

**TITLE 114  
INSURANCE COMMISSIONER  
LEGISLATIVE RULE**

**SERIES 96  
HEALTH PLAN ISSUER INTERNAL  
GRIEVANCE PROCEDURE**

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**§114-96-1. General.**

1.1. Scope. – The purpose of this rule is to provide standards for the establishment and maintenance of procedures by issuers to assure that covered persons have the opportunity for the appropriate resolution of grievances. This rule is based upon the National Association of Insurance Commissioners' "Health Carrier Grievance Procedure Act" (Model #72), as amended in 2012. To the extent feasible, this rule should be construed consistently with related state and federal laws, but to the extent any provision conflicts with a provision of other related rules in this title (including, but not limited to, series 43, 46, 50, 51 and 53 of this title), the provisions of this rule shall control and take precedence.

1.2. Authority. – W. Va. Code §33-2-10 & 33-16H-4

1.3. Filing Date. --

1.4. Effective Date. --

**§114-96-1. Definitions.**

In addition to the definitions found in W. Va. Code of St. R. §114-95-2, the following definitions apply:

2.1. "Final adverse determination" means an adverse determination that has been upheld by the issuer at the completion of the internal grievance procedures or an adverse determination with respect to which the internal grievance procedures have been exhausted.

2.2. "Grievance" means a written complaint or, if the complaint involves an urgent care request submitted by or on behalf of a covered person, an oral complaint, regarding:

2.2.a. Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

2.2.b. Claims payment, handling or reimbursement for health care services; or

2.2.c. Matters pertaining to the contractual relationship between a covered person and an issuer.

### **§114-96-3. Grievance Reporting and Recordkeeping Requirements.**

3.1. An issuer shall maintain written records to document all grievances received, including the notices and claims associated with the grievances.

3.1.a. The records of all grievances initiated in each calendar year shall be arranged in a separate register, the contents and form of which shall be prescribed by the Commissioner.

3.1.b. The records shall be retained for the longer of five (5) years or until the Commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

3.1.c. The issuer shall make the records available for examination by the Commissioner and such other persons designated by the Commissioner.

3.2. An issuer shall annually submit to the Commissioner, at such time and in a format prescribed by the commissioner, a report containing a compilation and analysis of the grievances filed, their disposition and their underlying causes.

### **§114-96-4. Grievance Review Procedures.**

4.1. Whenever an issuer fails to adhere to the requirements of section 5 or section 7 of this rule with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the provisions of this rule and may file a request for external review in accordance with the procedures outlined in W. Va. Code of St. R. §114-97-1 *et seq.*

4.1.a. Notwithstanding subsection 1 of this section, the provisions of section 5 of this rule shall not be deemed exhausted based on a *de minimis* violation that does not cause, and is not likely to cause, prejudice or harm to the covered person as long as the issuer demonstrates that the violation was for good cause or due to matters beyond the control of the issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and the covered person.

4.1.a.1. The exception provided in subdivision a of this rule does not apply if the violation is part of a pattern or practice of violations by the issuer.

4.1.a.2. An issuer shall, within ten (10) days of receiving a written request from a covered person, provide a written explanation of basis, if any, for asserting that the alleged violation of section 5 or 7 of this rule does not entitle the covered person to claim exhaustion.

4.1.b. If an independent review organization rejects the grievance involving an adverse determination for immediate review on the basis that the issuer met the requirements of

the exception provided in subdivision a of this rule, the covered person has the right to resubmit and pursue a review of the grievance under this rule.

4.1.b.1. In this case, within a reasonable time but not exceeding ten (10) days after the independent review organization rejects the grievance involving an adverse determination for immediate review, the issuer shall provide to the covered person notice of the opportunity to resubmit and, as appropriate, pursue a review of the grievance under this rule.

4.1.b.2. For purposes of calculating the time period for re-filing the benefit request or claim under this paragraph, the time period shall begin to run upon the covered person's or, if applicable, the covered person's authorized representative receipt of the notice of opportunity to resubmit.

#### 4.2.

4.2.a. An issuer shall file a copy of the procedures required under subsection 4.1 of this rule, including all forms used to process requests made pursuant to section 5, 6 and 7 of this rule, with the commissioner. Any subsequent material modifications to the documents also shall be filed.

4.2.b. The commissioner may disapprove a filing received in accordance with subdivision a of this subsection that fails to comply with this rule.

4.3. In addition to subsection 4.2, an issuer shall file annually with the commissioner, as part of its annual report required by section 3 of this rule, a certificate of compliance stating that the issuer has established and maintains, for each of its health benefit plans, grievance procedures that fully comply with the provisions of this rule.

