

Complaints and Grievances

You have the right to file a complaint if you have a problem or concern. A grievance is any complaint other than one that involves an unfavorable determination about payment or authorization of medical services or supplies, i.e. when MCA decides not to pay or authorize medical services and supplies. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive.

If you have any of the complaints or problems below, you can **file a complaint**. **Here are some examples:**

Quality of your medical care

- Are you unhappy with the quality of care you've received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our plan's Member Services has dealt with you?
- Do you feel you are being encouraged to leave our plan (disenroll from our plan)?

Cleanliness

- Are you unhappy with the cleanliness or condition of a doctor's office, clinic, or hospital?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long:
 - By doctors, pharmacists, or other health professionals?
 - By Member Services or other staff at our plan?
 - Examples include waiting too long on the phone, in the waiting room, in the exam room, or when getting prescription

Information you get from our plan

- Do you believe we haven't given you a notice that we're required to give?
- Do you think written information we have given you is hard to understand?

The types of complaints listed below are all related to the *timeliness* of our actions related to coverage decisions and appeals.

Here are some examples:

- If you have asked our plan to give you a “fast response” for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When our plan does not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we don't do that, you can make a complaint.

Step-by-Step: Making a Complaint

Step 1: Contact us promptly – either by phone or in writing

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. You can contact Member Services at (602) 263-3000 or (800) 624-3879, TTY/TDD (866) 602-1982, 24 hours a day, 7 days a week.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you do this, it means that we will use our *formal procedure* for answering grievances. Here's how it works:
 - If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond to you in writing.
 - If we cannot resolve your complaint over the phone, we will respond to your complaint within 30 calendar days. .
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast response” to a coverage decision or appeal, we will automatically**

give you a “fast” complaint. If you have a “fast” complaint, it means we will give you **an answer within 24 hours.**

Step 2: We look into your complaint and give you our answer

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **The longest time we can take to answer a complaint is 30 days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more days (44 days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer.

You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to our plan by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to our plan).. If you make a complaint to this organization, we will work together with them to resolve your complaint.

Or you can make your complaint to both at the same time. If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

The Health Services Advisory Group is Arizona's Quality Improvement Organization. You may contact the **Health Services Advisory Group at** (800) 359-9909 or by writing:

Health Services Advisory Group, Inc.

1600 E. Northern Ave., Suite 100

Phoenix, AZ 85020