

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

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**POLICY NUMBER:** 10B

**POLICY TITLE:** Grievance/Appeal Procedures for Commercial Members - Wisconsin

**POLICY STATEMENT:** To assure a timely, efficient and consistent process for administering grievance procedures for members covered by Wisconsin based employer groups.

**NOTE:** It is the intent of this Policy and Procedure to comply with applicable law. To the extent there is conflict between the procedures in this Policy 10B and applicable statutory and/or regulatory law, the relevant statutes/regulations will control. Grievance procedures in Wisconsin are governed by Wis. Stat. § 632.83 and Wis. Admin Code Chapter 18.

- *All notifications to members will be in a cultural and linguistic appropriate manner.*
- *For concurrent care appeal decisions, enrollees are allowed to have continued coverage under their medical benefit pending the outcome of the appeal.*

**PROCEDURE:**

**A. Preliminary Matters:**

*At any time of the grievance process, Medical Associates Health Plans (MAHP) will inform the Member of his/her right to be represented by someone of his/her choosing and to communicate by conference call or other technology. The Member is given the opportunity to submit written comments, documents, records or other information relevant to the grievance. The Member can request access and copies of all documents relevant to the Member's grievance.*

**Under Wisconsin law, a “Grievance” is a written expression to an insurer expressing any dissatisfaction, including as to services or claims. A written request for appeal of a coverage decision (an adverse benefit determination) is considered a Grievance.**

*Note: According to the Wisconsin OCI interpretation of applicable law as communicated via SERFF, there is no limit to the time for a member to request a Grievance, including a Grievance regarding an adverse benefit determination.*

**Definition of “Grievance”:**

Wis. Admin Code § Ins. 18.01(4) defines “grievance” as “any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insured that has expressed in writing to the insurer by or on behalf of an insured including any of the following:

- a. Provision of services;
- b. Determination to reform or rescind a policy;
- c. Determination of diagnosis or level of service required for evidence-based treatment of autism spectrum disorders;
- d. Claim practices.”

**B. General Procedure for Handling a Grievance:**

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

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Upon receipt of a Grievance, including a quality-of-care Grievance regarding any practitioner or provider, the Grievance will be forwarded to Member Services and/or delegate to oversee the Grievance process.

- a. Written acknowledgement of the Grievance will be sent to the Member within five (5) business days of receipt (Attachment A).
- b. The substance of the Grievance and the action taken will be documented.
- c. The substance of the Grievance will be fully investigated, including all aspects of clinical care involved.
- d. The Member will have the opportunity to submit written comments, documents, records or other information relating to the Grievance.
- e. The Grievance Committee will review the Grievance within 30 calendar days of receiving the request. If the Grievance cannot be resolved within 30 calendar days, a letter will be sent to the Member or the Member's representative explaining that an additional 30 calendar days are needed (Attachment B). The letter shall state:
  - i. that the Grievance has not been resolved
  - ii. when resolution may be expected
  - iii. reason why additional time is needed.
- f. The Grievance Committee members may not have been previously involved in the initial decision or the subordinate of any person involved in the initial determination. If a committee member was previously involved or is a subordinate, this member will not participate in the resolution/decision of the Grievance Committee.
- g. The Member or Member's representative has a right to appear (via conference call or in person) before the Grievance Committee and shall be notified of this right in writing no less than seven (7) calendar days before the Grievance meeting (Attachment A)
- h. If the Member or Member's representative cannot appear in person, he or she may choose to communicate with the Grievance Committee by conference call. This option is given when the member is notified of his or her right to appear.
  - i. The Committee shall consist of three (3) persons who have not been previously involved in making the initial decision. Two (2) members shall be MAHP Members and one (1) member shall be the Chief Operating Officer (or his/her designee).
  - ii. Member Services shall document the meeting with formal minutes and under the direction of the chairperson and committee formulates the response of the grievance to the Member.
- i. Written notification of the disposition of the Grievance and the right to Independent Review, when appropriate, will be sent to the member within 30 calendar days of receipt of the Grievance (Attachment C or D)
  - i. Notification will include:
    - a) The specific reason for the Grievance decision in easily understandable language.
    - b) Reference to the benefit provision, guideline, protocol or other similar criterion on which the Grievance decision was based.
    - c) Notification that the Member, upon request, can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the Grievance decision was based.
  - ii. Notification that the Member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the Member's Grievance.
  - iii. A list of titles and qualifications of individual(s) participating in the Grievance review.
  - iv. For Grievances involving any clinical issues, a practitioner who has appropriate training and experience in the field of medicine involved in the medical judgment, will

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

---

review the Grievance. This practitioner will not have participated in any of MAHP's prior decisions on the case.

