Group Health Cooperative
of South Central Wisconsin

APPROVAL as appropriate:

Board _____ Exec Dir _____
Med Dir _____ Other Dir/Mgr _____

REVIEWED BY LEGAL COUNSEL
Yes ___ No ___ Date: x
Name: x

POLICY STATUS: _x__ Approved ___Pending

Policy and Procedure

Title: Appeal/Grievance Process – Member Appeals Committee
Responsible Party: T. Rumler/S. Sinnett **Div/Dept/Serv Area:** Member Services
Volume: III **Number:** INS.MS.001 **Date of Issue:** 6/93 **Page 1 of 8**
Formerly A2a.015 (7/08)/MS.001 (4/12) NCQA UM 8 A

PURPOSE:

The purpose of this policy is:

1. To document the role of the Member Appeals Committee in the grievance process of Group Health Cooperative of South Central Wisconsin (GHC-SCW).

2. To document the policies and procedures for thorough, appropriate and timely registering and resolution of member appeals.

DEFINITIONS:

1. **Adverse Determination** means an adverse benefit determination [as defined in 29 CFR 2560.503-1], as well as any rescission of coverage, as described in § 147.128 (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time).
2. **Appeal/Grievance** means a request for GHC-SCW to review an Adverse Determination.
3. **Post-Service Appeal** means a request to change an Adverse Determination for care or services that have already been received by the member.
4. **Pre-Service Appeal** is a request to change an Adverse Determination for care or service that GHC-SCW must approve, in whole or in part, in advance of the member obtaining care or services.

POLICY:

1. The Member Appeals Committee is the adjudicating body for GHC-SCW's grievance process.
   a. The voting members of the Committee include: two physicians, the GHC-SCW Insurance Operations Manager, and the GHC-SCW Chief Insurance Services Officer.
   b. The Committee shall also include non-voting members. Non-voting members may include, but are not limited to the following positions at GHC: Associate Medical Director; Manager of Care Management; Manager of Member Services; Community Services Coordinator; and Corporate Compliance Officer. Non-voting members shall act as consultants to voting members of the Committee.
   c. GHC-SCW's BadgerCare Plus Coordinators shall act on the Committee for all Appeals/Grievances involving Medicaid Members to ensure all Appeals/Grievances are adjudicated in accordance with Medicaid rules.
   d. The Committee is chaired by the Member Appeals Representative.

2. The Member Appeals Committee review process is the only formal review level under the U.S. Department of Labor Benefit Claims Procedure Regulation (29 CFR 2560.503-1 The following applies to Member Appeals Committee members:

Review Date	2/04								
Revision Date	8/97	8/98	6/00	7/02	9/03	8/09	11/09	12/10	3/11
	4/12	1/15	11/17	02/19					

a. Committee members who are medical professionals are free to exercise independent medical judgment and medical decision-making,

b. Appointment of a new person to review a pre-service appeal who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination

c. Reprisals, retaliation, recrimination or other adverse actions taken against Committee members for exercising independent medical judgment and medical decision-making during the member appeals process is prohibited at GHC-SCW.

3. GHC-SCW continues coverage under their insurance policy during the appeal process (This applies to covered services only). GHC-SCW does not allow for rescission of coverage.

4. GHC-SCW provides notifications of appeal rights to members in a culturally and linguistically appropriate manner Notification rights are offered in other than English, if requested by the members.

5. GHC-SCW notifies members of further appeal rights. A BadgerCare Plus member may request a State Fair Hearing for an appeal of an action. The parties to the State Fair Hearing include DHS, GHC-SCW, as well as the member and his or her representative or the representative of a deceased member's estate.

6. Bypassing internal appeal review: With a member's permission, the organization may refer an appeal directly to an independent review organization (IRO) without conducting an internal review.

7. A GHC-SCW member or authorized representative on behalf of the Member may file a written expression of dissatisfaction with the administration, claims practices or provision of services (this includes a member chosen representative including an attorney). The member has the right to appear before the Committee and present the appeal in person. GHC-SCW will consider any written expression of dissatisfaction as an appeal with the potential to go to Committee if the matter is not resolved to the member's satisfaction. The Member Services Supervisor will maintain oversight of the grievance process and the Member Appeals Committee.

