STATE OF WEST VIRGINIA

Offices of the Insurance Commissioner

BOB WISE
Governor

JANE L. CLINE
Insurance Commissioner

MAY 2004

WEST VIRGINIA INFORMATIONAL LETTER

No. 100A

TO: ALL HEALTH MAINTENANCE ORGANIZATIONS LICENSED TO DO BUSINESS IN THE STATE OF WEST VIRGINIA

RE: ANNUAL GRIEVANCE REPORT AND WRITTEN PLANS OF ACTION REGARDING COMPLAINTS

I. Purpose: The purpose of this Informational Letter is to clarify the requirements for the Annual Grievance Report to be filed by a health maintenance organization (HMO) as required by West Virginia Code Section 33-25A-12(4) and to update the Annual Grievance Report Form. In addition, this Informational Letter clarifies when HMO's that have received ten (10) or more complaints relating to the same or similar subject matter must submit written plans of action pursuant to West Virginia Code of State Rules, §114-53-5.10.

II. Annual Grievance Report. West Virginia Code Section 33-25A-12 states that HMO's must maintain a grievance procedure by which enrollees (or their authorized representatives) may report grievances with respect to any provisions of the HMOs' health maintenance contracts. West Virginia Code Section 33-25A-12(4) further states that each HMO must submit to the Commissioner an annual report in a form prescribed by the Commissioner which describes its grievance procedure and contains a compilation and analysis of the grievances filed, their disposition, and their underlying causes. A description of the HMO's grievance procedure must be attached to the Annual Grievance Report form. The form for this report is Attachment A to this Informational Letter. Each HMO must complete this form to account for all matters handled through its expedited and formal grievance procedures, and attach additional information and/or explanations on a separate sheet of paper. The report must cover all enrollees of the HMO, including PEIA and Medicaid enrollees. However, the report is not required to cover Medicare and Administrative Services Only ("ASO") enrollees.

The completed report and a description of the grievance procedure are due on or before March 1st following the end of the calendar year covered by the report, and should be forwarded to:

Director of Consumer Services
Office of the Insurance Commissioner
P.O. Box 50540
Charleston WV 25305-0540
Telephone (304) 558-3386
Fax (304) 558-4965

A copy of each expedited and formal grievance and the HMO's response to the grievance must be maintained by the HMO and available to the Commissioner and the public for inspection for three (3) years after the grievance procedure is complete.

III. Written Plans of Action. West Virginia Code of State Rules, §114-53-5.10 states:

> If a health maintenance organization receives ten or more complaints from members or enrollees within a six-month period that relate to the same or similar subject matter, the health maintenance organization shall develop a specific written plan of action as to the resolution of the complaints and file a report with the commissioner on how the complaints were successfully resolved.

For purposes of completing this report, the phrase "same or similar subject matter" will include the following categories:

Disputed Amount
Coordination of Benefits Dispute
Timeliness of Payment
Balance Bill Dispute
Non-Covered
Not Medically Necessary
Out-of-Area Non-Par Provider
Member Not Eligible for Service
No PCP Referral
Referral Denied
Emergency Services Denied
Quality of Care Issues
Mental Health Services Denied
Prescription Formulary
Limitations on Prescription
Inability to access a member service representative and/or medical management staff by phone
Members' handbooks and evidence of coverage not sent to the consumer within a reasonable period of time
Identification cards not sent to the consumer within an appropriate period of time
Misleading or outdated information noted in the HMO's Physicians Directory
Refusal to Insure
Cancellation
Nonrenewal

An HMO will be required to submit a corrective action plan if it receives ten (10) or more confirmed complaints regarding any of the above listed categories within a reporting period. Written plans of action will be submitted for semiannual calendar year periods (e.g. January–June, July-December). HMO's must submit these plans (when required) within thirty days of the end of a reporting period to:

Director of Consumer Services
Office of the Insurance Commissioner
P.O. Box 50540
Charleston WV 25305-0540
Telephone (304) 558-3386
Fax (304) 558-4965

IV. Definitions Relating to Reports. It is recognized that the HMO's licensed in this State have adopted different terms for use within their grievance procedures that may not be otherwise

defined in applicable statutes or rules. The Commissioner believes that a common understanding of the meanings of these terms will promote consistency within the information reported by all HMO's. Therefore, when completing the Annual Grievance Report and when tracking same or similar complaints, as appropriate, the following terms will be understood to have the meanings assigned herein:

Inquiry or General Concern. A statement of opinion, request for information, clarification of policy, or administrative service. Inquiries or general concerns are not an expression of any dissatisfaction, and are not subject to the appeal process.

Informal Complaint or Grievance. A non-written expression of dissatisfaction submitted by or on behalf of a covered person regarding:

- the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
- claims payment, handling or reimbursement for health care services; or
- matters pertaining to the contractual relationship between a covered person and an HMO.