- j. The Member Services Manager or designee logs all Grievances into the appeals/grievance Excel spreadsheet, documents the Grievance decision, and aggregates Grievances by category and turnaround time. The Quality Improvement (QI) Manager takes appeal reports to the Quality Improvement Committee (QIC) for review and approval (see Attachment G).
- k. Grievance Definitions for annual reporting to the Wisconsin OCI are set forth in Attachment I. Grievances will be categorized according to the definitions required by the OCI: Access to Care (ATC); Continuity of Care (COC); Cost Sharing (CSG); Drug & Drug Formulary (DRG); Emergency Services/Urgent Care (ERS); Experimental Service (EXP); Not a Covered Benefit (NCB); Not Medically Necessary (NMN); Network Adequacy (NET); Out of Network (OON); Plan Administration (PLA); Plan Providers (PLP); Preventive Services (PVS); Prior Authorization (AUT); Request For Referral (REF).
- l. Grievance reports will be reviewed for accuracy by the MAHP Member Services Manager and a designated Manager in the Health Care Services Department on at least an annual basis. Following this review, and on at least an annual basis, Grievance reports will be submitted to the Quality Improvement Committee for its review and approval.

**C. Procedures for Expedited Grievances:**

1. A request for an urgent care Grievance will be considered if the time for making a non-urgent care determination:
  - 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.
2. An urgent care Grievance will automatically be granted for 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.
3. If the urgent care Grievance involves an urgent concurrent review determination, the organization must continue service without liability to the Member until it notifies the Member of the decision, unless the service relates to an initial unauthorized admission.
4. Urgent care Grievances will be resolved **within 72 hours after receipt of the Grievance, or sooner** as needed to accommodate the clinical urgency of the situation.
5. Upon written request, MAHP shall mail or e-mail a copy of the member's complete policy to the member (or the member's authorized representative) as expeditiously as the Grievance is handled.
6. A practitioner can act on behalf of the Member when registering an urgent care Grievance.
7. The substance of the Grievance and the action taken will be documented.
8. The substance of the Grievance will be fully investigated, including all aspects of clinical care involved.
9. The Member will have the opportunity to submit written comments, documents, records or other information relating to the Grievance.
10. The Grievance Committee members may not be members who were previously involved in the initial decision and are not the subordinate of any person involved in the initial determination. If a committee member was previously involved or is a subordinate, this member will not participate in the resolution/decision of the Grievance Committee.

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

---

11. The Member or Member's representative has the right to appear before the Grievance Committee and is notified of this at the time the urgent care Grievance request is received.
12. If the Member or Member's representative cannot appear in person, he or she may choose to communicate with the Grievance Committee by conference call. This option is given when the Member is notified of his/her right to appear.
  - a. The committee will consist of three (3) persons who have not been previously involved in making the initial decision. Two (2) members shall be MAHP members and one member shall be the Chief Operating Officer (or his/her designee).
  - b. The Member Services Department shall document the meeting with formal minutes and under the direction of the chairperson and committee formulates the response of the Grievance to the member.
14. The Member, Member's representative or practitioner (if acting on the member's behalf) will be notified of the decision within 72 hours of receipt of the urgent care Grievance via telephone or written correspondence. Verbal notification will be followed by written correspondence. Notification will include:
  - i. The specific reason for the Grievance decision in easily understandable language.
  - ii. Reference to the benefit provision, guideline, protocol or other similar criterion on which the Grievance decision was based.
  - iii. Notification that the Member, upon request, can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the Grievance decision was based.
  - iv. Notification that the Member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the Member's Grievance.
  - v. A list of titles and qualifications of individual(s) participating in the Grievance review.
  - vi. For Grievances involving any clinical issues, a practitioner who has appropriate training and experience in the field of medicine involved in the medical judgment, will review the Grievance. This practitioner will not have participated in any of MAHP's prior decisions on the case.
15. The Member Services Manager or designee will log all Grievances into the appeals/grievance Excel spreadsheet, document the Grievance decision, and aggregate Grievances by category and turnaround time.
16. Grievance Definitions for annual reporting to the Wisconsin OCI are set forth in Attachment I. Grievances will be categorized according to the definitions required by the OCI: Access to Care (ATC); Continuity of Care (COC); Cost Sharing (CSG); Drug & Drug Formulary (DRG); Emergency Services/Urgent Care (ERS); Experimental Service (EXP); Not a Covered Benefit (NCB); Not Medically Necessary (NMN); Network Adequacy (NET); Out of Network (OON); Plan Administration (PLA); Plan Providers (PLP); Preventive Services (PVS); Prior Authorization (AUT); Request For Referral (REF).
17. Grievance reports will be reviewed for accuracy by the MAHP Member Services Manager and a designated Manager in the Health Care Services Department on at least an annual basis. Following this review, and on at least an annual basis, Grievance reports will be submitted to the Quality Improvement Committee for its review and approval.