4.4. A description of the grievance procedures required under this section shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons.

4.5. The grievance procedure documents shall include a statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement shall include the telephone number and address for the commissioner's office.

### **§114-96-5. First Level Reviews of Grievances Involving an Adverse Determination.**

5.1. Within 180 days after the date of receipt of a notice of an adverse determination sent pursuant to W. Va. Code of St. R. §114-96-1 *et seq.*, a covered person may file a grievance with the issuer requesting a first level review of the adverse determination.

#### 5.2.

5.2.a. The issuer shall provide the covered person with the name, address and

telephone number of a person or organizational unit designated to coordinate the first level review on behalf of the issuer.

5.2.b. In providing for a first level review under this section, the issuer shall ensure that the review is conducted in a manner under this section to ensure the independence and impartiality of the individuals involved in making the first level review decision.

5.2.c. In ensuring the independence and impartiality of individuals involved in making the first level review decision, the issuer shall not make decisions related to such individuals regarding hiring, compensation, termination, promotion or other similar matters based upon the likelihood that the individual will support the denial of benefits.

### 5.3.

5.3.a. In the case of an adverse determination involving utilization review, the issuer shall designate an appropriate clinical peer or peers, none of whom shall have been involved in the initial adverse determination and at least one of whom shall be of the same or similar speciality as would typically manage the case being reviewed..

5.3.b. In designating more than one clinical peer pursuant to subdivision a of this subsection, the issuer shall ensure that a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment is available for consultation.

5.3.c. In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person, without regard to whether the information was submitted or considered in making the initial adverse determination.

### 5.4.

#### 5.4.a.

5.4.a.1. A covered person does not have the right to attend, or have a representative in attendance, at the first level review, but the covered person is entitled to:

5.4.a.1.A. Submit written comments, documents, records and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and

5.4.a.1.B. Receive from the issuer, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits.

5.4.a.2. For purposes of subparagraph B, paragraph 1 of this subdivision, a document, record or other information shall be considered "relevant" to a covered person's

request for benefits if the document, record or other information:

5.4.a.2.A. Was relied upon in making the benefit determination;

5.4.a.2.B. Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the benefit determination;

5.4.a.2.C. Demonstrates that, in making the benefit determination, the issuer or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or

5.4.a.2.D. Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

5.5. For purposes of calculating the time periods within which a determination is required to be made and notice provided under subsection 5.6, the time period shall begin on the date the grievance requesting the review is filed with the issuer in accordance with the issuer's procedures established pursuant to section 4 of this rule for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

5.6.

5.6.a. An issuer shall notify and issue a decision in writing or electronically to the covered person within the time frames provided in subdivisions b and c of this subsection.

5.6.b. With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, the issuer shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty (30) days after the date of the issuer's receipt of the grievance requesting the first level review pursuant to subsection 5.1.

5.6.c. With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, the issuer shall notify and issue a decision within a reasonable period of time, but no later than sixty (60) days after the date of the issuer's receipt of the grievance requesting the first level review made pursuant to subsection 5.1.

5.7.

5.7.a. Prior to issuing a decision in accordance with the time-frames provided in subsection 5.6 of this rule, the issuer shall provide free of charge to the covered person any new or additional evidence, relied upon or generated by the issuer, or at the direction of the issuer, in

connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the covered person a reasonable opportunity to respond prior to that date.

5.7.b. Before the issuer issues or provides notice of a final adverse determination in accordance with the time-frames provided in subsection 5.6 of this rule that is based on new or additional rationale, the issuer shall provide the new or additional rationale to the covered person free of charge as soon as possible and sufficiently in advance of the date the notice of final adverse determination is to be provided to permit the covered person a reasonable opportunity to respond prior to that date.

5.8. The decision issued pursuant to subsection 5.6 of this rule shall set forth in a manner calculated to be understood by the covered person:

5.8.a. The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);

5.8.b. Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider and, if applicable, the claim amount;

5.8.c. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. For purposes of this subdivision, an issuer:

5.8.c.1. Shall provide to the covered person as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination; and

5.8.c.2. Shall not consider a request for the diagnosis code and treatment information, in itself, to be a request for external review pursuant to W. Va. Code of St. R. §114-97-1 *et seq.*;

5.8.d. A statement of the reviewers' understanding of the covered person's grievance;

5.8.e. The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the issuer's position;

5.8.f. A reference to the evidence or documentation used as the basis for the decision;

5.8.g. For a first level review decision issued pursuant to subsection 5.6 of this rule that upholds the grievance:

5.8.g.1. The specific reason or reasons for the final adverse determination,

including denial code and its corresponding meaning, as well as a description of the issuer's standard, if any, that was used in reaching the denial;

5.8.g.2. The reference to the specific plan provision on which the determination is based;

5.8.g.3. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in paragraph 2, subdivision a, subsection 5.4 of this rule, to the covered person's benefit request;

5.8.g.4. If the issuer relied upon an internal rule, guideline, protocol or other similar criterion to make the final adverse determination, either specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the final adverse determination and that a copy of the same will be provided free of charge to the covered person upon request;

5.8.g.5. If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provide to the covered person free of charge upon request; and

5.8.g.6. If applicable, instructions for requesting:

5.8.g.6.A. A copy of the rule, guideline, protocol or other similar criterion relied upon in making the final adverse determination as provided in paragraph 4 of this subdivision; and

5.8.g.6.B. The written statement of the scientific or clinical rationale for the determination, as provided in paragraph 5 of this subdivision;

5.8.h. If applicable, a statement indicating:

5.8.h.1. A description of the process to obtain an additional voluntary review of the first level review decision, if the covered person wishes to request a voluntary review pursuant to section 7 of this rule;

5.8.h.2. The written procedures governing the voluntary review, including any required time frame for the review;

5.8.h.3. A description of the procedures for obtaining an independent external review of the final adverse determination pursuant to W. Va. Code of St. R. §114-97-1 *et seq.* if the covered person decides not to file for an additional voluntary review of the first level review decision involving an adverse determination; and

5.8.h.4. The covered person's right to bring a civil action in a court of competent jurisdiction;

5.8.i. If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

5.8.j. Notice of the covered person's right to contact the Commissioner's office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the Commissioner's office.

5.9.

5.9.a. An issuer shall provide the notice required under subsection 5.8 of this rule in a culturally and linguistically appropriate manner in accordance with federal regulations.

5.9.b. To be considered to meet the requirements of subdivision a of this subsection, the issuer shall:

5.9.b.1. Provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;

5.9.b.2. Provide, upon request, a notice in any applicable non-English language; and

5.9.b.3. Include in the English version of all notices, a statement prominently displayed in any applicable non-English language clearing indicating how to access the language services provided by the carrier.

5.9.c. For purposes of this subsection, with respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten (10) percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

#### **§114-96-6. Standard Reviews of Grievances Not Involving an Adverse Determination.**

6.1. An issuer shall establish written procedures for a standard review of a grievance that does not involve an adverse determination.

6.2.

6.2.a. The procedures shall permit a covered person to file a grievance that does not involve an adverse determination with the issuer under this section.

6.2.b.

6.2.b.1. A covered person does not have the right to attend, or to have a representative in attendance at the standard review, but the covered person is entitled to submit written material for the person or persons designated by the carrier pursuant to subsection 6.3 of this rule to consider when conducting the review.

6.2.b.2. The issuer shall make the provisions of paragraph 1 of this subdivision known to the covered person within three working days after the date of receiving the grievance.

6.3.

6.3.a. Upon receipt of the grievance, an issuer shall designate a person or persons to conduct the standard review of the grievance.

6.3.b. The issuer shall not designate the same person or persons to conduct the standard review of the grievance that denied the claim or handled the matter that is the subject of the grievance.

6.3.c. The issuer shall provide the covered person with the name, address and telephone number of a person designated to coordinate the standard review on behalf of the issuer.

6.4.

6.4.a. The issuer shall notify in writing the covered person of the decision with twenty (20) working days after the date of receipt of the request for a standard review of a grievance filed pursuant to subsection 6.2.

6.4.b.

6.4.b.1. Subject to paragraph 2 of this subdivision, if, due to circumstances beyond the issuer's control, the issuer cannot make a decision and notify the covered person pursuant to subdivision a of this subsection within twenty (20) working days, the issuer may take up to an additional ten (10) working days to issue a written decision.

6.4.b.2. An issuer may extend the time for making and notifying the covered person in accordance with paragraph 1 of this subdivision, if, on or before the twentieth working day after the date of receiving the request for a standard review of a grievance, the issuer provides written notice to the covered person of the extension and the reasons for the delay.

