent Medical Review* for more information.

**ATTACHMENTS:**

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

**REFERENCE:**

---

**Revised 07/2022:** Updated for APL 21-011 and 21-004; DHCS approved 07/19/2022, DMHC approved on 12/21/2022

[i] CCR Title 28 §1300.68 (b)(6)
[ii] CCR Title 22 §53858 (a)(2)(c)
[iii] CCR Title 28 §1300.68.01 (a)(1); HSC 1368.01 (b)
[iv] HSC 1368.01 (b); CCR Title 28 §1300.68.01 (a)(2)
[v] DHS Contract A-14 2(G)
[vi] CCR Title 28 §1300.68.01(a)(3)
[ix] HSC 1368.01 (a)(2)
[x] HSC 1368.01 (a)(3)
[xi] CCR Title 28 §1300.68 (d)(3)
[xii] CCR Title 28 §1300.68 (d)(2)
[xiii] CCR Title 28 §1300.70.4 (b)(1)
[xiv] CCR Title 28 §1300.68 (d)(1); HSC 1367.042(a)(4); HSC 1368(b)(1)(a); CCR Title 28 §1300.68.01 (a)(4); HSC 1374.30(d)(2)
[xv] HSC 1368 (a)(5); CCR Title 28 §1300.70.4 (b)(1); HSC 1374.30 (m)
[xvi] CCR Title 28 §1300.67.04 (c)(2)(d); CCR Title 28 §1300.68 (b)(3)
[xvii] HSC 1368.1(a); HSC 1368.1 (b)

# MEMBER REPORT OF COMPLAINT/GRIEVANCE

In order to file a complaint (also known as a grievance), you may call Kern Family Health Care or complete the following form and return it to the Kern Family Health Care Member Services Department. 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 and/or phone number:

2900 Buck Owens Blvd

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

# 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 72 hours of receipt.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan **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 (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.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
The Friendly Face
Of Kern Health Systems

**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>