**D. Independent External Review by IRO**

**1. Statutory/Regulatory Definitions. (See Wis. Stat. § 632.835 & Wis. Admin Code § Ins. 18.10)**

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

---

Coverage Denial Determination means (i) an “Adverse Determination”, (ii) an experimental treatment determination, (iii) a pre-existing condition exclusion, (iv) denial of a request for referral when expertise is medically necessary but not available in-network, or (v) the rescission of a policy or certificate.

Adverse Determination is defined as treatment that “does not meet the health benefit plan’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.” This includes denial “of a request for a referral for out-of-network services when the insured requests health care services from a provider that does not participate in the insurer’s provider network because the clinical expertise of the provider may be medically necessary for treatment of the insured’s medical condition and that expertise is not available in the insurer’s provider network.

## **2. General Matters:**

- a. All Members who meet the independent external review criteria will be afforded the right to appeal a coverage denial determination to an IRO.
- b. Notification of independent external review rights will be given each time MAHP makes a coverage denial determination. The notice shall comply with Wis. Stat. § 632.835 and be accompanied by the informational brochure developed by the Office of Commissioner of Insurance (or similar form), describing the independent review process.
- c. Annually, members will be informed of the right to independent review.
- d. Wis. Stat. § 632.835 outlines notification requirements which will include:
  - i. A statement that the Member may have the right to an independent external review after the internal Grievance process is complete.
  - ii. A statement that the Member may be entitled to an expedited independent external review with respect to an urgent matter.
  - iii. A reference to the section of the policy or certificate that contains the description of the independent external review process.
  - iv. A statement that the Member should contact the Compliance Department for a list of IROs that MAHP has contracted with for the external review process.
  - v. An enclosure with the letter of the fact sheet from Office of the Commissioner of Insurance (OCI) on the independent review process (Attachment E).
- e. To request an independent review, a Member or Member’s authorized representative shall provide written notice of the request for independent review. When a request for independent external review is received by MAHP, written notification of the receipt must be sent to the selected IRO and the OCI **within 2 business days**.
- f. The IRO will determine if the Grievance meets the criteria for review. Examples of requests that do **not** meet the criteria for external review are as follows:
  - i. The Member has not exhausted the internal appeals process.
  - ii. The request does not qualify as an expedited request for review, so the request will be put through MAHP’s internal Grievance process.
  - iii. If the request exceeds the four (4) month limitation time frame. (The Member will be sent a letter of explanation.)
  - iv. The Grievance relates to administrative matters, including enrollment eligibility, not related to treatment or services.
  - v. Note: If the IRO determines the request does not meet the criteria for review, the IRO will notify the Member and MAHP within two (2) business days of receipt.

