Notice of Grievance Procedures

In accordance with Chapter 60 of Title 22
of the District of Columbia Municipal Regulations
Health Benefits Plan Members Bill of Rights

Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328

Please read this notice carefully. This notice contains important information about how to file grievances with us. You also have the right to ask us to assist you in filing a grievance, or review our decisions involving your requests for service or your requests to have your claims paid.

I. Definitions

"Adverse Determination" means a denial, reduction, limitation, termination, failure to make a payment for a benefit, or a delay of benefit to a member, regarding determinations about: the medical necessity, appropriateness, or level of care, or health care setting; whether a benefit is experimental or investigational; a decision to rescind coverage; or a member's eligibility to participate in a plan.

"Grievance" means a written request by a member or member representative for review of a decision by us to deny, reduce, limit, terminate or delay covered health care services to a member, including a determination about the medical necessity, appropriateness, or level of care, health care setting, or effectiveness of a treatment; a determination as to whether treatment is experimental; our decision to rescind coverage; failure to provide or make payment that is based on a determination of a member's eligibility to participate in a plan.

II. Levels of Review

The following levels of review will be available to a member:

Informal Internal Review

Formal Internal Review - following Informal Internal Review if grievance is not resolved

External Review - following a two-level internal review, the member has a right to request an external review. Request must be made within 4 months following receipt of an adverse formal internal review grievance decision.

A. Informal Internal Review

Any member dissatisfied with an adverse decision shall be provided an opportunity to discuss and review the decision with our quality control unit. The member has a right to designate a member representative to participate in the grievance process. A written decision to the member will be provided within 14 working days after the request for the informal internal review has been filed. The written explanation of a grievance decision following the informal internal review will also include notice to the member of their right to request a formal internal review.

B. Formal Internal Review

A member or member representative dissatisfied with the grievance decision may seek a formal internal review before a reviewer or a panel of health care professionals selected by us based upon the specific issues presented by the grievance.

Each request for a formal internal review shall be acknowledged by us in writing, to the member or member representative within 10 business days of receipt. If we have determined that there is insufficient information to complete the formal review, we shall notify the member that we cannot proceed with the grievance review without additional information, specifying what additional information is required and that we will assist the member in gathering the necessary information without further delay.

The reviewer or panel selected shall not have been involved in the grievance decision under review. In all reviews requiring medical expertise, the reviewer or panel shall include at least one medical reviewer trained and certified, by a recognized specialty board in the same specialty as the matter at issue. Each medical reviewer shall be a health care provider possessing a non-restricted license to practice and have no history of disciplinary action or sanctions pending or taken against them by any governmental or professional regulatory body.

Each formal internal review shall be concluded as soon as possible after receipt of all necessary documentation by us, but in no event later than 30 business days after we have received notice of the request for a formal internal review.

C. External Review

The member has a right to request an external review after exhausting our internal grievance process. The member has 4 months after the receipt of an adverse formal internal review decision to file a request for an external review with the Director of the Department of Health. The member also has a right to request external review if a grievance decision has not been rendered within 30 business days after the filing of a grievance.

D. Written Decision

When a decision is issued from any level of review, the following information will be included in the written decision:

1. a statement of the reviewer's understanding of the grievance;
2. the decision stated in clear terms and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision; and
3. a description of the process to request the next level of reviews, as applicable. These instructions will include telephone numbers and titles of persons to contact and the applicable time frames. These instructions will be in at least 12-point typeface.

E. Getting Assistance

You may contact us by submitting a request for review to:

Attn: Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328
FAX: 402-309-2579

If you are dissatisfied with the resolution reached through our internal grievance system regarding medical necessity, then you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases, District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
441 4th Street, NW
Suite 900S
Washington, D.C. 20001
1 (877) 685-6391

If you are dissatisfied with the resolution reached through our internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

For Non-Medical Necessity cases, Commissioner
Department of Insurance, Securities and Banking
1050 First St, NE
Suite 801
Washington, D.C. 20002
202-727-8000
Fax: (202) 354-1085

The District of Columbia established the Office of the Health Care Ombudsman and Bill of Rights within the District of Columbia Department of Health Care Finance. This office was created to counsel and provide assistance to uninsured District of Columbia residents and individuals insured by health benefits plans in the District of Columbia regarding matters pertaining to their health care coverage. Contact the Office of Health Care Ombudsman & Bill of Rights if you need help:

- Understanding your health care rights and responsibilities;
- Resolving problems with health care coverage, access to health care, or your health care bills;
- Appealing your health plan's decision; and
- Finding other health care resources.

You may contact the Office of Health Care Ombudsman and Bill of Rights at the following:

Government of the District of Columbia
Office of Health Care Ombudsman & Bill of Rights
441 4th Street, NW
Suite 900S
Washington, DC 20001
Direct Telephone Number: 202-724-7491 or 1-877-685-6391
General Fax: 202-442-6724
Confidential Fax: 202-478-1397
eMail: healthcareombudsman@dc.gov
Website: healthcareombudsman.dc.gov

F. Cultural and Linguistic Support

We want to be sure this information is helpful to you. Interpreting services are available toll free at 800-487-5553. Upon request, we will provide certificates of coverage and provider directories in Spanish, or large print for the visually impaired. We are prepared to help hearing impaired members who access TDD or TTY "text telephone" systems when contacting us.