CHAPTER 12
SECTION 10

GRIEVANCES AND GRIEVANCE PROCESSING

1.0. GRIEVANCE PROCESSING JURISDICTION

The regional contractor with claims processing jurisdiction for the beneficiary's claim address is responsible for processing grievances filed by or in behalf of the beneficiary. Should a grievance pertain to services received by the beneficiary in a region other than the beneficiary's claims processing region, the other region will cooperate with the region responsible for processing the grievance by providing information needed to process the grievance.

2.0. GRIEVANCES AND GRIEVANCE PROCESSING

The contractor shall develop and implement a single automated grievance system, separate and apart from the appeal process. The grievance system shall allow full opportunity for aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of a network provider, the health care finder, or other contractor or subcontractor personnel to furnish the level or quality of care and/or service to which the beneficiary may believe he/she is entitled. Any TRICARE beneficiary, sponsor, parent, guardian, or other representative who is aggrieved by any failure or perceived failure of the contractor, subcontractor or contracted providers of service or care to meet the obligations for timely, quality care and service at appropriate levels may file a grievance. All grievances must be submitted in writing. The subjects of grievances may be, but are not limited to, such issues as the refusal of a PCM to provide services or to refer a beneficiary to a specialist, the length of the waiting period to obtain an appointment, undue delays at an office when an appointment has been made, improper level of care, poor quality of care, or other factors which reflect upon the quality of the care provided or the quality and/or timeliness of the service. If the written complaint reveals an appealable issue, the correspondence shall be forwarded to the contractor's appeals unit for a reconsideration review. *If the complaint regards care for which Medicare was Primary payer, the complaint shall be forwarded to Medicare for resolution. The beneficiary shall be notified that the complaint was forwarded to Medicare and the address and phone number of where the complaint was forwarded.*

2.1. Contractor Responsibilities

It is the contractor's responsibility to conduct an investigation and, if possible, resolve the aggrieved party's problem or concern. In this responsibility the contractor shall:

2.1.1. Ensure that information for filing of grievances is readily available to all beneficiaries within the service area.

2.1.2. Maintain a system of receipt, identification, and control which will enable accurate and timely handling. All grievances shall be stamped with the actual date of receipt

within three workdays of receipt in the contractor's custody. The date of receipt shall be counted as the first day.

2.1.3. Investigate the grievance and document the results within 60 days of receipt of the grievance. The contractor shall notify the Contracting Officer of all grievances not reviewed within 60 days of receipt.

2.1.4. Provide interim written response by the 30th calendar day after receipt for all grievances not processed to completion by that date.

2.1.5. Take positive steps to resolve any problem identified within 60 days of the problem identification. If the problem cannot be resolved within that period of time, the Contracting Officer or Contracting Officer's Representative shall be informed of the nature of the problem and the expected date of resolution. If there is no resolution to the problem, the contractor should acknowledge receipt of the grievance and explain to the grievant why the problem cannot be resolved.

2.1.6. Written notification of the results of the review shall be submitted to the beneficiary within 60 days of the original receipt of the grievance. The letter will indicate who the grievant may contact to obtain more information and provide an opportunity *for the grievant, if not satisfied with the resolution,* to *request a second* review *by a different reviewer(s)*.

2.1.7. Ensure the involvement in the grievance review process of appropriate medical personnel, including personnel responsible for the contractor's quality assurance program in any case where the grievance is related to the quality of medical care or impacts on utilization review activities.

2.1.8. Maintain records for all grievances, including copies of the correspondence, the results of the review/investigation and the action taken to resolve any problems which are identified through the grievance.