Formal Complaint or Grievance. A written expression of a dissatisfaction submitted by or on behalf of a covered person regarding:

- the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
- claims payment, handling or reimbursement for health care services; or
- matters pertaining to the contractual relationship between a covered person and an HMO.

Expedited Complaint or Grievance. Any expression of dissatisfaction in which time is of the essence, such that a reasonable person would believe that a prevailing member would be able to realize the full benefit of a decision in his or her favor. Expedited complaints or grievances relating to coverage denials must be reported on the Annual Grievance Report form regardless of whether they are presented to the HMO as oral or written.

Confirmed Complaint or Grievance. Any expression of dissatisfaction pursuant to which the HMO's original decision is overturned or significantly modified, or pursuant to which the HMO has required corrective action or additional training on the part of a provider. A confirmed complaint does not include a complaint upon which the original decision of the HMO is overturned or significantly modified based upon additional information received by the HMO.

Appeal. A specialized form of grievance requested by a member or practitioner on behalf of member for reconsideration of an adverse decision (such as a Utilization Review determination, a benefit payment, an administrative action or a quality of care, obtaining coverage or service issue) with the goal of finding a mutually acceptable solution.

IV. This Informational Letter supercedes Informational Letter 100 dated April, 1996.

If you have any questions regarding the contents of this Informational Letter, you may contact Kathleen Beck, Director of the Consumer Service Division at (304) 558-3386 ext. 125.

ss:/Jane L. Cline
Jane L. Cline
INSURANCE COMMISSIONER

WEST VIRGINIA INSURANCE COMMISSIONER
HEALTH MAINTENANCE ORGANIZATION
ANNUAL GRIEVANCE REPORT

Attachment A

INSTRUCTIONS

W.Va. Code §33-25A-12(4) states that each health maintenance organization shall submit to the Commissioner an annual report in a form prescribed by the Commissioner which describes its grievance procedure and contains a compilation and analysis of the grievances filed, their disposition, and their underlying causes. Please complete in accordance with instruction contained in Informational Letter 100A and return to ***Director of Consumer Services, Office of the Insurance Commissioner, P.O. Box 50540, Charleston, WV 25305-0540, phone: (304) 558-3386.***

HMO Name: _____

Address: _____

City, State, Zip: _____

For questions, contact: (Name) _____ (Phone Number) _____

Report for Calendar Year Ending: _____ Date Completed (MM/DD/YY): _____

FORMAL GRIEVANCES

I. Service Denied: Precert/ Non-Covered	Total	Expedited	Non Expedited	# Physician Initiated	# Enrollee Initiated	# Resolved in Favor of Grievant	# Resolved Against Grievant	With-drawn	# Referred External Review	Level of Review	# Remaining Open	Other (Explain)
Non-Covered												
Not Medically Necessary												
Out-of-Area Non-Par Provider												
Not Eligible For Service												
No PCP Referral												
Referral Denied												
Emergency Services Denied												
Mental Health Services Denied												
Access to Care												
Referral to External Review Organization												
Prescription Formulary												
Limitations on Prescription												
Other (State Reason):												

II. Payment: Post-Service	Total	Expedited	Non Expedited	# Physician Initiated	# Enrollee Initiated	# Resolved in Favor of Grievant	# Resolved Against Grievant	With-drawn	# Referred to External Review	Level of Review	# Remaining Open	Other (Explain)
Disputed Amount												
Coordination of Benefits Dispute												
Timeliness of Payment												
Balance Bill Dispute												
Non-Covered												
Not Medically Necessary												

II. Payment: Post-Service (Continued)	Total	Expedited	Non Expedited	# Physician Initiated	# Enrollee Initiated	# Resolved in Favor of Grievant	# Resolved Against Grievant	With-drawn	# Referred to External Review	Level of Review	# Remaining Open	Other (Explain)
Out-of-Area Non-Par Provider												
Member Not Eligible for Service												
No PCP Referral												
Referral Denied												
Emergency Services Denied												
Quality of Care Issues												
Mental Health Services Denied												
Prescription Formulary												
Limitation on Prescription												
Other (State Reason):												

III. Service: Administrative Related Grievances	Total	Expedited	Non Expedited	# Physician Initiated	# Enrollee Initiated	# Resolved in Favor of Grievant	# Resolved Against Grievant	With-drawn	Level of Review	# Remaining Open	Other (Explain)
Inability to access a member service representative and/or medical management staff by phone											
Members' handbooks and evidence of coverage not sent to the consumer within a reasonable period of time											
Identification cards not sent to the consumer within an appropriate period of time											
Misleading or outdated information noted in the HMO's Physicians Directory											
Refusal to Insure											
Cancellation											
Nonrenewal											
Other (State Reason)											

Total Formal Grievances	Total	Expedited	Non Expedited	# Physician Initiated	# Enrollee Initiated	# Resolved in Favor of Grievant	# Resolved Against Grievant	With-drawn	# Referred to External Review	Level of Review	# Remaining Open

Turnaround Time (In Days)	Category I	Category II	Category III
Average			
Median			
Longest			
Shortest			