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

---

- g. Grievances eligible for independent external review rights must have exhausted the internal Grievance process, unless:
  - i. Both MAHP and the Member or the Member's representative, agree the Grievance should proceed directly to independent external review, or
  - ii. The IRO determines an expedited review is appropriate upon receiving a request from a Member or a Member's representative that is simultaneously sent to MAHP.
- h. An independent external review is available when:
  - i. Coverage for treatment has been denied because due to medically necessity, appropriateness, health care setting, level of care or effectiveness
  - ii. Coverage for treatment has been denied as experimental.
  - iii. The Grievance is based on a "coverage denial determination" (see definition, above), not a benefit determination.
- i. The IRO will determine:
  - i. If a conflict of interest exists. (The IRO shall provide written notification to MAHP, commissioner and the Member, or Member's representative within three (3) business days stating a conflict exists and decline to take the review.)
  - ii. The type of case for which the review is sought. (The IRO will determine if a case is a coverage denial determination or administrative issue. If the review is not a coverage denial determination, the IRO will notify MAHP, commissioner, Member or Member's representative of the determination within two (2) business days.)
  - iii. The specific question or issue that is to be resolved.
  - iv. Whether the case merits a standard or expedited review.
  - v. Criteria for the number and qualifications of the reviewer(s).
- j. The IRO will establish and maintain procedures to ensure that it is unbiased.
- k. All documentation will be sent without requiring written release from the Member.
- l. Information submitted to the IRO at the request of the IRO by either the Member, the Member's representative or MAHP, will be promptly provided to the other party for review.
- m. After the IRO's review, the decision notification will include:
  - i. The question/issue that was referred for review.
  - ii. A description of the qualification for the IRO's determination, including supporting documentation.
  - iii. The clinical rationale or explanation for the IRO's determination including supporting documentation.
  - iv. IRO decisions regarding adverse and experimental treatment determinations are binding on both the insured and MAHP.
- n. MAHP will have affected claims processed/reprocessed within 30 days of receipt of the IRO determination.
- o. MAHP will maintain data on each independent external review, including descriptions of the denied item(s), reason for denial, IRO decisions and reasons for decisions. This data will be reported to the Utilization Management Committee and the QIC to evaluate MAHP's medical necessity decision making process.
- p. MAHP will pay the fee submitted by the IRO within 30 days of receipt of the written invoice.

**3. Timelines: Standard Independent External Review:**

- a. The request for independent external review must be received at MAHP within four (4) months of the date of MAHP's Grievance decision letter.

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

---

- b. All documentation must be submitted to the selected IRO within five (5) business days of MAHP's written notification to the IRO of the receipt of the request.
- c. Additional information requested by the IRO must be sent within five (5) business days of the IRO request or an explanation of why the information is not being submitted.
- d. The IRO will send their decision in writing to MAHP and to the member within 30 business days of the receipt of the request or the receipt of the requested additional information, if applicable.

**4. Timelines: Expedited External Review:**

- a. If the request is an expedited Grievance, as determined by the selected IRO, all documentation must be sent to the IRO within one (1) business day of the expedited determination by the IRO.
- b. Additional information requested by the IRO for an expedited external review must be sent within two (2) business days of the IRO request.
- c. The IRO will make a determination within 72 hours of receipt or the requested additional information, and notify MAHP and the member within one hour of making their determination.

**E. Audit of the Grievance Process:**

Prior to the Grievance Committee meeting, an executive summary is prepared. When the grievance is completed, the designated Administrative staff updates the summary with the grievance decision. The executive secretary audits the file and completes the checklist (Attachment F) to ensure all grievance documents are included.

The Member Services Manager conducts a second audit. Once completed, he/she initials and dates the checklist (Attachment F). The designated executive secretary then scans the complete grievance file and links it to the member's file on the network system.

**F. Annual Grievance Reporting to the Wisconsin OCI:**

Wisconsin Stat. § 632.83, and Wis. Adm. Code Ins. 18.03 require that health benefit plans submit annual reports describing the internal grievance procedure and summarizing grievances received and resolved in the previous calendar year. This filing will be prepared and submitted by the Compliance Department in accord with the procedures of the OCI. Grievances on the appeals/grievance Excel spreadsheet for the prior calendar year will be audited by the Compliance Analyst or designee to confirm they are properly categorized pursuant to the Wisconsin OCI Grievance Definitions (see Attachment I).

NOTE: This policy and procedure identifies MAHP's grievance procedures. Member subscriber agreements may override this document to the extent permitted by law.

**G. Attachments:**

- A. Acknowledgement and Grievance Meeting Notification Letter
- B. Grievance Extension Letter
- C. Grievance Resolution Letter no IRO option
- D. Grievance Resolution Letter with IRO option
- E. Fact Sheet on the Independent Review Process in Wisconsin from the OCI.
- F. File Audit Checklist

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

---

- G. Clinical Criteria for Automatic Expedited Review
- H. Wisconsin Request for Additional Information
- I. Wisconsin OCI – 26-007 Grievance Definitions (as of 2/2/2016)

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Barb Koerperich, MSN  
Director of Quality and Health Care Services

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Date

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Karen Hoffmann  
Director of Operations

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Date

Original Effective Date: 06/95  
Revised Date(s): 02/96, 02/97, 08/97, 08/98, 01/99, 04/99, 08/99, 10/99, 04/00, 04/01, 07/01, 01/02, 02/02, 05/02, 06/02, 12/02, 01/03, 02/03, 12/03, 04/04, 01/05, 03/05, 05/06, 02/07, 01/08, 05/08, 02/09, 11/09, 04/10, 04/11, 03/12, 04/13, 04/14, 05/15, 05/16, 05/17, 5/18, 5/19, 3/20, 9/21

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**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

---

Date

**Attachment A  
Acknowledgment Letter &  
Grievance Meeting  
Notification Letter**

Name

Address

City, State Zip

Dear

On (**Date**), Medical Associates Health Plans (MAHP) received a written request from you to file a grievance. The grievance request is on behalf of (**name of patient**). The request is for services received at (**name of Provider/facility**) on (**DOS**).

