

## Section 10 How to file a grievance

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### What is a Grievance?

A grievance is different from a request for an organization determination, a request for a coverage determination, or a request for an appeal as described in Section 11 and Section 12 of this manual because grievances do not involve problems related to coverage or payment for care or Part D benefits, problems about being discharged from the hospital too soon, and problems about coverage for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

For problems about coverage or payment for care, problems about being discharged from the hospital too soon, and problems about coverage for SNF, HHA, or CORF services ending too soon, you must follow the rules outlined in Section 11.

If you have a problem about our failure to cover or pay for a Part D prescription drug, you must follow the rules outlined in Section 12.

### What types of problems might lead to you filing a grievance?

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) ODS Advantage PPORX.
- Problems with the Member Service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, in a network pharmacy, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, network pharmacists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, network pharmacies, or hospitals.
- If you disagree with our decision not to expedite your request for an expedited coverage determination, organization determination, redetermination, or reconsideration.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.
- Failure by the Plan to provide required notices.
- Failure to provide required notices that comply with CMS standards.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In certain cases, you have the right to ask for a "fast grievance," meaning your

grievance will be decided within 24 hours. We discuss these fast grievances in more detail in Section 11 and Section 12.

## **Filing a grievance with ODS Health Plan, Inc.**

**If you have a complaint, we encourage you to first call Member Services at the number on the cover of this booklet or shown in Section 1. We will try to resolve any complaint that you might have over the phone.** If you request a written response to your phone complaint, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the ODS Advantage Grievance procedure.** You, the member, your authorized representative, your legal representative or any other provider or someone determined to have an appealable interest in the proceeding may file a grievance. You must file a grievance within 60 calendar days from the date of the event or incident that caused you to file the grievance. If you miss the deadline, you may still file a grievance and request an extension of the time frame. Your request must be in writing and include the reason you did not file the grievance on time.

You can **mail** your grievance to ODS Health Plan, Inc., Attn: Grievance Unit-ODS Advantage, P.O. Box 40384, Portland OR, 97240-4038, or **fax** your grievance to 503-243-5105 Attn: Grievance Unit-ODS Advantage. You may also file your grievance **in person** at ODS Health Plan, Inc., 601 S.W. Second Ave. Suite 700, Portland OR 97204.

If you **call** Member Services at 1-877-299-9062, and TTY at 1-800-433-6313, Monday through Friday from 7:30 a.m. to 5:30 p.m. Pacific time, they will record the grievance and repeat back to you the grievance as written to confirm the accuracy. The grievance will be noted with the time and the date. If you mail, fax or email your grievance, the received date and time will be noted on your letter.

The ODS Advantage Appeal and Grievance Department will then send an acknowledgement letter to you within 7 calendar days of the receipt on your letter or telephone call. You may be asked to provide additional information, which will be requested in the letter, before ODS Health Plan, Inc. can make a decision. We have 30 calendar days starting from the date the grievance was received to make a decision. Sometimes ODS Health Plan, Inc. may need more time to make a decision regarding quality of medical care. If ODS Health Plan, Inc. needs more time, you will receive a letter requesting the extra time and telling you why ODS Health Plan, Inc. needs more time to make a decision. When ODS Health Plan, Inc. has made a decision you will receive a letter explaining their decision. The letter will also explain what you can do if you don't agree with ODS Health Plan, Inc.'s decision and your right to file a quality of care grievance with Acumentra Health (QIO) in Oregon. We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

You may file a "fast" grievance if ODS Health Plan, Inc. turns down your request for a "fast" coverage determination and you have not yet received the service, or denies your request for a "fast" redetermination and you have not yet received the service. You must file the "fast" grievance within 48 hours from the date you received the decision that ODS Health Plan, Inc.

would not process your “fast” coverage determination or “fast” redetermination. Indicate clearly on your request you would like a “**FAST GRIEVANCE REQUEST**”. You may file a “fast” grievance by **phone, fax, or in person as listed above**. ODS Health Plan, Inc. will respond to your “fast” grievance in writing within 24 hours of receipt of your “fast” grievance.

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the timeframe by up to 14 days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

### **For quality of care problems, you may also complain to Acentra Health (QIO)**

Complaints concerning the quality of care received under Medicare, including care during a hospital stay may be acted upon by the plan sponsor under the grievance process, by an independent organization called Acentra Health (QIO), or by both. For any complaint filed with Acentra Health (QIO), the plan sponsor must cooperate with Acentra Health (QIO) in resolving the complaint. See Section 1 for more information about Acentra Health (QIO).

#### **How to file a quality of care complaint with Acentra Health (QIO)**

Quality of care complaints filed with Acentra Health (QIO) must be made in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. See page 2 of the introduction for more information about how to file a quality of care complaint with Acentra Health (QIO).