6.5. The written decision issued pursuant to subsection 6.4 shall contain:

6.5.a. The titles and qualifying credentials of the person or persons participating

in the standard review process (the reviewers);

6.5.b. A statement of the reviewers' understanding of the covered person's grievance;

6.5.c. The reviewer's decision in clear terms and the contract basis in sufficient detail for the covered person to respond further to the issuer's position;

6.5.d. A reference to the evidence or documentation used as the basis for the decision;

6.5.e. If applicable, a statement indicating:

6.5.e.1. A description of the process to obtain an additional review of the standard review decision if the covered person wishes to request a voluntary review pursuant to section 7 of this rule; and

6.5.e.2. The written procedures governing the voluntary review, including an required time frame for the review; and

6.5.f. Notice of the covered person's right, at any time to contact the Commissioner's office, including the telephone number and address of the Commissioner's office.

#### **§114-96-7. Expedited Reviews of Grievances Involving an Adverse Determination.**

7.1. An issuer shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.

7.2. In addition to subsection 8.1 of this rule, an issuer shall provide expedited review of a grievance involving an adverse determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services, but has not been discharged from a facility.

7.3 The procedures shall allow a covered person to request an expedited review under this section orally or in writing.

7.4. An issuer shall appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer or peers shall not have been involved in making the initial adverse determination.

7.5. In an expedited review, all necessary information, including the issuer's decision shall be transmitted between the issuer and the covered person by telephone, facsimile or the

most expeditious method available.

7.6.

7.6.a. An expedited review decision shall be made and the covered person or, if applicable, the covered person's authorized representative shall be notified of the decision in accordance with subsection 8.8 of this rule as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two (72) hours after the receipt of the request for the expedited review.

7.6.b. If the expedited review of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

7.7. For purposes of calculating the time periods within which a decision is required to be made under subsection 8.6 of this rule, the time period within which the decision is required to be made shall begin on the date the request is filed with the issuer in accordance with the issuer's procedures established pursuant to section 4 of this rule for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

7.8.

7.8.a. A notification of a decision under this section shall, in a manner calculated to be understood by the covered person, set forth:

7.8.a.1. The titles and qualifying credentials of the person or persons participating in the expedited review process (the reviewers);

7.8.a.2. Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider and, if applicable, the claim amount;

7.8.a.3. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. For purposes of this paragraph, an issuer:

7.8.a.3.A. Shall upon request provide to the covered person, as soon as practicable, the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning, associated with any adverse determination; and

7.8.a.3.B. Shall not consider a request for the diagnosis code and treatment information, in itself, to be a request for external review pursuant to W. Va. Code of St. R. §114-97-1 *et seq.*;

7.8.a.4. A statement of the reviewers' understanding of the covered person's grievance;

7.8.a.5. The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the issuer's position;

7.8.a.6. A reference to the evidence or documentation used as the basis for the decision; and

7.8.a.7. If the decision involves a final adverse determination, the notice shall provide:

7.8.a.7.A. The specific reasons or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as description on the issuer's standard, if any, that was used in reaching denial;

7.8.a.7.B. Reference to the specific plan provisions on which the determination is based;

7.8.a.7.C. A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

7.8.a.7.D. If the issuer relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

7.8.a.7.E. If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

7.8.a.7.F. If applicable, instructions for requesting:

7.8.a.7.F.1. A copy of the rule guideline, protocol or other similar criterion relied upon in making the adverse determination in accordance with subparagraph D, paragraph 7, of this subdivision;

7.8.a.7.F.2. The written statement of the scientific or clinical rationale for the adverse determination in accordance with subparagraph E, paragraph 7

of this subdivision;

7.8.a.7.F.3. A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to W. Va. Code of St. R. §114-97-1 et. seq.;

7.8.a.7.F.4. A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction;

7.8.a.7.F.5. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

7.8.a.7.F.6. A notice of the covered person's right to contact the Commissioner for assistance with respect to any claim grievance or appeal at any time, including the telephone number and address of the Commissioner's office.

7.8.b.

7.8.b.1. An issuer shall provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations.

7.8.b.2. To be considered to meet the requirements of paragraph 1 of this subdivision, the issuer shall:

7.8.b.2.A. Provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;

7.8.b.2.B. Provide, upon request, a notice in any applicable non-English language; and

7.8.b.3. For purposes of this subdivision, with respect to any United States County to which a notice is sent, a non-English language is an applicable non-English language if ten (10) percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

7.8.c.

7.8.c.1. An issuer may provide the notice required under this section orally, in writing or electronically.

7.8.c.2. If notice of the adverse determination is provided orally, the issuer shall provide written or electronic notice of the adverse determination within three (3) days

following the oral notification.

**§114-96-8. Penalties.**

Any issuer failing to comply with the requirements of this rule is subject to the penalties prescribed in W. Va. Code §33-3-11.