KERN HEALTH SYSTEMS

Policy and Procedure Review / Revision

KHS Policy & Procedure: 5.01-P, KHS Member Grievance Process

Last approved version: 06/2020

Reason for revision: Policy revised to comply with APL 20-020 Medi-Cal RX. Policy has been approved by DHCS and DMHC.

Reviewer	Date	Comment/Signature
Emily Duran Chief Executive Officer	8/24/22	
Martha Tasinga Chief Medical Officer	8/24/2022	M Tasinga
Alan Avery Chief Operating Officer	6/14/2022	Alan Avery
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(CEO decision(s))
Board approval required: Yes ___ No ____ QI/UM Committee approval: Yes ___ No ___
Date approved by the KHS BOD: _____ Date of approved by QI: _____
PAC approval: Yes ___ No ___ Date of approval by PAC: _____
Approval for internal implementation: Yes ___ No ___
Provider distribution date: Immediately _____ Quarterly _____

Effective date: _____
DHCS submission: _____
DMHC submission: _____
Provider distribution: _____

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: 08/26/2022	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:

Member grievances and appeals are documented, investigated, and resolved within thirty (30) calendar days. There is no discrimination against a member, including termination of coverage, on the grounds that the complainant 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 in threshold languages at KHS headquarters, on the KHS website 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. 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.

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.
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.
Disputed Health Care Service	Any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary.
Discrimination Grievance	A member grievance involving alleged discrimination on the basis of any characteristic protected by federal or state nondiscrimination law. This includes, without limitation, sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56.
Exempt Grievance[i]	Grievances received over the telephone, facsimile, by e-mail, or online through the plans internet website, that are not potential quality of care concerns, coverage disputes, disputed health care services involving medical necessity, experimental or investigational treatment, or denial of urgent care or emergency services, [xiii] 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 written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. 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, 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.
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 the plan's grievance system, including entities with delegated authority.
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.
Coverage Decision	The approval or denial of health care services by a plan, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract. A "coverage decision" does not encompass a plan or contracting provider decision regarding a disputed health care service.
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 3.71-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.
Interpretation	The process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account.
Qualified Interpreter	An individual who is able to interpret from one spoken or signed language to another language effectively, accurately and impartially both receptively and expressively, using any necessary specialized vocabulary.

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

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.[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.

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[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 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**.[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]

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.[vii]

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.[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 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. The response shall include that the determination may be considered by the Department's Independent Medical Review system. 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.
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.

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*:

- *#3.70-P: Cultural and Linguistic Services*
- *#3.71-P: Linguistic Services*
- *#11.11-I: Cultural Competency*
- *#12.02: Translation of Written Member Informing Materials*

7.0 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:

Revision 2021-09: Revision related to the publication of DHCS APL 21-004 Standards for Determining Threshold Language, Nondiscrimination requirements, and Language Assistance Services. Approved by DHCS on 10/13/2021. **Revision 2021-05:** Revision related to the publication of DHCS APL 20-020 Medi-Cal RX. Approved by the DHCS (MCL RX 14.A and 14.B) on 11/02/2021. Approved by DMHC on 2/4/2022. **Revision 2020-02: 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); HSC 1368 (a)(4)(b)(i)
[ii] CCR Title 28 §1300.68.01(a); HSC 1368.01(b); HSC 1367.01(h)(2); CCR Title 28 §1300.68.01(b); CCR Title 28 § 1300.68.01(b)(2)(A)
[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)
[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, 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
The Friendly Face
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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>