This letter is to notify you that the Grievance Committee will meet (**day and time of meeting**). The meeting will be at MAHP, 1605 Associates Dr., Suite 101, Dubuque, Iowa. You have the right to appear in person. You may also invite a representative to be present at the Grievance Committee meeting. You or your representative may present any written and/or oral information you would like the Committee to consider.

If you choose to appear before the Committee, you must notify us. If you are unable to appear before the Committee, you may schedule a conference call. Please confirm at 563.584.4885 or 1.866.821.1365.

Sincerely,

Laura A. Boge  
Member Services Manager

Medical Associates Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-821-1365 (TTY: 1-800-735-2942).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-821-1365 (TTY: 1-800-735-2942)

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

---

Date

**Attachment B  
Wisconsin Grievance Extension Letter**

Name  
Address  
City, State, ZIP

Dear

Medical Associates Health Plans is in the process of reviewing your grievance, but is in need of additional information. Therefore, we need to inform you that a 30-day extension is necessary for the resolution of your grievance. We apologize for the delay.

In order to proceed with your grievance, please provide the additional information necessary for resolution as soon as possible. If you have any questions, feel free to contact the Member Services Department at (563) 584-4885 or 1-866-821-1365.

Sincerely,

Laura A. Boge  
Member Services Manager

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LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-821-1365 (TTY: 1-800-735-2942)

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

---

**Attachment C  
WI Grievance Resolution Letter No IRO option**

Date

Name  
Address  
City, State ZIP

Dear Name:

As you are aware, the Grievance Committee of Medical Associates Health Plans met on Date. The Committee met to review and resolve the matter relating to the denial of services for you at Provider on DOS.

In regards to your request for services with Provider at the Provider Site, your Subscriber Agreement, Contract, states: "Contract language"

The Grievance Committee considered all the information presented by you, as well as the information provided by the staff of Medical Associates Health Plans. Based upon the terms of the Subscriber Agreement, the conclusion of the Grievance Committee was that services had been appropriately denied at Provider/location.

You have now exhausted Medical Associates Health Plans' internal appeals and grievance processes.

Sincerely,

Chief Medical Officer  
Medical Associates Clinic & Health Plans

Cc: Chief Operating Officer  
Director of Quality and Health Care Services  
Grievance Committee Members

Director of Operations  
Director of Finance

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LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-821-1365 (TTY: 1-800-735-2942)

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

---

Date

**Attachment D  
WI Grievance Resolution Letter with IRO Option**

Name

Address

City, State ZIP

Dear Name:

As you are aware, the Grievance Committee of Medical Associates Health Plans met on Date. The Committee met to review and resolve the matter relating to denial of services for you at Provider on DOS.

In regards to your request for services with Provider at the Provider Site, your Subscriber Agreement, Contract, states: "Contract language"

The Grievance Committee considered all the information presented by you. The Committee also considered the information provided by the staff of Medical Associates Health Plans. Based on the terms of your Subscriber Agreement, the conclusion of the Grievance Committee was that Services had been appropriately denied at Provider/location.

You have now exhausted Medical Associates Health Plans' internal appeals and grievance processes. If you wish, you may pursue your decision to another level. You have the right to send your grievance to an Independent Review Organization (IRO). To file with an IRO, you will need to send the following information to Medical Associates Health Plans, Attention Laura Boge, Member Services Manager, at 1605 Associates Drive, Dubuque, IA 52002:

1. A written request for the IRO within four (4) months of receipt of this letter.
2. An explanation for why your claim should be paid, including any supporting documentation.
3. If someone is filing on your behalf, include a statement signed by you, authorizing them to be your representative.

The decision of the IRO is binding on Medical Associates Health Plan and on you.

I have enclosed an informational brochure on the Independent Review Process. This was developed by the Wisconsin Office of the Commissioner of Insurance.

If you have any questions, please feel free to contact our Member Services Department at (563) 584-4885 or toll free at (866) 821-1365.