PROCEDURE:

1. Appeal/Grievance must be written unless a Member is unable to submit a written appeal form. If the Member is unable to submit a written appeal form, they may submit the appeal orally.

   a. The appeal/grievance should include all information that is pertinent to reconsideration.

   b. Appeals/grievances will be accepted without time limitation in compliance with Section Ins. 18.03.

   c. GHC-SCW allows a practitioner or other authorized representative to act on behalf of the member for the member appeals process; this includes anyone a member chooses, including an attorney. To protect the member's confidentiality, GHC-SCW must receive written notification from the member appointing the representative. GHC-SCW will then direct all information to the member and their representative regarding the appeal. GHC-SCW notifies members of their right to have a representative act on their behalf at all levels of appeal when it notifies them of a denial decision.

2. GHC-SCW will document the substance of the appeal and any actions taken in the Member Services database.

a. The database will contain information of the investigation of the substance of the appeal, including any aspect of clinical care involved, and document its findings. A review of the appeal must be conducted that does not give deference to the denial decision.

b. The database will log the date of notification to the member of the disposition of their appeal and resolution of the case.

3. Receipt of the member's appeal/grievance must be acknowledged within **five (5) business days of receipt**. The letter will also notify the member of the Member Appeals Committee meeting and provide information regarding the appeals process and the member's appeal rights, including:

   a. The opportunity for the member to submit written comments, documents, records, and other information relating to the appeal/claim for benefits;

   b. A full investigation of the substance of the appeal, including any aspects of clinical care involved must be conducted, taking into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

   c. Upon request and free of charge, reasonable access to (and copies of) all documents, records, and other information relevant to the claimant's claim for benefits.

   d. The right to request interpreter services.

4. The Member must be notified in writing of the meeting at least **seven (7) calendar days** prior to the scheduled meeting date.

   a. The letter must include the date, time, and location of the meeting at which the appeal will be heard.

   b. The letter must also advise the Member of their right to present their appeal in person.

5. GHC-SCW will provide the member free of charge any new or additional evidence considered, relied upon, or generated by GHC-SCW in connection with the appeal. The member will receive this with adequate time for review before the appeal is heard. Information cannot be added, changed, or deleted without adequate notice to the member. This information is included with the 5-day letter and at no cost to the member.

6. Information presented to the Committee and member may include but is not limited to the following:

   a. Confidential Appeal Information Form. This includes a brief chronology of events in date order.

   b. Appeal Outline Guide

   c. Members Appeal Communication

   d. Care Management Approval/Denial Letter when appropriate.

   e. Information sent by the member

f. Letters of support from Providers

g. Medical Records- Include all records related to the case. This may include Primary or Specialty Care OV, PT, UC, ER, etc. Position in packets with the oldest notes first working to the current notes at the end.

h. Care Management Notes - Non MD Reviewer Note Type and Member Communication Note Type. (Member Communication is a new note type established 9-1-10).

i. Adjudication Review of claim/s when appropriate

j. Supporting Documentation including but not limited to TAC, P&P, Millimum criteria, Certificate Language, CRM notes.

7. The Member may bring a representative to the meeting.

   a. If the member is not able to attend the meeting, he or she will be provided the opportunity to communicate with the Committee by conference call or other appropriate technology.

   b. GHC-SCW allows a practitioner or other representative to be present with the Member during the Member Appeals Meeting. To protect the Member's confidentiality, GHC-SCW must receive written notification from the member appointing the representative. GHC-SCW will then direct all information to the member and their representative regarding the appeal.

8. The Medical Director reviews appeals involving clinical issues.

   a. The Medical Director will consult with an actively practicing practitioner in the same or similar specialty that typically treats medical conditions and/or performs procedures appropriate to the case. This individual will be independent of any of the MCO's prior decisions regarding the case. This practitioner will exercise independence in decision-making, and will not be the subordinate of a person involved in an initial denial or prior review.

   b. **Person or people deciding the appeal.**

      1) The organization must appoint a person not involved in the prior adverse decision to review the appeal. The appointed person must be neither the individual who made the Adverse Determination that is the subject of the appeal nor a subordinate of (i.e., directly supervised by) such individual, although the practitioner who made the initial Adverse Determination may review the case and overturn the previous decision.

