# Grievance Process

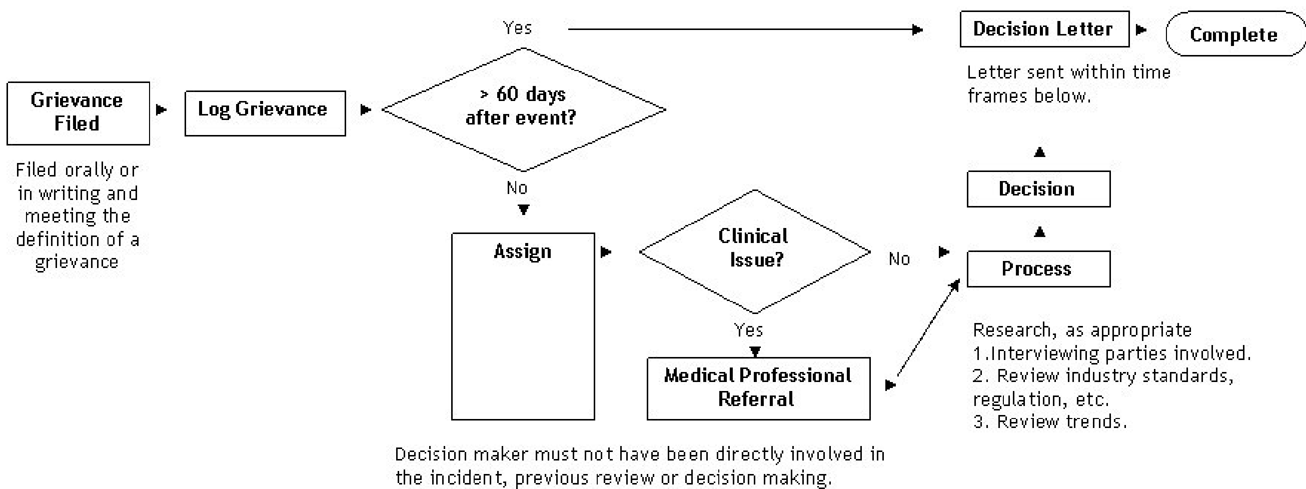
**Definition**

Grievance: Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration or invoked an extension to an organization determination or reconsideration time frame.

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

**Process**

## Grievance Process Diagram




**Time Frames**
Grievances should be processed within thirty (30) days of the date received. A 14-day extension may be granted if the member requests the extension or if the organization justifies a need for additional information and documents how the delay is in the interest of the member.
Expedited grievances must be resolved in 24 hours. Grievances unresolved within 30 days are referred to the Plan for resolution (if handled by a delegated entity).
Grievances filed over 60 days after an event will typically not be process, unless the claim is of great significance (i.e., threat to safety).



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**How to contact us when you are making a complaint about your medical care**

| Complaints about Medical Care | |
|---|---|
| **CALL** | (562) 799-0319 Calls to this number are not toll free, unless dialed locally. Hours of operation are 8 a.m. to 8 p.m. Monday through Friday and daily during the enrollment/disenrollment periods. (877) 541-4111. Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m. Monday through Friday and daily during the enrollment/disenrollment periods. |
| **TTY** | (877) 551-4111<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m. Monday through Friday and daily during the enrollment/ disenrollment periods. |
| **FAX** | (562) 799-0507 |
| **WRITE** | Golden State Medicare Health Plan<br>c/o Member Services<br>3030 Old Ranch Parkway<br>Suite 155<br>Seal Beach, CA 90740 |
| **MEDICARE WEBSITE** | You can submit a complaint about Golden State Medicare Health Plan directly to Medicare. To submit an online complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. |

For more information on making a complaint about your medical care, see Chapter 9 in the Evidence of Coverage document.

**Filing a Grievance**
A member grievance can be filed orally or in writing (includes email or facsimile) by the member or their representative. The plan will accept any information or evidence concerning the grievance orally or in writing prior to 60 calendar days after the event. To ensure the accuracy of the nature of the grievance, a written response is recommended. The grievance can be filed directly to the Plan, provider or facility. Grievances filed orally, may be responded to orally unless the enrollee requests a written response or the grievance concerns quality of care. If a written grievance is filed, a written response is required.

A member must file a grievance no later than 60 days after the event or incident that precipitates the grievance. A log will be maintained at each primary care clinic or facility that serves members. Any staff member within the organization who receives a compliant will forward it to the appropriate department, as well as forward any appropriate grievance as defined above to the Plan monthly, excluding informal and administrative complaints.

Members are notified of their right to file an expedited grievance in the Evidence of Coverage provided at enrollment.

**Expedited Grievance**

The Plan or delegate will respond within 24 hours to a member's expedited grievance whenever:

- The time frame to make an organization determination or reconsideration is extended by the Plan or delegate; or
- The request for an expedited organization determination or reconsideration is denied.

The Plan or delegate will transmit details of grievances to appropriate decision-making levels in the organization timely and will ensure prompt notification of the resolution to the enrollee or their representative using an approved notice.

**Time Frames**

The objective will be to resolve grievances as soon as possible, but within thirty (30) days of the date received. Prompt, appropriate action, including a full investigation of the grievance as expeditiously as the enrollee's case requires, based on the enrollee's health status, but no later than 30 calendar days from the date the oral or written request is received, unless extended as permitted under 42 CFR 422.564(e)(2). A 14-day extension may be granted if the member requests the extension or if the organization justifies a need for additional information and documents how the delay is in the interest of the member. Expedited grievances are resolved in 24 hours. Grievances unresolved within 30 days are referred to the Plan for resolution.

Notification of investigation results are provided to all concerned parties as expeditiously as the enrollee's case requires, based on the enrollee's health status, but not later than 30 calendar days from the date the grievance is filed with the health plan.

Medicare health plans must disclose grievance data to Medicare beneficiaries upon request.