Sincerely,

Laura A. Boge

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

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Member Services Manager

Cc: Chief Operating Officer  
Director Health Care Services  
Director of Finance  
Director of Operations  
Grievance Committee Members

Enclosures: OCI informational Brochure

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LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-821-1365 (TTY: 1-800-735-2942)

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

---

**Attachment E  
Fact Sheet on the Independent Review Process in Wisconsin from the OCI**

# MEDICAL ASSOCIATES HEALTH PLANS OPERATIONS POLICY AND PROCEDURES MANUAL

STATE OF WISCONSIN

## Fact Sheet on the Independent Review Process in Wisconsin

OFFICE OF THE COMMISSIONER OF INSURANCE

PI-203 (R 01/2019)

This fact sheet provides general information on the independent review process in Wisconsin. If you have specific questions on how it may apply to your situation, please contact your insurance company or the Office of the Commissioner of Insurance (OCI).

### What is an independent review?

An independent review is a process allowing an outside expert to provide a second look at your claim. Because the reviewer is not affiliated with you or the insurer, the reviewer is able to conduct an independent and unbiased review of your claim.

### What types of disputes can be decided through independent review?

An independent review is available whenever your health plan denies you coverage for treatment because it maintains the treatment is not medically necessary or it is experimental, including a denial of your request for out-of-network services when you believe the clinical expertise of the out-of-network provider is medically necessary. The treatment must otherwise be a covered benefit under the insurance contract.

An independent review is also available whenever your health plan denies you coverage for treatment on the basis of a preexisting condition exclusion.

You may also request an independent review if the insurer rescinds your health insurance policy or certificate. Rescission means the insurer retroactively cancels your policy or modifies the terms of the policy because it maintains you did not answer the health questions on the application for insurance completely and accurately.

If you and your insurer disagree about whether or not your dispute is eligible for independent review, you may request it be sent to an Independent Review Organization (IRO). The IRO will decide if it has the authority to do the review.

### What types of disputes are not eligible for independent review?

You may not request an independent review if the requested treatment is not a covered benefit. For example, if your policy specifically excludes coverage of weight loss treatment, your request to have the

insurer cover your weight loss treatment would not be eligible for independent review, even if you believed the treatment was medically necessary.

Also, if your dispute involves an administrative issue such as whether your premium was paid on time, it is not eligible for an independent review. However, you would be able to ask the insurer to review your concerns through its internal grievance process.

If you have coverage through Medicare, Medicaid, or another federal plan, or if you are covered through your employer's self-funded plan, you are not eligible to request the independent review described in this publication. These plans generally have a different appeal process, which is explained in your member materials.

### Who conducts the independent reviews?

The independent review process provides you with an opportunity to have your dispute reviewed by experts who have no connection to your health plan. The IRO assigns your dispute to a clinical peer reviewer who is an expert in the treatment of your medical condition. The clinical peer reviewer is generally a board-certified physician or other appropriate medical professional.

In some cases, the IRO will also consult with an attorney or other insurance expert. The IRO has the authority to uphold or reverse the health plan's decision.

### When can I request an independent review?

Whenever your insurer makes a coverage denial determination, it must provide you with information on your appeal rights, including its internal grievance procedures and your right to request an independent review. In most cases, you will need to complete your health plan's internal grievance procedure before requesting an independent review.

### How do I request an independent review?

The insurer's final written decision on your grievance should include a notice explaining how to request an independent review. Send your written request for independent review to the address provided in the insurer's final written decision within 4 months of the date the grievance procedure was completed.

## MEDICAL ASSOCIATES HEALTH PLANS OPERATIONS POLICY AND PROCEDURES MANUAL

Be sure to include:

- Your name, address, and phone number
- An explanation of why you believe the treatment should be covered
- Any additional information or documentation supporting your position
- If someone else is filing on your behalf, a statement signed by you authorizing the person to be your representative
- Any other information requested by your insurer

**What documents should I provide to help the IRO make a determination?**

You may provide the IRO any information you think will support your case. This may include your medical records and test results, a letter from your physician or research articles from peer-reviewed medical journals.

**What if I need care now?**

Generally, you must complete your health plan's internal grievance procedure before requesting an independent review. However, you do not need to complete this process if both you and the insurer agree to proceed directly to independent review or if you need immediate medical care.

If you need immediate medical treatment and believe the time period for resolving an internal grievance will cause a delay, jeopardizing your life or health, you may ask to bypass the insurer's internal grievance process.