      2) As with initial UM denial decisions, a physician or other appropriate clinical peer must evaluate medical necessity decisions for adverse appeal decisions.

      3) Practitioners consulted under these circumstances are afforded the same independent judgment and decision-making autonomy as Committee members.

   c. **Same-or-similar-specialist review**

      1) For appeals involving clinical issues, including appeals about whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, a health care practitioner who has appropriate training and experience in the field of medicine involved in the case must review the appeal. NCQA refers to this practitioner as a **same-or-similar specialist**.

2) The *same specialty* refers to a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A *similar specialty* refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.

3) Depending on the type of case, a same-or-similar specialist may be a physician, behavioral healthcare practitioner, chiropractor, dentist, physical therapist or other type of practitioner, as appropriate.

4) Member Services will submit medical necessity appeals requiring specialty reviews to the Medical Director at the time the appeal letter is received.

9. An appeal/grievance must be resolved within **thirty (30) calendar days** of receipt.

   a. A **post-service appeal** is a request to change an Adverse Determination for care or services that have already been received by the member. If the appeal/grievance relates to a **post-service** appeal and the appeal/grievance cannot be resolved within thirty (30) calendar days, an extension of an additional thirty (30) calendar days must be requested. A post-service appeal is a request to change an Adverse Determination for care of services that have already been received by the member. All post-service appeals/grievances will be resolved within sixty (60) calendar days from the date of receipt of the proposal.

   b. A **pre-service appeal** is a request to change an Adverse Determination for care or service that the organization must approve, in whole or in part, in advance of the member obtaining care or services. A member's request for an appeal of a denial for service excluded from the organization's benefits package is a preservice appeal if the member has not received the requested services. In this case, the member may not receive coverage for the requested care or service unless the organization approves it. If the appeal/grievance relates to a **pre-service** appeal, the appeal/grievance must be resolved within thirty (30) calendar days of receipt. A thirty (30) day extension is not permitted for pre-service claims unless granted by the member verbally or in writing. A pre-service appeal is a request to change an Adverse Determination for care or service that the organization must approve, in whole or in part, in advance of the member obtaining care or services.

   c. If the appeal/grievance is from a Medicaid/BadgerCare member, the HMO must provide an initial response (5-day letter) within ten (10) business days and a final response (approval/denial) within thirty (30) calendar days of receiving the grievance. If the HMO is unable to resolve the grievance within thirty (30) calendar days, the time period may be extended another fourteen (14) calendar days from receipt of the grievance if the HMO notifies the enrollee in writing that: 1) the HMO has not resolved the grievance; 2) the HMO expects to resolve the grievance by a specified date; and 3) the HMO needs the additional time for reasons specified by the HMO. The total timeline for an HMO to finalize a formal grievance may not exceed (45) calendar days from the date of the receipt of the grievance. A copy of the Members appeal request is sent to the GHC-SCW BadgerCare Member Advocate who is also in attendance at the Member Appeal Meeting.

10. The Member Appeals Representative will prepare the agenda including all materials pertinent to each appeal.

    a. The Member Appeals Representative will copy and distribute all materials to each Committee member and the grievant prior to the scheduled meeting.

    b. One copy of all materials will be kept in the Member Appeals Committee binder in the Member Services Department files.

11. The Member Appeals Representative will chair the meeting and maintain minutes.

    a. Minutes will be copied and distributed to Committee members by the Member Appeals Representative.

    b. One copy of the minutes will be kept in the Member Appeals Committee binder in the Member Services Department files.

