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## **7 How to file a Grievance**

### **What is a Grievance?**

A grievance is any complaint, other than one that involves a request for an organization determination, a coverage determination, or an appeal, as described in [Section 8](#) of this manual because grievances do not involve problems related to approving or paying for care or problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

If we will not give you the services you want and you believe that you are being released from the hospital or SNF too soon, or your HHA or CORF services are ending too soon, you must follow the rules outlined in [Section 8](#).

### **What types of problems might lead to your 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) the Plan.
- Problems with the service you receive from Member Services.
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- Problems getting appointments when you need them, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in more detail in [Section 8](#).
- You believe our notices and other written materials are hard to understand.
- We don't give you a decision within the required time frame (on time).
- We don't forward your case to the independent review entity if we do not give you a decision on time.
- We don't give you required notices.

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 we will answer your grievance within 24 hours. We discuss fast grievances in more detail in [Section 8](#).

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## Filing a grievance with our Plan

If you have a complaint, please call the phone number for **Part C Grievances** in Section 1 of this booklet. We will try to resolve your complaint over the phone. If you ask for a written response, 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 deliver 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 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 Acentra 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 or extends the time frame for a "fast" coverage determination or a "fast" organization determination and you have not yet received the service, or denies your request or extends the time frame for a "fast" redetermination or a "fast" appeal 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, "fast" organization determination, "fast" redetermination or "fast" appeal. Indicate clearly on your request you would like a

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**“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 address 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 time frame by up to 14 days if you ask for 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 Acumentra Health (QIO)**

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to an independent review organization called the Quality Improvement Organization (QIO) which is Acumentra Health in the state of Oregon, or both. If you file with Acumentra Health, we must help Acumentra Health resolve the complaint. See Section 1 for more information about Acumentra Health.

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

You must write to Acumentra Health to file a quality of care complaint. You may file your complaint with Acumentra Health at any time. See page 5 for more information about how to file a quality of care complaint with Acumentra Health.