When you obtained your coverage, your health plan should have provided you with written information explaining the independent review process. You may also contact the health plan to request information on the independent review process.

When you have the information you need, send your request for an expedited independent review at the same time you send the insurer your expedited grievance request. The IRO's medical director or other medical professional will review your request and decide if an immediate review is needed. If so, it will review your dispute on an expedited basis.

If the IRO decides your health condition does not require its immediate review of your dispute, it will notify you to first complete the internal grievance process.

**Is there a cost involved?**

There is no cost to you for requesting an independent review. Your health plan is required to pay the IRO's fees.

**How long does the independent review process take?**

Within 5 business days, the insurer must send to the IRO:

- all relevant medical records and other documentation used in making its decision
- all of the documentation you sent to support your request

The IRO then has 5 business days to request any additional information it may need from the insurer or from you, and no more than 30 business days to make its decision.

If the IRO determines this time period could jeopardize your life or health, the insurer must send its documentation within 1 day and the IRO then has 2 business days to request any additional information. The IRO must notify you and the insurer of its decision no later than 72 hours after receiving the review request.

**How does the IRO make its decision?**

The IRO must consider all of the documentation and other information provided by you and the insurer, including medical or scientific evidence, the applicable insurance contract, and any legal bases.

It may reverse an insurer's denial based on an experimental treatment determination if it determines the treatment has been approved by the FDA, when required, and also when medically and scientifically accepted evidence clearly demonstrates the treatment is proven safe and can be expected to produce greater benefits than the standard treatment without posing a greater adverse risk.

**Does my health plan have to abide by the decision?**

Yes, the decision of the IRO is binding.

**What if I have more questions?**

Your insurer's customer service department should be able to answer any questions you may have regarding the independent review process.

Additional information on the federal external review process may be found from the U.S. Department of Health and Human Services at The Center for Consumer Information & Insurance Oversight's website: [www.cms.gov/CIIIO/Programs-and-Initiatives/Consumer-Support-and-Information/External-Appeals.html](http://www.cms.gov/CIIIO/Programs-and-Initiatives/Consumer-Support-and-Information/External-Appeals.html).

For more information on the entire appeals process, see the [Consumer's Guide to Health Insurance, Grievances and Complaints](#) publication available on OCT's website.

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

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If you have a specific complaint about your insurance, you should first attempt to resolve your concerns with your insurance agent or with the company involved in your dispute. If you do not get satisfactory answers from the agent or company, contact OCI. A complaint form is available on OCI's website at [ociaccess.oci.wi.gov/complaints/public/](http://ociaccess.oci.wi.gov/complaints/public/).

OCI's Website  
[oci.wi.gov](http://oci.wi.gov)

Phone

(608) 266-0103 (In Madison)  
or  
1-800-236-8517 (Statewide)

Mailing Address  
Office of the Commissioner of Insurance  
P.O. Box 7873  
Madison, WI 53707-7873

E-Mail  
[ocicomplaints@wisconsin.gov](mailto:ocicomplaints@wisconsin.gov)  
Please indicate your name and phone number.

Deaf, hearing, or speech impaired callers  
may reach OCI through WI TRS

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

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**Attachment F  
Wisconsin Grievance Checklist**

(Please initial and date that you have reviewed the contents)

**Letter requesting Grievance from member:** \_\_\_\_\_  
(date stamped) (Member Services)

All information recorded in Excel  
(Member Services) \_\_\_\_\_

Acknowledgement letter sent to member  
(within 5 days) (Exec Assistant) \_\_\_\_\_

Letter sent to member indicating needing  
more time and why. (Exec Assistant) \_\_\_\_\_

Pre Grievance Executive Summary  
(include information packet & minutes)  
(Exec Assistant) \_\_\_\_\_

Grievance Meeting Minutes (Exec Assistant) \_\_\_\_\_

IRO Rights letter (sent if experimental or  
if decision is based on medical necessity)  
(Exec Assistant) \_\_\_\_\_

Letter sent with Grievance decision  
(Exec Assistant) \_\_\_\_\_

Letter from IRO with decision  
(Exec Assistant) \_\_\_\_\_

IRO refund sent back to member  
(This applies if decision overturned in  
anyway) include letter and copy of check  
(Member Services) \_\_\_\_\_