12. The Member Appeals Representative responds to each grievance in writing within 30 days from the member's written appeal with the Committee's decision regarding their appeal. The notice must include the title of each reviewer for a benefit appeal or the title, qualifications and specialty (e.g., MD, DO, PhD) of each reviewer for a medical necessity appeal. It must also specifically state that these individuals participated in the appeal review. Participant names do not need to be included in the written notification to members, but must be provided to members upon request.

    a. If the appeal/grievance relates to a post-service appeal that has had an extension, the member must be notified in writing of the Committee's decision no later than sixty (60) calendar days from receipt of the Member's written grievance. If the appeal/grievance relates to a pre-service appeal, the member must be notified within thirty (30) calendar days of receipt unless the member has granted a 30-day extension. If the denial decision is upheld, the member is informed of further appeal rights if any. The denial letter will explain the reason for the denial, definitions when appropriate, criteria on which the decision was based and any discussion related to the decision. Administrative Rights are included in denial letters to members covered by Employee Trust Fund (ETF). It is the Member Services internal department goal to send written notification to members within five (5) business days of the meeting date.

    b. Although there are allowable extensions for initial UM decisions, there are only two acceptable provisions for extending the appeal timeframe to obtain additional information.

        1) The member voluntarily agrees to extend the appeal time frame

        2) Federal program regulations allow the organization to request additional information from the member. If the appeal does not qualify for an extension, the organization must make the appeal decision within the allotted timeframe based on the information it has.

    a. In cases that involve a Medicaid/BadgerCare Member, the Member will be notified of his/her right to also appeal directly to the Department of Health and Family Services or to the Division of Hearings and Appeals.

13. An **expedited appeal** is a request to change an Adverse Determination for urgent care. A Member or practitioner may request that an appeal/grievance be expedited. Expedited appeals do not require a written grievance. The Medical Director will use urgent care criteria in determining the approval for an expedited appeal. Urgent care is defined as any request for medical care or treatment with respect to which the application of the time period for making non-urgent care determinations:

    a. Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment; or

    b. In the opinion of a practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request; or

An expedited review will be granted to all requests concerning admissions, continued stay, or other health care services for a member who has received emergency services but has not been discharged from a facility

14. Processing Expedited Appeals

    a. An expedited appeal/grievance will be resolved as expeditiously as the medical condition requires, but no later than 1BD, not to exceed 24 hours from the date the grievance is received.

    b. Expedited appeal requests received outside of normal business hours will be routed to Medical Answering for immediate handling.

    c. The Member Appeals Representative will coordinate the resolution of an approved expedited appeal with the Member Appeals Committee.

    d. The Member Appeals Representative will notify the member and/or practitioner of the Committee's decision within twenty-four (24) hours using the most expeditious method available (e.g., telephone, fax, etc.). Written notification will be sent to the member and practitioner no later than three (3) calendar days after the initial oral notification.

    e. A copy of the appeal must be included in the Member Appeals Committee binder in the Member Services Department files. The Member Appeals Representative will maintain a record of all appeals by completing an entry into the Member Services database. Each entry will include a dated summary of each appeal. The response and resolution will be noted. The information contained in the log will be presented in the Member Services' Quarterly Report and the Annual Report.

15. Trends will be analyzed to help determine improvements in benefits, services, or policies of GHC-SCW.

16. Quarterly reports of Medical Assistance appeals will be prepared for the Department of Health and Family Services.

17. Annual reports are prepared for the GHC-SCW Board of Directors and other GHC-SCW Quality Committees.

18. ERISA Notification Requirements: Notification when Decision is not in favor of the Member. A denial notice must include:

    a. The specific reason for upholding the denial, in an easy to understand language; and

    b. Reference to the specific plan provisions, guideline, protocol, or other similar criterion upon which the upheld denial is based; and

       A notification statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

    c. A statement outlining the claimant's right to sue under section 502 (a) of the Employee Retirement Income Security Act of 1974 (ERISA) following an adverse benefit determination on review; and

    d. A statement making any internal rule, guideline, protocol, et al relied upon in making an Adverse Determination available free of charge to the claimant upon request; and

e. A statement making an explanation of the scientific or clinical judgment for any determination based on medical necessity or experimental treatment exclusions or limits available free of charge to the claimant upon request; and

f. A statement making a list of medical and vocational experts consulted during the review process available free of charge to the claimant upon request.