All information reviewed and filed  
(Member Services) \_\_\_\_\_

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

---

**Attachment G  
Clinical Criteria for Automatic Expedited Review**

1. All denials for continued home health care.
2. All denials for continuing Physical Therapy within 6 months of a CVA, head injury/surgery, or other acute trauma.
3. All denied first requests for Physical Therapy within 4 months of a CVA, head injury/surgery, or other acute trauma.
4. All denials for continuing Physical Therapy within 6 months of a major joint (e.g. hip, total knee) surgery.
5. All denied first requests for continuing Physical Therapy within 4 months of major joint surgery.
6. All denials for chemotherapy, radiation therapy or proposed treatment of a known malignancy.
7. All denials of a proposed AIDS therapy in an AIDS patient.
8. All denials of a proposed “experimental” treatment in a terminal patient.
9. Any request by a practitioner for medical services and/or pharmaceuticals for urgent determination/recon review of denied services.
10. Any call where there is a refusal by the provider to proceed with a scheduled service/test because MAHP denied authorization on a service, which requires prior authorization (e.g. surgery scheduled but no authorization issued on which to proceed).
11. Any denied services during concurrent review in any inpatient facility.

\*All other pre-service cases would be judged case-by-case as to whether failure to grant an expedited review/denial could mean harm to the member if it was delayed to appeal/grievance time standards.

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

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**Attachment H  
Wisconsin Request for  
Additional Information**

Date

Subscriber Name  
Address  
City/State/Zip

Dear Subscriber:

On (Date), a written request for a grievance was received from you by Medical Associates Health Plans (MAHP). The Grievance is regarding the denial of coverage for you for (Service) to be done at (Place) on (Date). This letter is to notify you that additional information is required to evaluate your grievance. We have requested additional information from (Who) on (When). You may want to contact (Who) on the status of your request.

Once all the information is received, MAHP will make a decision on your grievance. If the information is not received within 60 days of your grievance request, the grievance will be closed.

If you have any questions on pre-service claims, please call Health Care Services at 563.584.3275 or 1.800.325.7442 or Member Services at 563.584.4885 or 1.866.821.1365.

Sincerely,

[[Name], Manager, Member Services]  
[[Name], Health Care Services]

CC.

Medical Associates Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-821-1365 (TTY: 1-800-735-2942).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-821-1365 (TTY: 1-800-735-2942)

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

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**Attachment I**

**Wisconsin OCI - 26-007 Grievance Definitions**

*(as of 2/2/2016)*

1. **Access to Care (ATC)** – A grievance related to a provider’s hours of operation, waiting times, or hours of availability.
2. **Continuity of Care (COC)** – A grievance related to continuity of care.
3. **Cost Sharing (CSG)** – A grievance related to deductibles, coinsurance, copayments or maximum out of pocket limits. \*
4. **Drug & Drug Formulary (DRG)** – A grievance related to prescription drug benefits; a drug formulary; or any prescription drug benefit or formulary requirements, preauthorization, processes and/or procedures.
5. **Emergency Service/Urgent Care (ERS)** – A grievance related to total or partial denial of coverage, member liability for charges in excess of maximum allowable amount for use of emergency services out of network or cost differential between Emergency Service and Urgent Care.
6. **Experimental Service (EXP)** – A grievance related to experimental or investigational treatment.
7. **Not a Covered Benefit (NCB)** – A grievance related to a denial of benefit for services specifically excluded in policy/certificate and is not subject to external review.
8. **Not Medically Necessary (NMN)** – A grievance related to a denial of benefits determined by the plan as not medically appropriate based on medical evidence.
9. **Network Adequacy (NET)** – A grievance related to network adequacy including but not limited to geographic availability, number and type of plan providers, or telemedicine. \*
10. **Out of Network (OON)** – A grievance related to denial of or application of out of network benefits due to services received by an out of network provider including but not limited to out of network ancillary services related to an in-network service, member erroneously advised by any entity that a provider is in network, or member referred to an outdated provider directory. \*
11. **Plan Administration (PLA)** – A grievance related to customer service issues, underwriting, or similar administrative functions including, but not limited to billing, enrollment, and terminations.
12. **Plan Providers (PLP)** – A grievance related to administration of services by plan providers including quality of care.
13. **Preventive Services (PVS)** – A grievance related to preventive services verses diagnostic services. \*
14. **Prior Authorization (AUT)** – A grievance related to total or partial denial of benefits due to lack of prior authorization or for timely completion of prior authorization.
15. **Request For Referral (REF)** – A grievance related to a denied request for a referral to an in network or out of network provider prior to receiving services or for timely completion of request for referral.